Emily Anne Staples Tuttle papers.

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Dateline Denver

NATIONAL CONFERENCE OF STATE LEGISLATURES JULY 6, 1978

David Obey

George Will

Alan Rosenthal

Delegates Focus on Legislative Power

Ballroom, 10:00 am-12:15 pm

The recent resurgence of Congress in federal decision making and the reassertion of legislative power in the states will be the focus of discussion at today's Opening Plenary Session on "The Legislature as an Institution." Featured speakers are Rep. David R. Obey (D-Wi.), Professor Alan Rosenthal and columnist George Will.

Obey, now in his fifth congressional term, served as chairman of the Democratic Study Group's Task Force on Congressional Reform in 1974. He will examine the motivation behind Congress' decision to take a more aggressive role in establishing federal policy, assessing whether this has been a gradual development or one triggered by a specific incident. The need for extensive hearings, negotiation and debate on legislation are among the problems which Congress still faces in attempting to assert itself as the policy-making branch of the federal government. Obey will discuss each of these obstacles and explore ways in which Congress and the state legislatures can better share innovative ideas and work together toward common goals.

Discussion will then shift to the state level, as Rosenthal looks at state legislatures' efforts to become the policy-making branch of state government. Recent improvements and modernizations in the legislatures will be highlighted, including increased staffing and staff specialists and the use of computers, television, videotape systems and other new technologies. Rosenthal will assess the tangible results of these improvements, suggest areas which still need substantial work and advise delegates on future problems which can be anticipated and planned for.

As Director of the Eagleton Institute of Politics at Rutgers University, Rosenthal has worked with or consulted with legislatures in more than half the states. His books on state legislative politics, including *Strengthening the States, Legislative Performance in the States* and *Politicians and Professionals,* reflect his broad experience in this area.

Political analyst George Will is scheduled to wrap up the plenary session with his observations on how well Congress competes with the President in making federal decisions, in contrast to how much state legislatures are actually making state government policy.

Will, a former congressional staff member, became contributing editor of *Newsweek* in 1976, writing a biweekly column in addition to his nationally syndicated column which now appears in 210 newspapers across the country. From his vantage point as an observer of the political scene, he will comment on the direction in which state legislatures appear to be headed.

Concurrent Sessions

Energy, Science, Natural Resources, Transportation, Urban and Rural Development

Thursday, 2:45-5:30 pm

An International Look At U.S. Energy Policy
Moderator: Rep. Mary O'Halloran (Ia.)
Breckenridge Room

The State Legislative Role in Water Management
Moderator: Sen. Dan Noble (Co.)
Colorado Room

Financing State Highway Systems
Moderator: Sen. Eugene Snowden (In.)
Empire Foyer

Fiscal Affairs

Thursday, 2:45-5:30 pm

Tax and Expenditure Limits
Moderator: Sen. James Kadlecek (Co.)
Empire Room

Education, Human Resources, Law and Justice

Thursday, 4:00-5:30 pm

The Impact of Spending and Taxing Limitations on School Districts
Moderator: Dr. Bill Wilken, NCSL
Terrace Room

Domestic Violence
Moderator: Herrick Roth
Gold-Century Rooms

General Government Operations

Thursday, 2:45-5:30 pm

Legislative Foresight: Public Choices for the Future
Moderator: Rep. Gordon O. Voss (Mn.)
Beverly Room

Federal Preemption: National Uniformity vs. States' Rights
Moderator: Robert Grimm, President, State Governmental Affairs Council
Silver Room

Civil Service Reform: The Legislative View
Moderator: Sen. Paul Offner (Wi.)
Savoy Room

Agenda

Thursday, July 6

8:00 am-6:00 pm	Registration, *Lobby*
7:30-8:30 am	Demonstration Two-Way Videoconference by Satellite, *University of Colorado Medical Center TV Studio*
7:45-10:00 am	Legislative Staff Breakfast Meeting, *Empire Room*
7:45-10:00 am	Legislative Leaders Breakfast Meeting, *Silver Room*
10:00 am-12:15 pm	Opening Plenary Session: "The Legislature as an Institution," *Ballroom*
1:00-2:30 pm	General Luncheon for All Delegates: "State Legislatures and Our Future Society," *Ballroom*
2:45-5:30 pm	Concurrent Sessions
4:30-6:00 pm	Nominating Committee Meetings, *Director's Rooms 540/541*
4:30-10:00 pm	Family Night Activities: Western Style Rodeo/Barbecue, *Old Coliseum*

Friday, July 7

8:00 am-2:00 pm	Registration, *Lobby*
7:45-9:00 am	Legislative Leaders Breakfast Meeting, *Assembly I*
9:00-11:30 am	Concurrent Sessions
9:00-11:30 am	Spouses Program, *Silver Room*
11:45 am-1:30 pm	General Luncheon for All Delegates: "The Influence of Media on Political Institutions," *Ballroom*
1:45-3:30 pm	Concurrent Sessions
3:45-5:30 pm	Concurrent Sessions
5:00-7:00 pm	Canadian Reception for U.S. Legislative Leaders, *Colorado Room*
7:00-10:00 pm	State Dinner, *Ballroom*
6:30-10:00 pm	Junior Delegates Program, *Court St. entrance of Denver Hilton*

Saturday, July 8

9:30-11:30 am	Annual Business Meeting, *Ballroom*
11:30 am-12:00 noon	Regional Caucus Meetings
12:00 noon-2:00 pm	Closing Plenary Session/Luncheon for All Delegates: "Creative Federalism: Relations Among Our Governments," *Ballroom*
2:00 pm	Adjournment

Concurrent Close-Up:

An International Look at U.S. Energy Policy

Participants will look at America's energy future and implications of possible U.S. choices on the rest of the world. If there is a risk of an energy crisis or a major world depression, should the U.S. try to decentralize electricity production? What are the implications of small-scale alternatives?

Domestic Violence

Panelists will examine the problem of domestic violence and services available, the role of the legislature in addressing the problem, and how the legal system handles victims of battering.

The State Legislative Role in Water Management

The content and implications of a National Water Policy for the state legislature, its challenge to the states' historical management of their own water resources, and changes in the traditionally passive federal role will be discussed.

National Columnist to Address Breakfast Session

Silver Room, 7:45-10:00 am

An in-depth look at "The Legislative Leader's Role in State-Federal Relations" will accompany the orange juice and coffee at this morning's Legislative Leaders Breakfast Meeting.

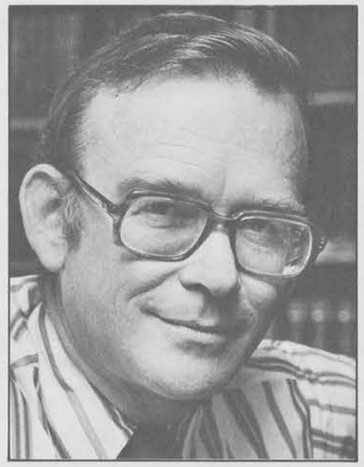
Neal Peirce, nationally known columnist on state/local affairs, will examine recent, current and expected federal developments of concern to state legislatures. Legislative leaders must look beyond their own statehouses, ready to act on as well as react to events in Washington, Peirce advises.

Peirce is well qualified to offer such advice and to delineate the areas on which legislators should focus their attention. As a founder and contributing editor of the *National Journal* and as political editor of the *Congressional Quarterly* throughout the 1960's, Peirce has been in constant touch with the nation's states and cities. He travels his beat—the 50 states—two weeks each month, writing a weekly column on state and local government and federal relations. The column, which began in 1975, has appeared in over 150 newspapers.

"I think you need to combine reporting from the grass roots and commentary to give focus and a national perspective to what's happening," Peirce says. He provides this national perspective not only through his column, but also through a set of nine volumes on "people, politics and power" in each of the states and regions of the United States. "I'm trying to report the best—and worst—of what's happening in our states and communities," he explains, "to cross-fertilize ideas, to show the amazing new forces at work at the local level across the country."

Following Peirce's call for legislative watchfulness in Washington, Maj. Ldr. Stanley Fink of the New York State Legislature will describe some of the ways in which state legislators can keep up with and influence federal events. Fink will discuss the operation of his state's Washington office as one of the ways he has found successful in highlighting state legislative concerns at the federal level. An increasing number of states are choosing this means of staying in touch with federal representatives and officials. Several states also hold regular meetings with their federal delegations, either in Washington or in the state capitals.

Rep. Richard Hodes, Chairman of NCSL's State-Federal Assembly, will wrap up the breakfast session with a discussion on NCSL's Washington Office of State-Federal Relations. Hodes will describe the capabilities and services available to legislative leaders to assist them in increasing their understanding of state-federal issues and augment their ability to have an impact on federal decision making.



Neal Peirce

Other Thursday Morning Meetings

Empire Room, 7:45-10:00 am

After meeting separately in committees throughout the past year, legislative staff members will have an opportunity to breakfast together this morning.

Dr. Robert S. Herman, outgoing NCSL Staff Vice President and Special Advisor to the Speaker in New York, will address delegates on "Legislative Staff in the Modern Legislature."

University of Colorado Medical Center, 7:30-8:30 am

Delegates who are not interested in starting the day with a healthy breakfast may prefer to begin with a two-way interactive videoconference. A satellite demonstration will link participants at the University of Colorado's Medical Center with those at NASA Headquarters in Washington, D.C.

Legislative representatives and White House staff in Washington will "meet" with public television personnel and interested legislators and staff in Denver to discuss "Videoconferencing for State Legislatures: How It Works, Applications, Costs." The focus will be on potential legislative applications of satellite videoconferencing, including interstate seminars, crisis conferences and data transmission.

NCSL will provide transportation from the downtown Denver hotels to the medical center. The NASA studio is located at 600 Independence Avenue, S.W. in Washington.

Birch Room, 7:45-10:00 am

National Association of Black Women Legislators Breakfast

Time Out for Fun . . .

Those who have the time to get down to the serious business of enjoying Denver can take advantage of one of the three tours which NCSL has planned for today.

Tour #1: Georgetown/Narrow Gauge Trainride, 8:00-4:00.

Tour #2: U.S. Air Force Academy/Broadmoor Luncheon, 8:00-4:00.

Tour #3: U.S. Air Force Academy/NORAD, 8:00-4:30.

Family Night, 6:00-10:00 pm

A special evening of family fun will begin with a western style barbecue prepared by the Colorado Cattlemen's Association and the Sheep Growers Association. Food will be followed by a real western rodeo, complete with team roping and bronco riding.

Legislatures in the Future and Tax Limitations Highlight Afternoon Program

Ballroom, 1:00-2:30 pm

The Reverend Jesse L. Jackson will reflect on "State Legislatures and Our Future Society" in an address to delegates at today's luncheon session. He will discuss the current changes he perceives in traditional values and the role of state government and its leaders in affecting or controlling these changes.

As founder and national president of Operation PUSH (People United to Save Humanity), Jackson is particularly concerned with the values and directions adopted by young people today. "If you tell me you can't manage your child at 16, you're probably right," Jackson concedes. "But you could have done it at age 6. You must raise the child while the child is a child." His PUSH Program for Excellence in big city schools aims at changing attitudes and motivations of students through parental, peer and other local community influences.

Jackson advocates an "old-fashioned, no-nonsense, nose-to-the-grindstone ethics" to achieve equity for all Americans, regardless of race. He will discuss the efforts which state governments can undertake to achieve equal opportunity, with an emphasis on how states and private enterprise can cooperate to improve the employment situation.

Long an advocate of racial equality and human rights, Jackson was appointed National Director of the Southern Christian Leadership Conference's Operation Breadbasket by the late Dr. Martin Luther King, Jr. in 1967. He served in that position until Christmas, 1971, when he founded PUSH.

Jackson's column for the Los Angeles Times syndicate appears in over 30 newspapers across the country.

Cassettes Available

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Jesse Jackson

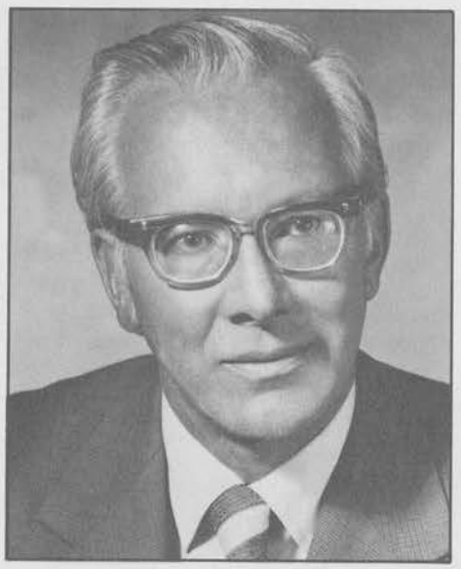
Gold-Century Rooms, 2:45-5:30 pm

"To lock yourself into expenditure limitations in the Constitution just runs counter to the sensible principles of constitution-making," economist Walter Heller said in a recent interview with *State Legislatures*. Acknowledging the public's anti-tax and anti-government mood, Heller pointed out that "you can never anticipate what shifts in public sentiment may occur." Such limitations may be a "constitutional hamstring," Heller warned, "if in the future, public opinion should swing back towards a larger government role, as in the case of a severe economic depression."

Heller, chairman of the Council of Economic Advisers under Presidents Kennedy and Johnson, will be the lead speaker at this afternoon's concurrent session on "Tax and Expenditure Limits." He views the tax limitation effort, most recently highlighted in the passage of the Jarvis-Gann initiative, as "essentially a retrograde movement."

Lewis K. Uhler, president and co-founder of the National Tax Limitation Committee, will join Heller in examining the economic and theoretical concept of placing tax limits on government, focusing on the pros and cons of statutory vs. constitutional approaches.

Following Heller's comments and a question/answer period, California



Walter Heller

Speaker Leo T. McCarthy will present his views on the issue of tax limits. Tennessee Rep. David Copeland and New Jersey Sen. John Russo will join participants in a panel discussion on the legislative response to tax limitation, moderated by Colorado Sen. James M. Kadlecek.

Discussion of the impact of Proposition 13 and similar "tax revolt" measures will explore the legislative decisions needed to comply with sizable reductions in revenues.

Editor
Andrea Kailo

Production & Design
Jean Gwaltney

NCSL Officers

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Dateline Denver

NATIONAL CONFERENCE OF STATE LEGISLATURES JULY 7/JULY 8, 1978

Ford to Address Legislators at Final Session

Gerald Ford

Ballroom, 12:00-2:00 pm, July 8

Former President Gerald R. Ford will address delegates at Saturday's closing plenary session and luncheon. Speaking on "Creative Federalism: Relations Among Our Governments," Ford will discuss the best ways for state legislators to express their views to the President and his Cabinet.

Ford will share his perspective on the ways in which a president can best use state and local government experiences in his search for solutions to common national or regional problems. This will include an examination of intergovernmental relations mechanisms—such as NCSL—which provide effective communications between the President's office and state and local officials.

During his thirteenth consecutive term as a Member of Congress from Michigan, Ford was nominated Vice President on October 12, 1973; he was confirmed to this office on December 6. He succeeded to the presidency on August 9, 1974, following the resignation of Richard Nixon.

Since leaving office in January, 1977, Ford has traveled over 400,000 miles, lecturing on college campuses and speaking to a variety of organizations. He is a Distinguished Fellow of the American Enterprise Institute in Washington, D.C.

Luncheon Fare: Politics and the Media

Sander Vanocur

Ballroom, 11:45 am-1:30 pm, July 7

Sander Vanocur, veteran broadcast journalist, will keynote Friday's luncheon session, sharing his views on "The Influence of Media on Political Institutions." Vanocur, now in charge of political and investigative reporting for ABC Television, will focus on the effect of both broadcast and print media on state and federal legislative institutions.

The national news media devotes a relatively small amount of its time and space to political developments at other than the federal level. Vanocur will discuss ways in which the media can be encouraged to cover positive and innovative state and local government developments, as well as reporting on negative events. He will examine the respective obligations and inherent conflicts between elected state officials and journalists.

After reporting for the *Manchester Guardian, The New York Times*, BBC and CBS, Vanocur joined NBC's Washington staff in 1957. Since that time, national politics has been his primary beat. He was appointed NBC White House Correspondent in 1961, and became National Political Correspondent for that network in 1964. Following several years of anchoring a number of television news programs, Vanocur was named vice president in charge of special reporting units for ABC Television.

As Director of the Duke University Fellows in Communications, Vanocur heads a program for the study of the influence of journalism on the political process.

Concurrent Sessions

Education, Human Resources, Law and Justice

Friday, 9:00-11:30 am

Legislative Oversight of State Mental Health Programs
Moderator: Rep. Hannah Atkins (Ok.)
Beverly Room

Jurisdiction Over Indian Reservations
Moderator: Spkr. Edward Manning (R.I.)
Gold Room

Friday, 1:45-3:30 pm

Older Americans: Alternatives To Nursing Home Care
Moderator: Sen. Jim Caldwell (Ar.)
Gold-Century Rooms

New Approaches to Sentencing
Moderator: Sen. Anthony Derezinski (Mi.)
Colorado Room

Friday, 3:45-5:30 pm

Child Pornography Laws
Moderator: Rep. Larry Burkhalter (Mi.)
Assembly 1

Energy, Science, Natural Resources, Transportation, Urban and Rural Development

Friday, 9:00-11:00 am

Nuclear Facility Decommissioning
Moderator: Rep. Mary O'Halloran (Ia.)
Savoy Room

Design for Success (Spouses Program)
Moderator: Anne Anderson, Colorado Host Committee
Silver Room

Friday, 1:45-5:30 pm

The National Energy Plan
Moderator: Rep. Bill Hilsmeier (Co.)
Empire Room

Friday, 1:45-3:30 pm

Water Quality Management: A Legislative Perspective
Moderator: Spkr. Nels Smith (Wy.)
Statler Room

Innovative Urban Programs: How Will the National Urban Policy Help the States?
Moderator: Sen. Douglas Bereuter (Ne.)
Vail Room

Friday, 3:45-5:30 pm

State Uses of Satellite Remote Sensing
Statler Room

Who Owns America's Farmland? State Legislation Limiting Corporate and Foreign Ownership
Moderator: Sen John Garamendi (Ca.)
Beverly Room

Fiscal Affairs

Friday, 9:00-11:00 am

Disability Pensions
Moderator: Sen. Paul Hanaway (R.I.)
Century Room

Legislative Oversight: Auditing as an Alternative to "Sunset"
Panel Discussion
Terrace Room

Friday, 1:45-3:30 pm

Property Tax Relief and Revenue Policy Choices
Moderator: Sen. John Mutz (In.)
Silver Room

Friday, 1:45-5:30 pm

Appropriations Workshop Number 1: Budgetary Information Systems
Moderator: Rep. Phyllis Kahn (Mn.)
Savoy Room

Inflation and the Decline of the Dollar
Moderator: Sen. Audrey P. Beck (Ct.)
Terrace Room

Friday, 3:30-5:30 pm

Appropriations Workshop Number 2: Appropriations and the Review of Federal Funds
Moderator: John Andreason, Legislative Fiscal Officer, Idaho
Empire Lounge

Appropriations Workshop Number 3: Opening Up the Appropriations Process
Moderator: Sen. Joe Clarke (Ky.)
Breckenridge Room

General Government Operations

Friday, 9:00-11:00 am

Time Management in the Legislature: Roundtable Number 1
Moderator: Rep. Don Avenson (Ia.)
Breckenridge Room

Time Management in the Legislature: Roundtable Number 2
Moderator: Rep. Joe D. Holt (Mo.)
Vail Room

Establishing and Documenting Legislative Intent
Moderator: Sen. Duane Woodard (Co.)
Statler Room

Public Television Coverage of State Legislatures and Internal Legislative Uses of Television and Videotape
Moderator: Dr. Phillip Halstead, NCSL
Empire Lounge

Friday, 1:45-3:30 pm

Legislative Information Systems: The Future of State-Federal Cooperation
Moderator: Sen. David J. Regner (Il.)
Beverly Room

Improving Staff Committee Effectiveness
Moderator: Dr. Kenneth Kirkland, NCSL
Breckenridge Room

"Capitolizing" on the Arts
Moderator: John Wolfe, Host of "In the Square," a daily radio interview program on the arts
Denver Art Museum, the Seminar Room

Friday, 3:45-5:30 pm

Legislative Internship Program
Moderator: Assy. William Passannante (N.Y.)
Assembly 3

SFA Policy Resolutions Submitted for Approval

The following resolutions were among those adopted by the State-Federal Assembly during 1977-1978. Each resolution was accepted by at least three-quarters of the states attending the respective SFA. They will be brought to the floor for ratification at NCSL's Annual Business Meeting on Saturday.

Criminal Justice

Federal Criminal Code Revision: NCSL supports Congressional efforts to revise and simplify the federal criminal code and assure a balance between state and federal criminal jurisdiction.

Education

Administration of Federal Education Programs: NCSL urges appointment of a sub-cabinet official with budgetary authority over federal education programs who will be responsible for liaison with the legislative and executive branches of state and federal government.

Energy

Nuclear Power Plant Licensing and Siting: NCSL recommends that states be given the responsibility for determining the need for nuclear power and for performing environmental analyses of proposed sites and facilities.

Nuclear Waste: While NCSL believes the federal government should have ultimate responsibility for accidents involving nuclear wastes, it asks the President, Congress and the Department of Energy to assist impacted states with funding for assessment of proposed nuclear waste repository sites.

Energy Impact Assistance: NCSL believes if states are to be responsible for a share of energy impact funding, states should also share with the federal government the authority to determine how the funds are to be spent.

Government Operations

Public Pension Recommendations: NCSL supports prohibiting changes in pension benefits by any body other than the state legislature and recommends the consolidation of state and local government pension plans into one plan.

U.S. Civil Service Reform: NCSL urges Congress to adopt legislation which would reform the federal Civil Service system. NCSL supports the Civil Service Reform Act of 1978 as a model for effective personnel management at all levels of government.

Taxable Bond Option: NCSL opposes adoption of a taxable bond option program by the federal government.

(continued on page 4)

Concurrent Close-Up

Appropriations Workshop Number 2: Appropriations and the Review of Federal Funds

One of three workshops on the appropriations process, this session will focus on different state procedures for reviewing federal funds flowing into the state and the political pressures involved in passing legislation providing for legislative review.

Public Television Coverage of State Legislatures

Representatives from 12 states using television coverage will look at the costs, funding, formats, equipment and staffing of public television coverage of state legislatures. Panelists include two producers of television shows covering the legislatures in Oregon and Florida.

Design for Success

An analysis of individual goals and approaches to positive living is designed for spouses of legislators.

Agenda

Friday, July 7

8:00 am-2:00 pm	Registration, *Lobby*
7:45-9:00 am	Legislative Leaders Breakfast Meeting, *Assembly 1*
9:00-11:30 am	Concurrent Sessions
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6:30-10:00 pm	Junior Delegates Program, *Court St. entrance of Denver Hilton*

Saturday, July 8

9:30-11:30 am	Annual Business Meeting, *Ballroom*
11:30 am-12:00 noon	Regional Caucus Meetings
12:00 noon-2:00 pm	Closing Plenary Session/Luncheon for All Delegates: "Creative Federalism: Relations Among Our Governments," *Ballroom*
2:00 pm	Adjournment

Delegates to Adopt Policy Positions

(continued from page 3)

Industrial Development Bonds: NCSL opposes the President's recommendation to restrict the use of industrial development bonds and the limitation of these bonds to federally determined "distressed areas."

Social Security Financing: NCSL encourages Congress to re-examine the schedules for financing of the social security system. NCSL also recommends that payroll taxes be reduced and the social security retirement fund strengthened.

Human Resources

Intergovernmental Cost Sharing for Public Health Programs: NCSL urges the federal government to strengthen a state-federal partnership to finance and deliver public health services. Responsibility for the delivery of public health services and the design of public health programs should remain with the state and local governments. NCSL also urges an increase of federal financial support for public health activities.

Older Americans: NCSL backs reauthorization of the Older Americans Act by Congress in September 1978 and supports renewed funding of the act for at least two years. NCSL urges that the reauthorization legislation give states authority and funding required to implement programs under the act.

Natural Resources

National Water Policy: NCSL sees a need for more coordinated and consistent federal policies which recognize state policies and programs as the basis for a national effort toward water resources management. NCSL believes that water policy must be developed at the state level, and that the role of the federal government is to provide technical and financial assistance to the states.

Indian Water Rights: NCSL recommends that, where conflicting claims to water occur, tribes, states and non-Indian users seek to resolve the dispute through mediation, with federal involvement when necessary.

Rural Development

Federal Programs for Rural Development: NCSL asks that all federal policies, programs and regulations be implemented with regard for the needs and problems of rural communities.

Transportation

Interstate RRR: An Interstate Resurfacing, Restoration and Rehabilitation Program should be maintained to ensure that the federal and state investment is protected by preventing deterioration of the system. Program funds should be sufficient to cover program needs.

Mass Transit: NCSL believes that a greater financial commitment to the nation's mass transit system is needed. NCSL urges Congress and the Administration to increase federal funds for operating costs.

Urban Development

National Urban Policy: NCSL urges the Administration and Congress to ensure that all federal programs for states and localities complement and reinforce state community development strategies.

Indian Affairs

Federal, State and Tribal Jurisdiction: NCSL calls on Congress to legislate those areas that cannot be resolved by dialogue between the states and tribes. NCSL is working to create a commission of legislators, Indian leaders and federal representatives in charge of discussing and resolving jurisdictional problems.

Afternoon Tea and Magic

The Governor's Mansion will be the final stop of the day for those who choose to tour Victorian Denver on Friday afternoon (2:30-4:30). The tour will begin with a guided walk down Millionaire's Row, viewing such beautiful homes as the Malo and Grant Humphries Mansions. Following tea at the Governor's home, volunteers from the Molly Brown House will present an historical fashion show, featuring styles from the 1890's to the 1930's.

Those with children might prefer to spend a day in City Park (8:30-4:30). The Denver Zoo has more than 250 different forms of animal life. Its natural habitat enclosures were the first of their kind in the United States. A box lunch in the park will be followed by a special behind-the-scenes tour of the Denver Museum of Natural History to see how lifelike animal displays are made.

Fun for the children will continue with an evening of suspense and magic. Ronald McDonald will join junior delegates for dinner. The evening activities conclude with a special showing of "Close Encounters of the Third Kind."

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National Conference of State Legislatures

1978 Annual Meeting, Denver, Colorado
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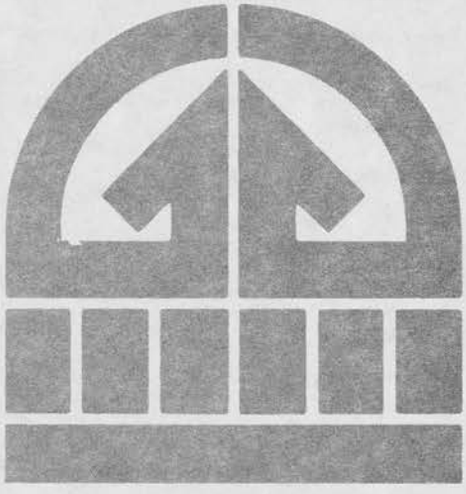

Adolph Coors Co.

American Federal Savings & Loan Association

Arvada Plaza Theater (Wolfberg Theaters)

Arthur Andersen & Co.

Atchison Topeka & Santa Fe Railway Company

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Ed Nielson

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American Insurance Association

Arthur Young & Company

Bethlehem Steel Corp.

Bristol Myers Co.

Baldwin-United Corp.

Bill Threlkeld

Boettcher & Company

Broadmoor Hotel

Boulevard Colorado National Bank

Burlington Northern, Inc.

Brown Palace Hotel

Bank of America

Beneficial Management Corp.

Colorado Cable Television Association

Colorado Wool Grower's Association

Colorado Building & Construction Trades Council

Colorado Chiropractic Association

Colorado Automobile Dealer Association

Colorado Council on The Arts and Humanities

Colorado Association for Housing & Building

Colorado Federal Savings & Loan Association

Colorado Municipal League

Colorado Cattlemen's Association
Dave Rice - Doug Huddleston

Colorado Rural Electric Association

Central Bank of Denver
Eric Schmidt

Colorado & Southern Railway

Colorado Municipal Bond Dealer's Association

Colorado Solid Wastes

Colorado Association of Life Underwriters

Colorado-Wyoming Restaurant Association
Donald Quinn

C. F. & I. Steel Corporation

Centennial Turf Club

Capital Finance Services

Colorado Medical Society

Container Corporation of America

Colorado Life Convention
Capital Life Insurance
Security Life & Accident
Western Farm Bureau

Climax Molybdenum (AMAX)

Columbia Savings & Loan Association

Colorado Ski Country

Cloverleaf Kennel Club

Central Bank of North Denver

Conoco (Continental Oil Company)

Congress Lounge
Nick Frangos

Chevron U.S.A. Inc.

Colorado Beer Distributors Association

Colorado Flower Growers Association
Dick Kingman

C. A. Norgren Company

Consolidated Oil & Gas, Inc.

Colorado National Bank

Colorado State Bank

Denver Center for The Performing Arts

Denver & Rio Grande Western Railroad

Distilled Spirits Council of the U. S. Inc.

Dow Chemical U.S.A.

Empire Savings & Loan Association

Energy Transportation Systems, Inc.

Eastman Kodak Company

Elmer Fox, Westheimer & Company

Exxon Company

Electric Service Corporation

First Federal Savings & Loan Association

Fashion Bar, Inc.

First National Bank of Bear Valley

First National Bank of Denver
John E. Fuller

First National Bank of Englewood

First National Bank of Julesburg

First National Bank of LaJara

First National Bank of Westminster

Gates Rubber Company

General Mills

General Motors Corporation

Gulf Oil Corporation

Getty Refining & Marketing Company

Great Western Sugar Company
Al Auger

Greely National Bank

Gerald H. Phipps, Inc.

Home Federal Savings of the Rockies

Huntington Alloys, Inc.

Household Finance Corporation
Jim Pratt

Holland & Hart

Honeywell Inc.

Independent Bankers of Colorado
North Valley Bank
Berthoud National Bank
Home State Bank
Citizens State Bank
Bank of Orchard Mesa
Columbine National Bank
Bank of Denver

Interstate Racing Association

Independent Insurors of Colorado

Jim Christiansen

J. C. Penney Company

Jim Dandy Fried Chicken

KBTV Channel 9

Keebler Company

King Soopers, Inc.

K-M Concessions

Kay Johnson

Kansas-Nebraska Natural Gas

Larimer Square

Littleton National Bank

Midland Federal Savings & Loan Association

Motor Vehicle Manufacturers Association

Mountain Bell
Stan Sours - Dan Tomlinson

Martin Marietta Aerospace

Majestic Savings & Loan Association

Mobil Oil Corporation

Montbello State Bank

Monfort of Colorado, Inc.

Mile High Kennel Club

McDonald's

Nabisco, Inc.

Otero Savings & Loan Association

Philip Morris

Pepsi-Cola Bottling Company

Patrick Associates

Packaging Corporation of America

Phillips Petroleum

Plaza Cosmopolitan Hotel

Perrill, James C.

Pueblo Greyhound Association

Public Service Company of Colorado

P. I. P. E. of Colorado

Rocky Ford National Bank

Rio Grande Industries

Rocky Mountain Greyhound Park

Rockwell International

Routt County National Bank

7-Eleven Stores

Samsonite

Samuel Gary Oil Producer

Sears Roebuck & Company

Signal Drilling Company

South Colorado National Bank

Security National Bank

Southwest State Bank

Sun Company, Inc.

Stearns-Roger, Inc.

Schwinn Bicycle Company

TransAmerica Finance Services

TRW, Inc.

United Bank of Denver

U. S. League of Savings & Loan Associations

United Telecommunications, Inc.

Union Carbide Corporation

United System Service

URS Company

Wards

Webb Resources, Inc.

Western Electric Company

Western Crude Oil Inc.

American Cyanamid

Great-West Life Assurance Co.

NCSL VISITS
THE SOVIET UNION

The National Conference of State Legislatures is pleased to announce a unique two-week study tour of Soviet regional and local government, November 24 to December 9. This special trip to Leningrad, Moscow, and Tallinn, will provide legislators, legislative staff, and your immediate families a rare and inexpensive opportunity to cross cultural lines — to meet your counterparts in the Soviet Union.

A special low-cost fee of $1,110.00 (based on current airfares, tariffs, and currency exchange rates) covers round trip charter flight from New York City and return, complete pre-departure program, and all meals and hotel accommodations. A highlight of the trip will be a special regional and local government seminar program. Delegates will have opportunities to explore with Russian officials in small-group settings such issues as environmental policy, public health and social services, education, transportation, and growth planning. Throughout the trip, delegates will be accompanied by English-speaking Soviet authorities.

In addition, the package price of $1,100.00 includes:

- overnight and morning in beautiful Helsinki, the capital of Finland
- excursions and sightseeing activities with English-speaking guides
- three theater performances and a banquet

BROCHURES CONTAINING MORE DETAILED INFORMATION AND AN APPLICATION FORM ARE AVAILABLE AT THE NCSL PUBLICATIONS TABLE LOCATED IN THE CONVENTION LOBBY OF THE DENVER HILTON.

DATELINE WASHINGTON

NATIONAL CONFERENCE OF STATE LEGISLATURES • JULY 3, 1978 • VOL. III NO. 12

Development Bank Legislation Moves to Hill

Vice President Mondale announced on June 20 an Administration proposal to establish a national development bank. The announcement, made at the annual convention of the U.S. Conference of Mayors, moves the final piece of urban policy legislation to the Hill.

The development bank would provide assistance to distressed areas through *loan guarantees* of up to $15 million on plant construction and equipment, *interest rate subsidies* on bank guaranteed debt, *grants* up to 15 percent of the capital costs of an approved project, taxable development *bonds* with a 35 percent subsidy rate and a facility to improve private loan liquidity.

The national development bank will be a new entity under the direction of three cabinet secretaries from HUD, Commerce and Treasury. Financial assistance will only be available to areas which meet three of four criteria designed to measure distress:

- unemployment above the national average for five years;
- employment growth below the national average for five years;
- population growth below the national average for five years;
- per capita income less than the national average.

In addition, no jurisdiction will be eligible if its per capita income exceeds 125 percent of the national average. Ten percent of the bank's funds would be set aside, however, to assist "pockets of poverty" in areas which do not

(continued on page 9)

Vice President Walter Mondale, addressing the U.S. Conference of Mayors' convention in Atlanta.

Inside:

SFA Mid-year Supplement

Natural Gas Accord Reached

House and Senate energy conferees reached a final agreement June 13 on the natural gas pricing bill, but the actual drafting will probably not be completed for another four to six weeks. Meantime, the conference committee staff is working to complete drafting on the coal conversion, energy conservation and utility rate reform bills agreed to last fall.

Sen. Russell Long (D-La.), chairman of the Finance Committee and leader of the Senate conferees on the energy tax bill, is still adamant about not convening the tax conference until the natural gas bill gets past the Senate floor, however. Since the natural gas bill has been threatened with another filibuster by Senators opposed to deregulation, this may leave little time for completion of energy tax negotiations before the October adjournment of the 95th Congress.

The parliamentary strategy now is to send the four completed bills to the Senate first. If approved, they will be returned to the House, where they will be debated as a single package. Since the drafting of the coal conversion bill is furthest along, it will probably be brought before the Senate first, followed by the utility rate reform and conservation bills.

NCSL policy calls for natural gas to continue under price regulation, but be priced to encourage further exploration of domestic reserves, and to insure adequate supplies for highest valued uses such as residential, agricul-

(continued on page 5)

UPDATE

Proposition 13

The federal-state and national implications of California's recently passed Proposition 13 are still being assessed throughout the nation. Officials at the Department of Labor are taking a wait-and-see attitude regarding maintenance of CETA public service employee layoffs, while preparing to lay out up to $27 million weekly in unemployment claims for regular state and local employees. Rep. Phillip Crane (R-Ill.) has proposed a federal constitutional amendment limiting government spending to 35 percent of national income. Several states now have similar measures under way. Meanwhile, Atlanta Mayor Maynard Jackson placed the blame for the "tax revolt" on state legislatures' refusal to give "home rule on taxes to America's mayors." NCSL has scheduled sessions on this topic during the annual meeting in Denver. NCSL contact: Paul Sweet, 202/624-5414.

Title XX Funding

The House Ways and Means Committee unanimously reported HR 12973, the Fraser-Keys bill, which increases the Title XX authorization by $200 million in FY 1979, bringing the total Title XX funding level to $2.9 billion in FY 1979, $3.15 billion in FY 1980 and $3.45 billion in FY 1981. The full House is expected to vote on the measure under suspension of the rules. The Senate will likely act on the Dole-Gravel amendment to the Public Assistance Amendments (HR 7200) after the July 4 recess. This amendment would provide the same incremental funding increases as the House bill. Copies of the House Ways and Means Committee report can be obtained from NCSL. NCSL contact: Barbara Simcoe, 202/624-5409.

Education Amendment

The Elementary and Secondary Education bill (HR 15) is scheduled for House action at any time. An NCSL-supported measure providing special grants to areas with high concentrations of low income children is now threatened by an amendment which Rep. John Ashbrook (R-Oh.) plans to offer on the House floor. This amendment will change eligibility criteria and have the effect of including all counties with as low as 2 percent low-income enrollment, rather than the 20 percent now in both the House and Senate bills. The net result will be that the $400 million authorization will be diverted to a greater number of counties—not concentrated where the monies are most needed. NCSL policy supports the concentration measure and opposes dilution of its original purpose. NCSL contact: Sandra Kissick, 202/624-5423.

Oil Spill Liability

In a temporary victory for the states, Senator Muskie's Subcommittee on Environmental Pollution deleted all portions of a bill which would preempt states from establishing their own liability fund to provide compensation for damages and clean-up costs caused by discharges of oil and hazardous substances. The bill now goes to the full Senate Committee on Environment and Public Works, where it is likely the preemption provision will be restored. NCSL contact: Joan Warren, 202/624-5431.

SFA MID-YEAR SUPPLEMENT

DATELINE WASHINGTON

NATIONAL CONFERENCE OF STATE LEGISLATURES • JULY 3, 1978

Review of 1978 State-Federal Issues

Education

• Proposed Title I legislation contains many of the policy recommendations which NCSL has endorsed. Specifically, the bills now before both houses provide for additional Title I compensatory education funding for schools with high concentrations or large numbers of Title I children. They also provide for federal support of state compensatory education programs and more flexible use of Title I funds in schools with extraordinarily high proportions of Title I children. NCSL lobbied to retain the concentration program and permit increased federal funding for state compensatory programs.

• FY 1979 funding for authorized sections of the Elementary and Secondary Act was approved by the House in early June. Concentration and state incentive grants must receive House approval before funding can take place. A threatened amendment may dilute the concentration grant money so that it is spread among a greater number of counties (see Update, p. 2).

Energy

• Nuclear siting and licensing legislation is now being considered in both chambers of Congress. In testimony before the House, NCSL has urged the federal government to set a date by which to demonstrate "technologically safe and politically workable" nuclear disposal facilities, or else halt licensing for new nuclear power plants. NCSL recommends a stronger state role in the siting and licensing of both nuclear waste disposal facilities and nuclear power plants. Legislators hope to arrange a meeting with officials of the Federal Interagency Task Force on Nuclear Waste appointed by the President last March.

• Energy impact assistance legislation now before the Senate would enable governors to set up impact assessment teams of federal, state and local officials to analyze and project the public facility and service needs of areas designated by the governor as likely to undergo rapid energy development. NCSL has submitted a written statement to the Senate subcommittee hearing this bill to urge that any energy impact assistance legislation incorporate a strong state legislative role.

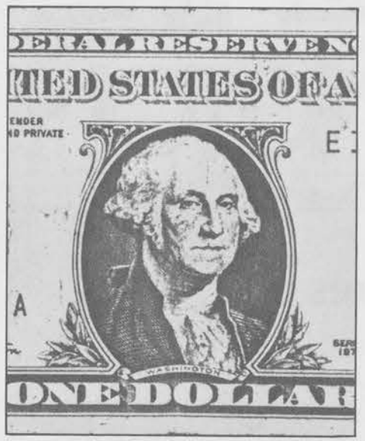
Negotiation with DOE is taking place to arrange for state legislative involvement in the President's policy review of solar energy programs.

Other Issues

The Administration is putting the finishing touches on a bill to consolidate federal funding for comprehensive state energy **management** planning. . . . House and Senate energy conferees have reached an agreement on national gas pricing (see p. 1). . . .

Fiscal Assistance

• The Anti-Recession Fiscal Assistance—countercyclical aid—program is due to expire in September and prospects for reauthorization remain uncertain. NCSL has testified in opposition to the President's proposal to eliminate states as recipients of supplemental funds.



Sen. Edmund Muskie (D-Me.) has proposed a two-tiered program of assistance. The first tier would be the present countercyclical program, which would phase itself out as the economy improved. The second tier, effective upon termination of the present program, would be directed toward those jurisdictions (state and local) suffering the most pronounced economic crises.

Committees in both chambers of Congress have held hearings on countercyclical assistance, but the bills have not yet been reported out and no action has been scheduled.

• Members are considering a compromise on the President's Tax Reform and Reduction Act of 1978 which has been stalled in the House Ways and Means Committee. NCSL has voiced its opposition to a proposed amendment which would eliminate the deduction for state sales, gasoline and personal property taxes on an individual's federal income tax return. Elimination of these deductions would restrict the already limited flexibility which elected state and local officials have in meeting the service demands of their constituents without relying on the property tax.

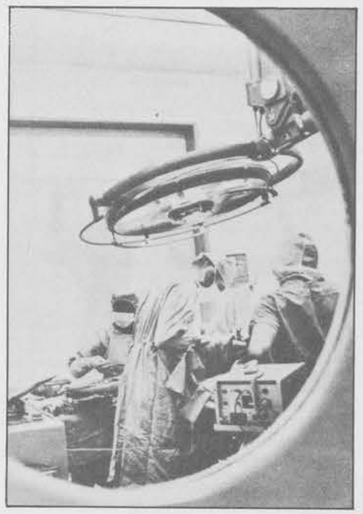
Other Issues

IRS-approved deferred compensation retirement plans have been in jeopardy, but the Treasury Department now indicates that no action will be taken to terminate approvals for such plans until Congress has time to legislate in this area. . . . NCSL has been asked by President Carter to present its views on the FY 1980 budget. State legislators and staff should contact NCSL by August 1.

Health and Welfare

• In the absence of an announcement on National Health Insurance, welfare reform continued to dominate the human resources arena.

After three weeks of meetings with representatives of the New Coalition, Administration officials and key members of Congress agreed on June 7 to some basic aspects of a compromise welfare reform measure. The major features, based in large part on the New Coalition's proposals, include a cost of about $9-11 billion, $2 billion in fiscal relief for states and localities, a national minimum benefit of $4200 for a family of four and provision of 700,000 public service employment slots.



Though considerable progress had been made toward reaching a compromise in the House, both House and Senate leaders recently agreed that it was too late in the session for welfare reform to make its way through the upper chamber. It is therefore unlikely that a reform bill will be enacted this year.

The New Coalition will continue to work with federal officials to ensure passage of welfare reform legislation in the next session of Congress.

• Hospital cost containment legislation, being considered in committees of both chambers, has hit some recent amendment snags. The proposal under scrutiny in the House would allow a two-year voluntary cost containment program to operate in place of a mandatory system. If the voluntary program failed to reduce the rate of increase in hospital revenues by 2 percent each year, then a mandatory program would be triggered. States already operating effective cost containment programs would be exempt from mandatory control. Moreover, the bill would provide federal financial support to encourage other states to develop and administer their own systems.

Other Issues

Senate and House committees have reported legislation to reauthorize the Older Americans Act. . . . House DNA legislation (HR 11192) contains strong preemptive language designed to preclude state and local government involvement in this area. Prospects for Senate consideration of the issue remain unclear. . . . Both houses have marked up bills regarding state legislative control of health service agencies created under the National Health Planning Act. The House version gives state government more involvement in the health planning process.

SFA Committee Meetings

State-Federal Assembly
Wednesday, 3:45
Ballroom

The State-Federal Assembly will meet to discuss and ratify the policy resolutions approved during the committee sessions listed below.

Criminal Justice Committee
Wednesday, 10:30-3:30
Beverly Room

Delegates will be briefed on the status of legislation to reorganize the Law Enforcement Assistance Administration. Rep. Alan E. Norris, Ohio Minority Whip, will discuss the selection, appointment and tenure of federal judges.

Education Committee
Wednesday, 10:30-3:30
Gold Room

Committee members will review recent elementary and secondary education legislation. Following lunch, the group will discuss the future of NCSL Education Committee and staff activities in light of mounting efforts to roll back state and local taxes.

Energy Committee
Wednesday, 9:30-3:00
Silver Room

"Liquified Energy Gas and Pipeline Safety Legislation" will be the topic of discussion for a panel of state and federal officials and energy experts. Alan Hoffman, Department of Energy Staff Coordinator, will speak to the afternoon session on the Carter Administration's Domestic Policy Review of Solar Programs.

Government Operations Committee
Wednesday, 11:00-3:30
Assembly Room #1

Committee staff will be briefed on state-federal issues and will re-consider NCSL's policy position on the U.S.-U.K. Tax Treaty. The meeting will conclude with a session on commercial bank underwriting of state and local government revenue bonds.

Human Resources Committee
Wednesday, 9:30-3:30
Century Room

The morning session will begin with briefings and a discussion of current federal initiatives, including welfare reform, cost containment, health planning, national health insurance and CETA. Members will consider proposed policy resolutions. Sen. Tarky Lombardi (N.Y.) will lead a discussion of home health care. Representatives of the National Association of Insurance Commissioners and the Conference of Insurance Legislators will sponsor a luncheon program on national health insurance.

Natural Resources Committee
Wednesday, 10:00-3:00
Colorado Room

Delegates will discuss NCSL policy resolutions and hear from Rep. John Anderson (Ct.) and Assy. Pete Grannis (N.Y.) on state legislative efforts to control auto emissions.

Rural Development Committee
Wednesday, 11:00-4:00
Statler Room

Following a general discussion of rural issues for the coming year, Sen. Richard Gannon (Ks.) will speak on multi-national grain marketing. In an afternoon session, NASA official Jerry Freibaum will present a program on satellite communications.

Transportation Committee
Wednesday, 9:00-3:00
Vail Room

Members will review key transportation issues and proposed policy resolutions for 1978-79. Following a lunch break, Stan Feinsod, Director of the American Public Transit Association's Office of Planning and Policy Analysis, will discuss the legislative role in public transit. General Ben Davis, Assistant to the Secretary of Transportation, will conclude the meeting with comments on the 55 mph speed limit.

Urban Development Committee
Wednesday, 1:00-4:00
Terrace Room

The committee will convene for an afternoon discussion of urban development issues and future committee activities. Harry Schwartz, Assistant Secretary for Congressional and Intergovernmental Relations at HUD, will report on the Administration's proposed national urban policy and state incentive grant program.

SFA to Consider New Policy Positions

State-Federal Assembly members will consider several new policy resolutions at the Annual Meeting (see below). Other issues may be raised by delegates.

Energy

Liquified Energy Gas—Delegates will consider a policy position on the adequacy of existing laws regulating the safety of facilities to accept, store and transport liquified energy gases.

Low Level Nuclear Waste—Committee members will discuss a possible position on the storage and transportation of nuclear waste which has a low level of radiation.

Government Operations

Commercial Bank Underwriting—Participants will vote on allowing banks to buy municipal bonds.

Human Resources

Alternatives to Long Term Care for the Elderly—Members will discuss alternatives to nursing home care for senior citizens.

Home Health Care—The committee will question the value of proprietary vs. non-profit providers.

Age Discrimination in Employment—Legislators will consider a resolution on mandatory retirement and age discrimination.

National Health Insurance—Committee members will offer options for national health insurance.

Natural Resources

Alaska National Interest Lands Act—SFA members will debate the uses of large portions of land in Alaska and precluding development from many areas.

Western Public Lands—The committee will examine efforts to classify the uses of federal lands in the West and preclude development from some areas.

Low Head Hydro-Electric Dam Funding—Federal funding to underwrite the cost of installing small hydro-electric generators will be discussed.

Urban Policy

Public Works—Delegates will question support of labor intensive public works vs. the more traditional bricks and mortar approach.

Natural Gas Controls Retained Until 1985

(continued from page 1)

tural and industrial feedstock consumption. NCSL also wanted intrastate gas markets to be brought under regulation to effect a uniform regulatory system. As approved by the conference committee, the bill reflects all of these recommendations except the open-ended call for continued regulation.

The natural gas compromise would impose price controls on almost all gas, intra- and interstate, until January 1, 1985. New gas prices would be raised from their current $1.49 per thousand cubic feet (Mcf) to almost $2 per Mcf at enactment, with a cap on annual increases based on the GNP deflator plus 3.7 percent until April 20, 1981. Between then and 1985, prices would be allowed to rise up to the GNP deflator plus 4.2 percent a year. At a 6 percent inflation rate, this would bring prices to an estimated $3.72 per Mcf by 1985.

After a six-month trial period for deregulation beginning in 1985, either Congress or the President could reimpose controls on new, intrastate and special development incentive gas for one 18-month period to end by January 1, 1989. Prices during the re-control period would be keyed to an extension of the price trend line for new gas before decontrol.

The agreement also establishes an incremental pricing provision for higher-cost gas to help insulate residential and other high-priority users from massive price increases by shifting most of the burden onto industrial customers, beginning with most industrial boilers. Intrastate customers would not be affected, and there are exemptions for utilities, schools, hospitals, agricultural use and industrial uses of less than an average 300 Mcf a day during a peak month. State laws preventing a pass-through of higher prices to customers subject to incremental pricing would be preempted.

The agreement would not preempt those states with statutory limits on price redetermination clauses in intrastate gas contracts, however. These clauses enable a contract price to be renegotiated when prices for new contracts reach a stipulated point, and some states have acted to control the inflationary effects of such clauses.

On the energy tax wrangle, Long, Energy Secretary James Schlesinger and House Ways and Means Committee chairman Al Ullman (D-Or.) are again trying to reach some understanding on the crude oil equalization tax. Called the "centerpiece" of the National Energy Plan by the administration, this controversial provision would tax price-controlled domestic oil to bring it up to world oil prices over the next three years.

Ullman, a House energy conferee, wants the revenues to be rebated to individuals to avoid stagflationary effects. This is essentially the measure proposed by the administration and passed by the House last summer.

Long, however, wants the revenues plowed back to the oil companies to encourage more production. Last winter, he and his staff proposed to rebate the tax in the form of an energy investment voucher, which taxpayers could invest in a DOE-approved company of their choice. This proposal has since been modified to avoid erratic investment patterns by having the rebates go to mutual investment funds. Ullman has said he might accept a reasonable modified plan for next year if Long can work out the details.

Urban Policy

• NCSL has been deeply involved in efforts to encourage early Congressional approval of the national urban policy released on March 27. Fifteen pieces of legislation have now been sent to Congress to implement the urban package.

The Administration has indicated that there are six priority bills which will be emphasized: supplemental fiscal assistance (see p. 4), state incentive grants, employment tax credits, differential investment tax credits, the national development bank (see p. 1) and the labor-intensive public works program. Other aspects of the urban policy package include: multi-modal transportation grants, an urban volunteer corps, an inner city health initiative, section 312 rehabilitation loans, urban parks, a targeted Title XX program (see below), a neighborhood self-help fund, and livable cities and neighborhood crime prevention programs.

With its backlog of other legislation, Congress is likely to move quickly on urban programs only if state legislatures strongly encourage action. NCSL will focus on a few key components of the urban package: state incentive grants, supplemental fiscal assistance, investment tax credits and the national development bank.

• House and Senate committees have completed mark-up of bills to reauthorize the Comprehensive Employment and Training Act (CETA). NCSL was successful in getting both panels to agree to an amendment which would require local prime sponsors to submit copies of their comprehensive employment and training plans to the appropriate committee in each house of the state legislature.

Following extensive floor debate, both houses are expected to pass CETA legislation. Conflicts may arise in conference regarding wage rates, restrictions on wage supplementation and time limits on holding public service jobs. Meanwhile, in the absence of formal reauthorization, appropriations bills have been reported out without CETA funds. This means that the program will have to operate at current levels in FY 1979 unless there is a supplemental appropriations bill.

• Both the House and Senate are expected to pass legislation increasing the Title XX social services ceiling. Funding would increase from $2.5 billion in the current fiscal year to $3.45 billion in FY 1981 (see Update, p. 2).

Transportation

• NCSL has lobbied strenuously against passage of no-fault insurance legislation which would mandate that each state legislature adopt federal standards for no-fault as "state law" within four years of the bill's passage. States failing to adopt the required standards would have the plan imposed upon them by the U.S. Department of Transportation.

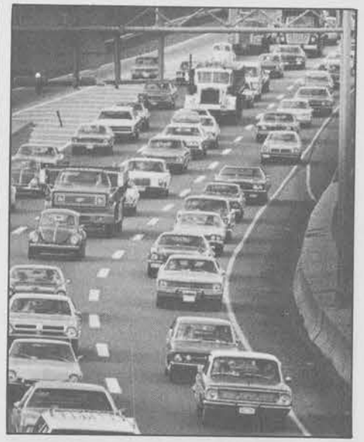
Though a bill has been before the Senate since Commerce Committee approval on May 9, Senate leaders have indicated that no-fault will not be a high priority issue unless there is some indication that the House will act favorably on a similar bill. In 1974, the Senate passed a national no-fault bill, only to have it die in the House.

No-fault legislation has made its way through the House Subcommittee on Consumer Affairs. The next step is action before the full House Interstate and Foreign Commerce Committee, probably in early July. Time will be a major factor determining passage in either house this year.

• Substantially different surface transportation legislation has been reported out of committee in both houses. The Senate bill would provide a one year program of $8.7 billion for highways and highway safety, while the House Public Works and Transportation Committee has asked for $12.3 billion. The major difference occurs in the proposal for the bridge program: the House bill seeks $2 billion; the Senate provides only $450 million. Transit would receive $4.9 billion under the House proposal and $3.3 billion from the Senate.

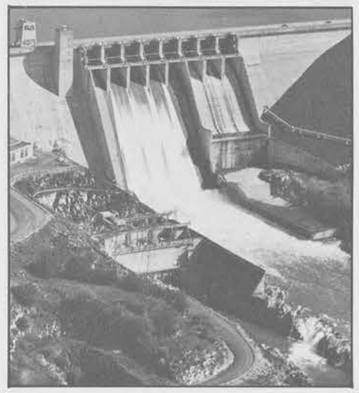
NCSL has successfully lobbied to remove a planning proposal which would send federal highway planning monies directly to Metropolitan Planning Organizations. A similar proposal remains in the Senate transit legislation.

Conference action will be required after Congress resumes work on highway and transit bills later this summer. It is expected that legislation offering limited funding increases will be on the President's desk in September.



Water Policy

• Early action on the President's national water policy, announced on June 6, appears unlikely. The policy focuses on four key areas: improved planning and management of federal water programs; a new national emphasis on water conservation; enhanced federal-state cooperation and improved state water resources planning; and increased attention to environmental quality.



Much of the policy can be implemented through Administrative order. However, legislation is required to change the cost-sharing arrangements for building federal water projects, for allowing states to increase the price of water used for municipal and industrial purposes (with rebates to municipalities or other public works entities), and for increased funding for state planning grants and technical assistance to states for water conservation.

The necessary legislation is now being reviewed by the Office of Management and Budget. This includes a bill to change the cost-sharing arrangements, requiring states to contribute up to 10 percent of the cost of projects authorized in the future. The President believes that this will directly involve states in the decisions of when and where to build a project and will result in only the most beneficial and cost-effective projects being built.

NCSL is working with Carter's domestic policy staff to secure nominations for a task force of federal, state and local officials proposed to monitor federal water policy.

Other Issues

Oil spill liability legislation, now under consideration in the Senate, may enable states to establish their own liability funds to provide compensation for damages and clean-up costs. States will have to work to prevent preemption in this area.

Indian Affairs

• Several NCSL recommendations were accepted in the House version of the Basic Indian Education Act of 1978, included as Title XI of the Elementary and Secondary Education Act. The proposed changes strengthened the planning requirements for basic education of Indian students in public schools, and increased parental participation in defining educational goals.

The Senate education bill does not contain these provisions. Those which are retained by the House will have to be worked out in a House-Senate conference.

• The recently announced national water policy calls for identification and quantification of Indian water rights and resolution of disputes between Indians and non-Indian water users through negotiation whenever possible. This is identical to the policy position which NCSL had previously approved. NCSL, however, urged that the states have the option to begin adjudication in state courts when negotiation was unsuccessful. The President's policy supports federal adjudication. NCSL is currently developing recommendations for negotiation procedures.

• Earlier this year, NCSL testimony proved instrumental in bottling the Tribal State Compact Act up in Senate committee. Passage of the bill might actually hinder development of agreements between states and tribes and would require unnecessary federal approval in many instances.

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States' Taxation Rights Preserved in Treaty

The Senate ratified a tax treaty with the United Kingdom on June 27, after reaching a compromise on a section of the treaty which would have affected state taxation of multinational corporations.

Controversy a few days earlier had centered on the states' use of the "unitary" method of taxing multinationals. Following an agreement to place a reservation on the objectionable portion of the treaty, the Senate was able to gather the two-thirds majority needed for ratification. Recognizing that the federal government should not intrude into the constitutionally separate tax systems of the states, Treasury Department negotiators have vowed not to include a prohibition on the unitary taxation method as a part of any future treaty.

Article 9 (4) of this little publicized international taxation treaty would have restricted the rights of those states which use the unitary tax method in assessing the profits of a United Kingdom-based subsidiary. The unitary method considers operations of parent companies, affiliates and subsidiaries as a whole rather than just considering multinational operations within the state.

Alaska, California and Oregon use this particular method extensively. According to a survey taken by Indiana revenue officials, approximately 23 states use the unitary method. Many states which use the "arms-length" method as general policy often fall back on the unitary method when the former method does not work. The "arms-length" method can be described as the amount that would be charged for prices used or profits received between unrelated parties under similar circumstances.

Proponents of Article 9 (4), led by the Carter Administration, maintain that the unitary method has provided states with more than their fair share of corporate tax revenue. The Treasury Department endorses the "arms-length" method as an "internationally accepted approach."

Negotiation of this treaty threw the states into the unfamiliar territory of the foreign treaty process. The technical debate surrounding the use of the unitary taxation method vs. the "arms-length" alternative was secondary to the federal preemption concern.

At the 1977 Annual Meeting, NCSL joined the National Association of Tax Administrators, the Multi-State Tax Commission, the National Association of Attorneys General and the Western Governors' Conference in opposition to Article 9 (4).

The United Kingdom will now be presented with a treaty which includes the reservation on the section dealing with the unitary taxation method. Since Articles 10 and 23 of this treaty would provide tax benefits to U.S. shareholders of British companies, it is hoped that this version will be accepted so that a new treaty negotiation process can be avoided.

NCSL contact: Jeff Esser, 202/624-5408.

Support Urged for Bank Concept

(continued from page 1)

otherwise meet the bank's criteria.

Rep. Richard Hodes (Fl.), chairman of NCSL's State-Federal Assembly, voiced NCSL's support for the national development bank concept. "We are particularly pleased that the Administration has recognized the wisdom of involving state governments in this program by making state economic development agencies eligible for bank funding," Hodes said. "Continued statewide coordination of economic development will enable the states to expand their fiscal support for the broadest possible range of private sector opportunities."

The development bank bill will be referred jointly to the Banking and Public Works committees in each chamber. Key members on this issue are Sens. Quentin Burdick (D-N.D.) and William Proxmire (D-Wi.) and Reps. Henry Reuss (D-Wi.) and Robert Roe (D-N.J.). Legislators may wish to write their state delegation to ask for speedy consideration of this proposal.

NCSL contact: Susanne Heigel, 202/624-5418.

CALENDAR

August 3-4, 1978

Alternative Revenue Sources Seminar, Holiday Inn State Capitol, St. Paul, Minnesota

August 10-12, 1978

Leadership Staff Seminar, Hotel Utah, Salt Lake City, Utah

September 7-8, 1978

State Innovations in Health Care, Olympic Hotel, Seattle, Washington

September 18-22, 1978

National Legislative Services and Security Association Training Conference, Host Inn, Harrisburg, Pennsylvania

September 25-28, 1978

Annual Training Seminar of the American Society of Legislative Clerks and Secretaries, Islandia Hyatt House, San Diego, California.

DATELINE WASHINGTON

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State Policy Affected By Supreme Court Rulings

The U.S. Supreme Court issued three rulings recently which support state policy-making flexibility in the areas of taxes and welfare. The Court, however, made it clear that Congress had the ultimate decision-making responsibility on these issues and should change the current statutes if there was disagreement with the Court's ruling.

The most far-reaching decision by the Court was a 6-5 ruling which upheld Iowa's tax on the sales of multistate corporations. Most of the 47 states with a corporate income tax use a three-factor formula to apportion taxes on corporations doing business in the state. The three factors are property located in the taxing state, total payroll of corporate employees in the state and total sales in the taxing state. West Virginia uses only two of these factors, property and payroll.

Iowa's plan takes only sales into account when apportioning taxes. An Illinois company, Moorman Manufacturing, challenged the Iowa one-factor plan as double taxation and a burden on interstate commerce. Other spokesmen for business contended that the Iowa plan would lead to tax competition among states. Nevertheless, the Court rejected the constitutional challenge and held that Iowa's formula had a rational basis. Justice Stevens, for the majority, said that proponents of national uniformity should take their case to Congress.

In another decision, the Court held 8-1 that Massachusetts could tax state and federal savings and loan associations at the same rate, even when the effect of the tax was discrimination against federal institutions. The difference in taxation between state and federal associations is caused by different reserve requirements.

The Court has also held that a state is not bound by federal requirements for a program if federal funds are not accepted for it. Illinois had decided not to participate in an AFDC program which required emergency family services for all needy families. Illinois chose to limit its emergency services to welfare families, but an appellate court ruled that they were required to provide the broader services. The Supreme Court reversed the lower court, but noted that its decision was based on a narrow reading of congressional intent, and this decision could be overturned by a statutory change.

In a ruling issued just before *Dateline* went to press, the Supreme Court decided that a U.S. District Court judge could force compliance with his orders to improve state penal conditions.

The 7-2 opinion given by Justice Stevens applies the Eighth Amendment ban on cruel and unusual punishment to state prisons. Specifically, the case involved the conditions of confinement in isolation cells in Arkansas institutions.

Analysts are divided over the ultimate impact of the decision. Some observers believe that penal conditions will be improved, while others believe that states will be forced to release large numbers of prisoners held under conditions which could be characterized as unfit by the Court's standards.

In another late case, the Court held 7-2 that one state cannot prevent another state from contracting to dump solid or liquid wastes on their land. New Jersey's law prohibiting Pennsylvania from dumping wastes was described by Justice Stewart as a restriction on interstate commerce.

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NCSL SUBCOMMITTEE ON AGING

PROPOSED POLICY RESOLUTION:

RELATING TO HOME HEALTH SERVICES

NCSL finds that there is increasing utilization of in-home health, homemaker and social services. NCSL expects that for humane and economic reasons, the trend for long term care will continue to show decreased use of nursing home services and increased use of in-home services.

NCSL further finds that in the past residents of many proprietary nursing homes have not received quality care. NCSL attributes this fact, in part, to the profit motives of certain operators of proprietary homes.

It is clear that as the demand for in-home services increases, more and more proprietors--including many presently in the nursing home industry--will want to become providers of these services. NCSL does not want to see the abuses in the nursing home industry repeated in the network of in-home services.

Recognizing the potential for abuse, the architects of the Medicare law included language to control the provision of in-home services by profit-making enterprises. As a result, proprietary home health agencies are found in only 20 states, and only around 20% of the 3000 Medicare-certified home health providers are proprietary.

To ensure that the provision of quality care rather than monetary gain is the guiding light in the network of in-home services, NCSL urges state legislatures to:

-develop ~~a single set of~~ uniform standards for quality in-home services;

-apply these standards equally to both voluntary nonprofit and proprietary providers of in-home services;

-carefully enforce compliance with these standards through licensure or certification laws; and

-pay special attention to actual and potential abuses of the recipients of in-home services, resulting from the profit motives of providers.

NCSL also recommends that the U.S. Congress--through the House Select Committee on Aging, the Senate Special Committee on Aging, or other appropriate panel--should study the track records, in terms of the quality of services, of both voluntary nonprofit and proprietary providers of in-home services. NCSL further recommends that, based on this study, the U.S. Congress should enact appropriate guidelines for states to follow in the development and enforcement of standards for quality in-home care.

executives ?

NCSL SUBCOMMITTEE ON AGING

PROPOSED POLICY RESOLUTION:

PROHIBITION AGAINST MANDATORY RETIREMENT

(3) adopted

NCSL finds that older Americans are discriminated against in a variety of ways, based solely on age. NCSL believes that age discrimination in the area of employment is often the single most disruptive and destructive occurence in the life of an older person. Mandatory retirement can have deleterious physical, economic, psychological and social effects on an older person who is able to work and who wants to continue working, but who is forced to quit because he or she has reached an arbitrarily determined retirement age.

Specifically, NCSL agrees with the findings of the House Select Committee on Aging of the U.S. Congress:

1. Mandatory retirement based on age alone is discriminatory against workers, is contrary to equal employment opportunity, and is, possibly, unconstitutional under the equal protection clause of the 14th Amendment.

2. There is already much concern over the cost of the Social Security system to current employees and employers. A declining birth rate combined with the increasing longevity of Americans, will result in a proportionately smaller labor force supporting a larger retiree population early in the next century. Later retirement and elimination of mandatory retirement at any set age could help ease this impending economic hardship.

3. Chronological age alone is a poor indicator of ability to perform a job. An employee who has been performing his or her assigned duties satisfactorily is entitled to the presumption that he or she will continue to be able to do so, subject to the findings of periodic physical examinations for certain types of employees (e.g., airline pilots, bus drivers, and others whose first lapse due to advancing age may threaten the lives of others.)

4. Mandatory retirement can cause hardships for older persons:

-It often results in a burdensome loss of income for an older person.

-It may well result in a lower retirement benefit under social security if the last years the employee would have worked would have brought higher earnings than earlier years.

-It is especially disadvantageous to some women who do not start work until after the children are grown or after being widowed or divorced. Forced retirement limits the work life of these women and reduces their ability to build up significant pension benefits.

(over)

-It can cause great economic hardship on a growing number of older workers who have many financial obligations usually considered to be the province of younger persons (e.g., home mortgages, installment payments on cars, financial responsibility for older parents.) College tuition

-It may well impair the health of many older persons whose jobs represent a major source of status, creative satisfaction, social relationships or self-respect.

5. Mandatory retirement causes loss of skills and experience from the work force, resulting in reduced national output.

6. Mandatory retirement causes an increased expense in government income maintenance programs such as Social Security and Supplemental Security Income, as well as social service programs.

The U.S. Congress and several States have enacted laws to prohibit, to some extent, the discharge or dismissal of a person from his or her job on account of age. However, NCSL finds that even in those areas where laws have been enacted, further action is required to fully eliminate employment discrimination on the basis of age.

Based on these findings, NCSL makes the following recommendations:

**Those state legislatures which have not enacted legislation to prohibit the use of mandatory retirement ages should do so prior to January 1, 1981.

**The U.S. Congress and those state legislatures which have enacted legislation, should amend their laws to ensure that all employees and employers--without exception--are subject to the provisions of laws which prohibit mandatory retirement.

Problem of young unemployed

NCSL SUBCOMMITTEE ON AGING

PROPOSED POLICY RESOLUTION:

PERSONAL ALLOWANCES OF CLIENTS OF

COMMUNITY-BASED RESIDENTIAL FACILITIES

(4) adopted 2.

NCSL has learned that the Commonwealth of Massachusetts is increasing the personal allowances of the clients of community-based residential facilities from $25 per month, presently provided under the federal Supplemental Security Income Program, to $40 per month. Massachusetts will be paying for the entire costs of the increased allowances.

NCSL is disturbed that the federal Social Security Administration (SSA) is unwilling to assist Massachusetts in the administration of the allowance increases. NCSL believes that it is reasonable to expect the federal government to assist in the implementation of this worthy, state initiated, state funded program by processing the increased allowances for Massachusetts. All that the SSA would have to do would be to write checks of 'x' plus $15 instead of 'x' for a certain category of SSI recipients (i.e., Massachusetts residents who are disabled, impaired or mentally retarded and who live in community-based residential facilities licensed by the Commonwealth.)

If the SSA does not administer the increased allowances:

1. Certain SSI recipients will receive 2 checks instead of one check.

2. Paperwork of the facilities--many of which are small operations, with limited accounting skills--will be unnecessarily compounded.

3. A new state bureaucracy will have to be created--at an estimated cost of $80,000 per year--just to process the $15 increase in the personal allowances of these SSI recipients.

4. The total amount of state dollars which could be used for these persons will be decreased by $80,000.

It is entirely possible that other States will follow the example set by Massachusetts in providing more adequate personal allowances for the disabled, impaired and mentally retarded clients of community-based residential facilities. NCSL believes that in the spirit fo partnership in government, the federal government should assist and encourage any State which takes the initiative to improve the quality of life for these persons.

NCSL recommends that the U.S. Congress should enact legislation requiring the SSA to administer state funded increases in the personal allowances of SSI recipients.

National Conference of
State Legislatures
Human Resources Task Force
July 5, 1978

R E S O L U T I O N

WHEREAS, the United States Senate will next week consider the bill S. 2410, "Health Planning Amendments of 1978;"

WHEREAS, that legislation contains provisions which would reverse the judgment of 25 state legislatures on the question of extending certificate of need requirements to the ambulatory, or non-institutional (private office) setting;

WHEREAS, such a measure would pre-empt the existing authority of an additional 19 state legislatures which have yet to exercise their preference on such an issue;

WHEREAS, it would further take away the ability of all state legislatures to treat Health Maintenance Organizations independently of other providers of ambulatory health care for certificate of need purposes; and

WHEREAS, Senators Dee Huddleston of Kentucky and Orrin Hatch of Utah propose to amend S. 2410 to remove its mandatory inclusion features, thus protecting and leaving the essential health policymaking decision regarding certificate of need to the prerogative of all state legislatures; therefore be it

RESOLVED, that the National Conference of State Legislatures adopt a policy of support for the HUDDLESTON-HATCH amendment to the Health Planning bill and so communicate that position in a letter to the sponsoring Senators.

VOCATIONAL REHABILITATION

(2) adopted

The NCSL has long supported the broad goal of the Vocational Rehabilitation Act: to assure the provision of comprehensive and coordinated programs of vocational rehabilitation. Since its inception in 1973, the Vocational Rehabilitation Act has proved to be one of the most successful of the human services programs in which the federal government participates. A large part of that success has been due to the involvement and support, both administratively and financially, of state and local governments.

Presently, the reauthorization of the Vocational Rehabilitation Act is under consideration by Congress. Several proposed amendments to the Act, however, represent a fundamental departure from existing legislation and would negatively alter current intergovernmental relationships by making vocational rehabilitation programs virtually automomous in terms of administration and allocation of funds. NCSL is concerned that such autonomy would seriously impede ongoing state initiatives to achieve greater integration and coordination of planning, budgeting and providing human services delivery systems.

NCSL registers the following objections to specific provisions within the proposed extension legislation for Vocational Rehabilitation:

1. Present policy would be extended regarding the specific administrative organizational structures a state must have in order to receive federal funds.

(1) adopted

NCSL believes it is inappropriate for Congress to dicatate how a State must organize its internal management structures to deliver public services. Such dictates create enormous service delivery problems for the States, undermine state efforts to reorganize the state executive branch, and ultimately diminish the accountability of state governments to their citizenry. As the number, variety and complexity of federal grant-in-aid programs increases, such as vocational rehabilitation, the necessity to provide better program coordination and rationalization at the state and local levels becomes all the more important. Different governmental organizational approaches are essential if diverse problems in the States are to be addressed effectively.

2. Proposed amendments would transfer responsibility for VR programs from the Secretary of HEW to the Commissioner of Rehabilitation.

3. Proposed amendments would empower the Commissioner of Rehabilitation to make a final decision as to whether a state VR program adheres to statutory and regulatory requirements. If the Commissioner finds a State out of compliance, he must immediately withhold

federal payments regardless of the filing of an appeal by the State. The Commissioner would be prohibited from releasing such funds until he is satisfied there is no longer a failure to comply or there is a final court order requiring the release of such payments.

4. Proposed amendments would exempt the Vocational Rehabilitation Act from the provisions of the Joint Funding Simplification Act. Congress enacted the Joint Funding Simplification Act in 1974 for the specific purpose of providing incentives and assistance to state governments in providing more comprehensive and better quality services to our citizens. Such an exemption would only lead to further isolation of these services to the detriment of the handicapped and the goals of the Rehabilitation Act.

5. Proposed amendments would mandate the state agency responsible for VR services must also serve as the agency for implementing the plan for Comprehensive Services for Independent Living.

   While in many States the VR agency may clearly be the appropriate agency to fulfill these new responsibilities, state governments must have the flexibility to decide, according to their circumstances, that a different agency or joint agencies may be more suitable for administering these activities.

NCSL seriously questions the assumption underlying many federal statutory requirements--exemplified by the Vocational Rehabilitation Act and proposed amendments to that Act-- that national purposes can be realized only through uniform requirements, particularly requirements that have no demonstrated effect on the quality of services delivered.

NCSL believes that the proper federal role in the human services area ought to be one of clearly articulating what the national purposes are, developing, in conjunction with the States, reasonable and meaningful performance criteria by which program operations and administration can be evaluated with respect to congressional intent, and providing the States with the latitude and assistance to experiment with methods to achieve the overall objectives of the legislation.

THE UNDER SECRETARY OF HEALTH, EDUCATION, AND WELFARE
WASHINGTON, D.C. 20201

JUN 30 1979

The Honorable Emily Staples
State Senator
Room 23G, Capitol Building
Aurora Avenue
St. Paul, Minnesota 55155

Dear Emily:

I have enclosed copies of materials outlining the Administration's proposal for Phase I of our National Health Plan, and the paper describing the total plan that we envision being enacted in future legislation.

The first phase of our National Health Plan goes a long way toward the goals that most of us share. It provides the framework for a program that stands a good chance of enactment in this Congress. It also establishes the framework for phasing in the full comprehensive, universal program we have designed. While addressing the need for catastrophic protection, it goes well beyond that to improve coverage for all Americans. It expands coverage for the poor, and puts a ceiling on the amount of out-of-pocket costs the elderly have to pay. It establishes the importance of preventive care in the group most at risk by assuring first dollar coverage to all expectant mothers and infants for all preventive and acute care services.

I appreciate all the time you devoted last year in the early development stages of these proposals. I hope you will carefully review all the material, and the Secretary would very much appreciate your reaction.

Sincerely yours,

Hale

Hale Champion

Enclosure

JUNE 12, 1979

THE CARTER ADMINISTRATION'S OUTLINE OF A FULLY IMPLEMENTED NATIONAL HEALTH PLAN

The Carter Administration is firmly committed to a universal, comprehensive National Health Plan. This white paper provides an outline description of such a plan when fully implemented, and relates it to the Phase I legislation which the President is proposing.

I. Background

The National Health Plan, and the Phase I legislation which serves as its foundation, derive from the President's commitment to the goals of universal, comprehensive coverage.

A. Early Commitments

President Carter has been working to improve health care since his days as Governor of Georgia. During the 1976 Presidential campaign, before a group of Black medical students, he first set forth his vision of the ideal health care system, including:

-- universal, mandatory coverage;

-- the same comprehensive benefits for everyone, including preventive care;

-- a variety of financing sources;

-- strong cost and quality controls and incentives for system reform; and

-- phasing of implementation according to national priorities, dealing with the most severe unmet health care needs first.

B. Presidential Principles

In July 1978, the President reiterated his support for universal and comprehensive coverage, to be achieved through a mixture of public and private financing. He issued a set of specific principles to guide the design of a tentative plan.

These principles remain the touchstone of the proposal the Administration is presenting today. They are notable because they call for a National Health Plan much broader in scope than simple insurance improvements -- a plan that includes other steps required to address the critical problem of health cost inflation and to expand access to care for millions of underserved Americans. The principles are:

1. The plan should assure that all Americans have comprehensive health care coverage, including protection against catastrophic medical expenses.

2. The plan should make quality health care available to all Americans. It should seek to eliminate those aspects of the current health system that often cause the poor to receive substandard care.

3. The plan should assure that all Americans have freedom of choice in the selection of physicians, hospitals, and health delivery systems.

4. The plan must support our efforts to control inflation in the economy by reducing unnecessary health care spending. The plan should include aggressive cost containment measures and should also strengthen competitive forces in the health care sector.

5. The plan should be designed so that additional public and private expenditures for improved health benefits and coverage will be substantially offset by savings from greater efficiency in the health care system.

6. The plan will involve no additional federal spending until FY 1983, because of the tight fiscal constraints and the need for careful planning and implementation. Thereafter, the plan should be phased in gradually. As the plan moves from phase to phase, consideration should be given to such factors as the economic and administrative experience under prior phases. The experience of other government programs, in which expenditures far exceeded initial projections, must not be repeated.

7. The plan should be financed through multiple sources, including government funding and contributions from employers and employees. Careful consideration should be given to the other demands on government budgets, the existing tax burdens on the American people, and the ability of many consumers to share a moderate portion of the cost of their care.

8. The plan should include a significant role for the private insurance industry, with appropriate government regulation.

9. The plan should provide resources and develop payment methods to promote such major reforms in delivering health care services as substantially increasing the availability of ambulatory and preventive services, attracting personnel to underserved rural and urban areas, and encouraging the use of prepaid health plans.

10. The plan should assure consumer representation throughout its operation.

C. Consultation

At the same time that the President issued the principles, he asked that the tentative plan serve as a basis for consultation with Congress, State and local officials, interest groups and consumer representatives. He told Secretary Califano:

> "I am directing you to develop a tentative plan as soon as possible which embodies these principles and which will serve as the basis for in-depth consultation with the Congress, State and local officials, interest groups, and consumer representatives. You should then provide me with detailed recommendations so that I can make final decisions on the legislation I will submit to the Congress next year."

The President also requested analysis of options for phasing toward a fully implemented plan, as follows:

> "To respond fully to my economic and budgetary concerns, you should develop alternative methods for phased implementation of the plan."

D. Legislative Approach

The approach that emerged from the phasing analysis and the consultation process was that the President would:

-- present an outline of the full universal and comprehensive plan to the 96th Congress; but

-- ask for legislative consideration of only the first phase at this time.

As Secretary Califano said when he announced the President's decision in March of this year:

> "Since January, my colleagues and I have consulted scores of Congressional leaders, committee and subcommittee chairmen, and health industry experts. With few exceptions, the overwhelming sentiment among legislators is that the 96th Congress cannot and will not digest a complete national health plan in one bite."

Many members asked that the President send a Phase I bill to the Congress and accompany it with a description of the total plan.

II. Summary: The Fully Implemented National Health Plan

When fully implemented, the National Health Plan (NHP) will guarantee universal comprehensive health insurance for every American, using a mixture of financing sources and preserving a significant role for the private insurance industry.

General structure. The two basic structural entities established in Phase I will continue:

- -- HealthCare -- a public plan providing comprehensive coverage to the aged, the disabled, the poor and the near poor, and offering comprehensive coverage to individuals and firms unable to obtain such insurance in the private sector.

- -- The employer guarantee -- employers will be required to purchase qualified comprehensive plans for their employees from private insurors or HealthCare, and to pay at least 75 percent of the premium.

Eligibility. Every American will be covered by HealthCare or a qualified private plan meeting HealthCare standards. Using the estimated U.S. population in 1980 of 231 million as a base, this includes:

- -- Employees and their dependents -- 160 million persons -- will be covered by the employer guarantee.

- -- The aged and disabled -- 29 million persons over 65 or eligible for disability benefits -- will be fully covered by HealthCare.

- -- Low income -- 37 million persons with incomes up to the federal poverty level ($7500 for a family of four in 1980 dollars) -- will be fully covered by HealthCare.

- -- Others -- 5 million persons who are neither poor nor aged and who do not have salaried incomes -- will be required to purchase qualified private insurance plans or HealthCare coverage (with premium costs prorated for the near poor). This mechanism will achieve universal, mandatory coverage.

Benefits. HealthCare and all qualified private plans will be required to incorporate uniform covered services and patient cost-sharing provisions.

The comprehensive package of covered services will consist of:

- -- unlimited hospital, physician and diagnostic services;

-- specific amounts of other services with annual limits:

  - o 100 days of care in a skilled nursing facility*
  - o 100 home health visits
  - o 20 days in a mental hospital
  - o $1000 in outpatient mental health care

-- cost free prenatal, delivery and both preventive and acute child health care up to the age of 6, as well as cost free preventive care for all ages, based on a lifetime health monitoring program; and

-- outpatient prescription drugs in excess of $250 per person annually.

The cost-sharing provisions will provide incentives for outpatient and preventive care and protect all Americans against large expenditures by:

-- elimination of deductibles (except for drugs);

-- an equal coinsurance rate of 25 percent across all covered services (except that there will be no coinsurance on prenatal, delivery, child health care up to the age of 6, or on other preventive care);

-- a limit on annual out-of-pocket expenses for covered services in excess of $1500 per family or $750 per individual; and

-- prohibition of cost sharing for the poor and more limited cost sharing for the near poor.

Financing. NHP will use a mixture of public and private premium financing while taking a number of steps to maximize equity:

-- Necessary subsidies for the poor, the near poor, the aged and disabled, low income workers and low wage employers will be provided through public general revenues.

-- Current Medicare payroll taxes will be retained but not increased.

-- Employers will be required to pay at least 75 percent of any mandated premium; employees, up to 25 percent.

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*This benefit is included as a transitional service to help persons with acute problems to return to their communities. Long term care will be a separate program.

-- Competition will be encouraged because private insurors will be free to price large group plans at rates reflecting actual costs. At the same time these plans will have to compete with a HealthCare premium controlled for inflation -- thus preventing exorbitant prices.

-- Every worker will be insured individually; in families with two wage earners dependents can be included in either worker's plan. This will discourage employers from seeking out "secondary" wage earners for whom they now pay no premium.

Reimbursement. Reimbursement and cost containment policies under NHP must attempt to resolve the key tension between the desire to expand coverage and the need to contain costs:

-- Hospitals will be paid by public and private insurors according to limits prescribed in the program that evolves from the Administration's hospital cost containment proposal.

-- HealthCare will pay physicians according to areawide fee schedules; physicians will have to accept the fee as payment in full and will not be allowed to bill patients for extra amounts.

-- The schedules will serve to advise privately insured patients of reasonable physician fees and to encourage them to shop for less expensive care. If private fees are not kept within reasonable limits voluntarily, consideration will be given to other measures to contain physician costs.

-- Incentives for competition will include favorable reimbursement policies for Health Maintenance Organizations (HMOs) and other organized settings.

-- Employers will be required to offer employees coverage by any qualified HMO in the area and to make equal contributions to the health plans they offer their employees. Employees will then have an incentive to choose more cost effective plans.

-- A commission will be established to determine whether physician reimbursement policies are containing costs sufficiently and achieving broad provider participation in HealthCare.

Administration. The fully implemented NHP will preserve a major role for private insurors while providing uniformity of coverage:

-- Private insurors will market and underwrite qualified insurance plans for most current beneficiaries, add new beneficiaries through the employer guarantee and increase income by bidding on claims processing for HealthCare.

-- HealthCare will consolidate Medicare and Medicaid administrative functions and standardize eligibility, benefits, and reimbursement policies.

System reform initiatives. NHP is designed as an umbrella to include non-insurance provisions addressing problems in the way the health care system operates. Some of these initiatives will be included in the Phase I legislation; others involve separate but complementary legislative or administrative steps. They include:

-- Limits on hospital capital growth.

-- Incentives for competition, primarily through HMO development and expansion and consumer information about physicians' fees.

-- Expansion of utilization review.

-- Establishment of a new process to assess and coordinate federal grant efforts in light of expanded insurance coverage, including submission of a five year plan beginning with the first year of Phase I implementation.

-- Incentives for redistribution of physicians.

-- Technology assessment.

-- Improved delivery of services: primary care in underserved areas; mental health; prevention.

-- Government-wide efforts to prevent accidents and eliminate occupational or environmental causes of disease.

Costs. When fully implemented, NHP will meet a fundamental requirement: Total health system costs, including dramatically expanded coverage and effective cost containment, will be less than those of the present health system with its inadequate coverage and lack of effective cost containment.

III. The Fully Implemented Plan Compared to Phase I

A. General Structure

The two basic structures of the fully implemented National Health Plan (NHP) -- the public plan, HealthCare, and a requirement that employers purchase qualified insurance for their employees -- will be established in Phase I.

These two entities are the key to a smooth transition from Phase I to the fully implemented plan. Once they are in place, several fairly simple expansions will lead to deeper and broader coverage for all.

1. HealthCare. For HealthCare, expansion will take two forms:

   - The most significant improvement will provide fully subsidized coverage for all of the Nation's poor -- by raising the income standard below which every person is eligible.

   - Nearly all aged and disabled will already be enrolled; their insurance will be improved by providing greater protection against out-of-pocket expenses.

2. Employer guarantee. Expansion of the employer guarantee will also be of two types:

   - Here the most significant improvement will be in the nature of insurance. Qualified plans will be required to incorporate uniform cost sharing provisions with greater protection against out-of-pocket expenses, thus providing comprehensive coverage to all working families.

   - Employers will assume responsibility for part time as well as full time employees.

B. Eligibility

When fully implemented, NHP will mandate basic health insurance for all Americans. Several mechanisms will be used to move the four population groups -- the low income, the aged and disabled, the employed and others -- toward this universal comprehensive coverage.

1. Low Income. There are roughly 37 million persons at or near the federal poverty level who are not aged or disabled. Of these, 15.7 million now receive fully subsidized coverage through Medicaid. In Phase I, HealthCare will establish a national minimum low income standard at 55 percent of the

federal poverty level, regardless of family composition -- thus adding 10.5 million persons to those who already have fully subsidized public coverage. The other 10.8 million persons in the low income group will be eligible to "spend down" to the 55 percent standard and obtain subsidized coverage thereafter. Roughly 4 million are expected to do so.

The fully implemented plan will raise the low income standard to full poverty level. Thus all 37 million low income persons will receive fully subsidized coverage with no "spend down" required.

2. Aged and disabled. There are roughly 29 million persons over 65 or eligible for disability assistance. About 24 million currently receive Medicare benefits; another 4 million are poor and receive fully subsidized coverage through Medicaid. Phase I will bring another 500,000 aged and disabled who are under the 55 percent of poverty standard, but not now covered, into HealthCare.

   NHP will bring in the other 400,000 aged and disabled previously excluded from Medicare, thus covering all 29 million.

3. Employed. Of the 156 million full time employees and their dependents, 128 million are currently covered by employer group plans. A total of 56 million are not adequately protected against major illness -- the 28 million without employer group coverage and 28 million more whose employer group coverage is deficient in this respect. Phase I will require all employers of full time workers to provide HealthCare or qualified private group plans, with catastrophic coverage. This will ensure that all 156 million full time workers and their dependents are covered by employer group plans and that 56 million within this group receive the protection against major illness they lacked before.

   NHP will require employers to cover part time workers and their dependents. (A part time worker is defined as one who works less than 10 weeks, 25 hours a week for the same employer.) This expansion will mean that employers are responsible for coverage of an additional 4 million persons.

4. Others. Dealing with the 9 million persons who are not categorized as low income, aged, disabled or employed full time is more complicated. Some persons without salaried incomes are covered by individual plans, which are usually very inadequate. Some are not covered at all. Phase I will allow individuals who desire to do so to purchase insurance from HealthCare that is similar to the minimum

employer guarantee plan. In addition, the "spend down" program described for the low income group will also be available to the 4 million part time employees who are not yet covered by the employer guarantee, and to others, after they use a sufficient amount of income for medical care.

With the fully implemented NHP, mandatory universal coverage will be achieved because all persons will be required to purchase qualified plans from private insurors or HealthCare (with premiums prorated for the near poor).

5. Results:

- o Every American will be fully covered by HealthCare or a qualified private plan.
- o Providers will be put on notice that no person is a poor risk because of inability to pay.

C. Benefits

The element of a health insurance plan known as "benefits" is really a combination of two features:

-- Which services are covered by the plan.

-- What out-of-pocket expenditures by individual patients for covered services are required. This is known as patient cost sharing. (It does not include premium payments, which are discussed in Section D.) Cost sharing may take the form of deductibles or coinsurance -- a consistent percentage of the cost of specified services. Total out-of-pocket spending by an individual may be limited to a specific amount.

1. Covered services. The services covered in Phase I and under the fully implemented plan will differ only slightly. Phase I will establish a lean but comprehensive package of required services for HealthCare and all qualified private plans. Physician, diagnostic and hospital services will be covered on an unlimited basis. Specific home health, skilled nursing facility and mental health services will also be covered.

Prenatal, delivery and all health care during the first year of life will be included for pregnant women and children in HealthCare or covered by the employer guarantee. Because of the importance of this benefit in preventing disease and improving health status, it will also be available to any person not otherwise covered, at a nominal premium. No cost sharing will be imposed on these maternal and infant care services.

NHP will build on Phase I by:

- o Adding outpatient prescription drug coverage. Unlike other benefits, this would operate on a $250 deductible basis for administrative ease and to target coverage on those who must take medication on a long term basis.

- o Adding complete child health care up to the age of 6, as well as preventive services for all persons, consisting of periodic checkups and counseling according to a life-time health monitoring program. No cost sharing will be imposed on these services.

2. Cost sharing. While eligibility is the key variable in moving to a fully implemented plan for the poor, the transition from Phase I to NHP turns on cost sharing for most other persons.

   - o The poor and near poor. Poor persons eligible for HealthCare will pay no cost sharing in Phase I. Under NHP, the same full subsidy will be provided, but, as noted, to a larger number of covered poor. Near poor persons enrolled in HealthCare will face a 25 percent coinsurance rate across most covered services, but these payments will be subsidized for those just over the poverty line.

   - o The aged and disabled. In Phase I, existing cost sharing arrangements (Medicare deductibles) will apply, but no aged or disabled person will pay more than $1250 for covered services annually. Under NHP, a 25 percent coinsurance rate across all covered services except prevention will be used instead of deductibles, and the limit on out-of-pocket expenditures will be lowered to $750 per person annually.

   - o Employer guarantee. Persons included in the employer guarantee in Phase I will be protected against out-of-pocket expenses for covered services in excess of $2500 annually; the same limit will apply to families or individuals. Insurors will be able to require any form of patient cost sharing they wish as long as it does not exceed the limit. Under NHP the catastrophic limit will be lowered to $1500 per family and $750 per person. Deductibles will be eliminated (except for drugs) and cost sharing in any qualified plan will be limited to a maximum of a 25 percent coinsurance rate across all covered services except prevention.

3. Results:

- o Establishment of a precedent-setting prevention benefit for all persons, including complete health care for children up to the age of 6, designed to turn the direction of health care from curing to caring.

- o A drug benefit with a moderate deductible which will free those who must pay for medication on a long term basis from a major financial burden -- especially important for the aged living on fixed incomes.

- o Substantial protection against out-of-pocket expenditures for every American.

- o Powerful incentives for outpatient care achieved by eliminating deductibles and establishing a maximum coinsurance rate across services.

- o Phased implementation of cost sharing above the poverty standard to avoid work disincentives.

D. Financing

Financing -- who pays for the insurance policy in the first place -- affects the affordability and the equity of the plan. Both Phase I and NHP will retain the two current sources of financing in addition to some State and local revenues:

-- General revenues will be used to cover the poor; to subsidize the aged (in conjunction with current payroll taxes); to subsidize the near poor, and to offset adverse employment effects of mandated insurance.

-- Premiums paid by individuals or employers will be the predominant method of financing insurance.

1. General revenues. In the transition from Phase I to NHP, general revenue financing will expand as the number of persons with subsidized coverage increases. The aged will continue to pay 25 percent of the HealthCare premium -- an amount similar to the Part B Medicare premium -- with any part not covered by the current payroll tax subsidized by general revenues. Increased use of payroll taxes to finance improvements for the aged is undesirable because of inflationary impact and competition with other Social Security needs.

2. Premiums. Under NHP, as in Phase I, employers will pay at least 75 percent of premium costs and employees up to 25 percent. With full implementation, the premium structure will be altered in several ways. There are many advantages to retaining premiums -- among them ease of administration and minimal disruption of current patterns. However, premiums alone are not designed to vary according to ability to pay. Thus, as coverage expands and financial burdens increase it becomes more important to deal with certain problems:

   - o Competition will be encouraged because private insurors will be free to price large group plans at "experience" rates, reflecting actual costs of care. The HealthCare premium will be set at the current areawide rate for small groups and individuals -- generally higher than private large group rates.

   - o Increased premium burdens may exacerbate a tendency for firms to discriminate against the "primary" wage earner in a family, who carries insurance for himself and his dependents. Under NHP, every worker will have to be individually insured, to prevent employers seeking out "secondary" wage earners for whom they now pay no premium. Dependents will be dealt with through a premium structure that allows their coverage through either of two wage earners in a family.

   - o Larger premiums will also pose disproportionate burdens for small, low wage firms and for near-poor workers. Gradual implementation of broader benefits (and, consequently, gradual growth of premiums) will give firms time to adjust and lessen the need for subsidies in the plan's early years. The subsidies established during Phase I will be expanded as necessary.

3. Results:

   - o Continuation of employer payment of at least 75 percent of the premium.

   - o Enhanced competition among plans without subjecting employers or individuals to exorbitant premiums.

   - o Avoidance of adverse employment effects.

   - o Provision of needed premium subsidies to the poor, the near poor, the aged and disabled, and low wage firms.

E. Reimbursement

The way in which Phase I and NHP pay providers will be the keystone of an aggressive effort to contain costs and foster more efficient delivery of care. This is crucial to resolving the dilemma that stands in the way of full implementation: Expansion of coverage costs more money -- yet we need to control disproportionate growth of the health sector and to limit federal budget increases.

Ideally, NHP reimbursement and cost containment policy will bring health cost inflation in line with GNP growth and, to the maximum extent possible, finance new expansion through savings in health care costs.

The fully implemented NHP will build on three elements in Phase I:

-- Hospitals will be paid according to a single reimbursement policy for public and private insurors that is expected to evolve from the Administration's current hospital cost containment proposal.

-- Physician reimbursement reform will feature a mixture of mandatory controls for HealthCare and voluntary steps on the private side.

-- Competitive incentives to enrollment in Health Maintenance Organizations (HMOs) and other organized care settings will be established.

1. Hospital cost containment. Phase I recognizes -- as does current Administration policy -- that spiralling hospital costs are a major cause of health care inflation, requiring sustained efforts at containment. National and State limits on capital growth will also be established. The Administration's hospital cost containment proposal is designed as a transitional program, providing for establishment of a commission to consider future policy. Under a fully implemented NHP, hospital reimbursement can be expected to evolve further as a result of the commission's recommendations.

2. Physician fees. Phase I will establish areawide physician fee schedules for HealthCare, based on current Medicare rates but reducing urban/rural and specialty differentials. Low Medicaid fees will be phased up to the average Medicare level; providers now charging fees over the limit will be held harmless for two years.

    o The fee schedules will be mandatory for HealthCare and physicians will not be permitted to bill patients for additional amounts.

- o Published fee schedules, together with a list of physicians who accept them as payment in full, will serve to advise privately insured patients of reasonable fee levels and to encourage them to shop for less expensive care.

To aid in making the transition to the fully implemented NHP, a commission will be established to consider whether costs for privately insured physician services are being contained by the voluntary provisions of Phase I, to whether the absence of mandatory controls on the private side has adversely affected provider participation in HealthCare and access to care for public beneficiaries.

3. Competition. Phase I and NHP will provide incentives for enrollment in HMOs, Independent Practice Associations (IPAs) and other organized care settings. These incentives recognize that organized settings internalize cost containment measures and can replace certain forms of regulation for their enrolled population. They include:

   - o Requiring employers to offer coverage by any qualified HMO in an area.
   - o Requiring that employers make equal contributions to the health plans they offer their employees. Employees will thus have an incentive to choose more cost effective plans.
   - o Requiring that for subsidized beneficiaries, HealthCare reimburse HMOs and other organized settings at rates that encourage competition with the fee-for-service sector.

   As we move to a fully implemented NHP, consideration will also be given to changes in the tax laws to discourage spending for benefits outside the plan and to provide a disincentive to high provider fees.

4. Future options. The importance of correcting the underlying causes of runaway health costs -- an absence of market forces and the ability of providers to determine the type and quantity of service purchased -- cannot be over-emphasized. HMOs, which have reduced total costs dramatically, are a key element in this strategy. NHP must be structured to pass on these savings to the consumer, thus encouraging greater and greater competition.

At the same time, the Administration recognizes the limits on competitive forces in a system traditionally characterized by third party payments and cost-plus reimbursement. If the combination of hospital regulation, physician reimbursement reform and competitive incentives does not substantially lower health care cost inflation and ensure provider participation in HealthCare, stronger and more comprehensive measures may be needed.

One method that has been suggested is a national health budget set by the Congress (or some other, newly created, national entity) in relation to GNP and allocated to hospital, physician and other sectors. Rates could be negotiated by providers, consumers and insurors to meet the sector allocation.

F. Administration

In accord with the goal of a significant role for private insurors, the fully implemented NHP will minimize disruption of existing administrative arrangements. At the same time, it will provide appropriate regulation of private plans and shift some public functions from States to the federal level to enhance equity.

Again, the two basic structural elements established during Phase I will provide the foundation for additional change.

1. HealthCare. HealthCare will be the key to increasing uniformity of treatment for public beneficiaries. During Phase I, Medicare and Medicaid rate setting will be merged and claims processing will be contracted to private firms on a competitive basis. Eligibility determination will remain split, with States continuing to certify current low income recipients whose eligibility is linked to welfare, and the federal Social Security Administration certifying the aged and disabled, as they do now. For the newly-entitled poor (55 percent of poverty and spend-down eligibles) the federal government will be responsible for eligibility and intake, although States can elect to operate these functions under performance contracts.

   When fully implemented, NHP will ensure uniformity of treatment for all those in need of subsidies through HealthCare. The combination of federal standards and private claims processing will improve efficiency of operation, prevent waste and fraud, and mitigate providers' and consumers' problems with the current Medicaid program.

2. Employer guarantee. The employer guarantee will move toward similar uniformity on the private side, but with insurors retaining the essential functions of marketing and claims processing. During

Phase I and subsequently, the federal government will be responsible for certifying the benefits, catastrophic coverage and the consumer protections offered by qualified private plans.

3. Results:

   - o The important coordination of public and private standards to provide nationwide uniformity.
   - o A major role for private insurors and increased income from claims processing.
   - o Steps to increase equity and encourage competition.

G. System Reform Initiatives

Many serious problems in the U.S. health care system will not be relieved by insurance changes alone. NHP is designed as an umbrella, incorporating important non-insurance system reform supplements to guarantee access to care, limit and improve distribution of resources and promote efficiency. Phase I and a fully implemented NHP will deal with these problems in a very similar way.

1. Elements in Phase I legislation. The Phase I legislation itself will contain:

   - o A new process for assessing health care needs and the adequacy of federal grant programs, in conjunction with insurance, to meet the needs. Beginning with the first year of Phase I implementation, this process will require the Secretary to submit a five year plan for each relevant federal program. It will subsequently serve as a guide to expansion from pre-Phase I efforts to initiatives consistent with the complete plan.
   - o Strengthening the health planning program by imposing national and State limits on hospital capital spending, as noted.
   - o Measures to increase competition by encouraging HMO enrollment, as also noted.
   - o Expansion of utilization review.

2. Other initiatives. In addition, the following legislative and administrative initiatives already under way will be part of the Phase I and NHP system reform effort:

   - o Revising federal health manpower policy to discourage increases in physician supply and to provide incentives for change in specialty and geographic distribution.
   - o Seed money to expand HMOs and other innovative settings, helping to ensure consumers a wider choice among delivery systems.
   - o Improving efficacy and productivity through assessment of new technology and procedures.
   - o Expanding programs that provide basic primary care for the neediest of the nation's underserved areas.
   - o Implementing fully the proposed Mental Health Systems Act now before the Congress.
   - o Continuing to build disease prevention and health promotion through preventive dental services in Title I schools; anti-smoking, drinking moderation, nutrition and exercise campaigns; effective screening programs, and community based health fairs.
   - o Expanding government-wide efforts to eliminate the causes of disease through prevention of accidents and through occupational and environmental health programs.

3. Results:

   - o Coordination among federal grant efforts, while maintaining Congressional jurisdiction and valuable oversight of individual programs.
   - o Important incentives for change not possible with an insurance initiative alone.

IV. Conclusion

In summary, it is rarely possible to solve every problem in an important sphere of our national life with a single bill. Proceeding step by step, we can help millions of people -- people whose needs must not go unmet while we wait for the noble dream of comprehensive coverage for all to be realized.

Medicaid, Medicare and the proposed Child Health Assurance Program (CHAP) are incremental in nature. Phase I of the National Health Plan will be another, very major step toward equitable, adequate and cost conscious health protection for all Americans.

At the same time, as we approach our ultimate goal the broader vision must be clear. The National Health Plan set forth in this paper provides the context for orderly growth toward the universal comprehensive coverage this Administration supports.

JUNE 12, 1979

SUMMARY FACT SHEET: PRESIDENT CARTER'S NATIONAL HEALTH PLAN LEGISLATION

I. THE BASIC APPROACH

President Carter is committed to a universal, comprehensive National Health Plan that

- provides basic health coverage--hospitalization, physician services, lab-tests, X-ray and preventive care--to all Americans;
- systematically contains health cost inflation; and
- reforms the health system to improve the quality, efficiency and availability of health care services.

In a time of budgetary restraint and concern about inflation, it is not possible to enact a full universal, comprehensive plan. Accordingly, in order to address the most pressing health needs of the nation, the President has decided to send the Congress an outline of a complete National Health Plan and propose legislation embodying Phase I of that Plan. The Phase I legislation will

- achieve universality by setting a limit on the out-of-pocket costs faced by American families as a result of major illness. This dramatically improves protection for 56 million workers and their families (who will have a $2500 limit) and 24 million aged and disabled who do not now have such protection (and who will have a $1250 per person limit);
- achieve universality by providing all pregnant women and children in the first year of life with critical pre-natal, delivery, and infant services;
- achieve greater equity by extending fully subsidized comprehensive care to an additional 15.7 million aged and non-aged poor;
- hold down costs through physician reimbursement reform and limits on capital expenditures as a complement to the already pending hospital cost containment bill; and
- reform the health care system by enhancing competition, increasing access to needed health care services, emphasizing prevention and improving the management of public health care programs.

In so doing, the Phase I legislation will take a major step toward a fully developed, universal, comprehensive National Health Plan.

II. THE BASIC PROBLEMS

A National Health Plan--not just a National Health Insurance proposal--is needed because this nation's Health Care system, despite its many strengths, also has serious flaws:

- Inadequate Coverage:
  - -- 18 million Americans have no health insurance
  - -- 19 million Americans have inadequate health insurance
  - -- An additional 46 million have inadequate protection against the cost of major illness.
- Escalating Costs
  - -- Total health costs in 1979 are 9.1 percent of the GNP ($206 billion)--and will rise steeply to 10.2 percent of the GNP ($368 billion) by 1984 without hospital cost containment.
  - -- Federal health costs in 1979 are 12.7 percent of the Federal budget ($62 billion)--and will rise steeply to 14.5 percent of the budget ($110 billion) in 1984 without hospital cost containment.
- Other System Failures. For example:
  - -- There is little competition even though the Administration is removing barriers to the growth of alternative methods of health care delivery and reimbursement. There are not yet enough Health Maintenance Organizations to give many consumers a real choice, although with 8 million members, HMO's are emerging as a significant element in health care.
  - -- There is an insufficient emphasis on prevention, primary care and outpatient services. Existing insurance often does not cover these more effective, less expensive services.
  - -- 51 million Americans live in medically underserved areas.

III. THE BASIC STRUCTURE

President Carter's National Health Plan legislation proposes two basic structures that will help meet immediate needs and that can be expanded to achieve a universal, comprehensive plan (as described in the outline submitted to the Congress with the proposal).

- Healthcare will be a new umbrella Federal insurance program that will consolidate Medicare and Medicaid in a single administrative structure, that will introduce needed economies and efficiencies and that will reduce fraud, abuse and waste in public health financing program.

-- It will, to the maximum extent possible, use the private sector--on a competitive bid basis--to perform critical administrative functions.

-- It will provide comprehensive coverage to the aged, the disabled and the poor.

-- It will offer insurance against major medical expenses, on an optional basis, to other individuals and to small firms unable to obtain such coverage from private carriers at a reasonable price.

- The Employer Guarantee builds on present group coverage and the strengths of the private insurance system. It is the fundamental mechanism for ensuring coverage for American workers and their families.

  -- Many employers presently offer insurance to employees; the "employer guarantee" mandates that all employers provide minimum coverage. In Phase I, employers will be required to provide full-time employees and their families both a standard package of benefits and protection against the costs of major illness.

  -- Subsequently, the employer guarantee can be expanded to require provision of comprehensive health care coverage by reducing the level of employee cost-sharing.

IV. IMPACT OF PHASE I

President Carter's National Health Plan Legislation will significantly improve health protection for every American: the aged and the disabled, the poor, the employed and their families, and all others.

A. The Aged and the Disabled

- Phase I will improve coverage for all 24 million now receiving Medicare

  -- For the first time, the cost-sharing faced by the aged and the disabled will be limited--to $1250 per person. (At present the aged and the disabled must pay coinsurance of 20 percent on all Medicare physician services.)

  -- After the first day, the aged and the disabled will be entitled to an unlimited number of fully subsidized hospital days. (At present, the number of fully subsidized days is limited.)

  -- The aged and the disabled will not face extra physician bills beyond those covered by Healthcare because physicians treating aged and disabled patients will be able to charge no more than the publicly set fee. (At present, physicians treating Medicare patients can charge extra, and about half do.)

- Phase I will increase the number of low-income aged and the disabled receiving fully-subsidized care by 1.2 million, from the 4 million presently receiving Medicaid to 5.2 million who will be covered under Healthcare.

B. Low-Income

- Phase I will provide fully subsidized comprehensive coverage to an additional 14.5 million non-aged low-income persons, as well as continuing to provide such coverage to the 15.7 million presently receiving Medicaid.

  -- The legislation will automatically make eligible for comprehensive care an additional 10.5 million non-aged poor with incomes below 55 percent of the poverty standard, who are not on Medicaid.

  -- In addition, the legislation will propose a "spend-down" provision to cover all those poor with incomes above 55 percent of the poverty standard. If a family of four has income of $5100 and it expends $1000 or more on medical expenses, it then "spends-down" to or below the 55 percent of poverty level ($4100 for a family of four) and becomes eligible for a year's fully-subsidized comprehensive care under Healthcare. An estimated 4 million will enter Healthcare by this route each year.

C. Employed

The mandated employer coverage required by the Phase I legislation will protect 156 million full-time workers (25 hours per week, 10 weeks) and their families by limiting out of pocket expenses to $2500 in a year. It will also provide prenatal, delivery and first year care without any patient cost-sharing.

- 56 million will receive protection against major illnesses that they do not have at present.

- These 56 million and tens of millions who already have group coverage against major illness will receive other improved benefits because the employer guarantee requires that:

  -- the employer plan offer a full benefit package (hospital, physician, lab, x-ray, preventive and mental health services) that would be available after $2500 in out-of-pocket expenses had been incurred.

  -- the employer plan pay at least 75 percent of the mandated premium costs; and

-- The employer plan continue to provide insurance 90 days after termination of employment.

-- The employer plan cover all dependents until age 22 (26 if in school) and for 90 days subsequent to the death of the worker.

-- The employer plan cover the mother and infant benefit discussed above.

D. All others

For the non-aged/non-disabled, non-poor, and non-employed--many of whom often have a difficult time obtaining individual insurance--Healthcare will

- Offer protection against the costs of major illness--by paying a premium to Healthcare, individuals can obtain a policy that limits out-of-pocket expenses to $2500.

- Offer just prenatal, delivery and first year care without any patient cost-sharing.

These individuals include the part-time employed, early retirees, divorcees and partially disabled individuals who do not qualify for Medicare.

V. OTHER PLAN FEATURES

A. Financing

1. The Aged and the Disabled. The present payroll tax of 1.05 percent on both the employer and the employee will continue to be paid to the Health Insurance Trust Fund. But there will be no payroll tax increases under Phase I. Similarly, the aged and the disabled will continue to pay a premium for physician services (presently $98), but the cost of this premium will count towards the $1250 per person out of pocket limit. In short, other than the premium for physician services, benefits for this group will be financed out of Trust Fund and general revenues.

2. The Low-Income. Benefits will be financed out of general Federal and State revenues. States will continue to contribute in an amount approximating what they otherwise would have paid under Medicaid, reduced by fiscal relief.

3. The Employed. Employers will pay at least 75 percent and employees at most 25 percent of the premium costs of the mandated plan. The National Health Plan Legislation will also address two special aspects of the employer mandate.

-- For the low wage or high risk employer, Phase I will provide a full subsidy for premium costs that, due to the mandate, exceed 5 percent of payroll.

-- For the low-income worker with a family, Phase I will expand the Earned Income Tax Credit--beyond the expansion already proposed in the Administration's welfare reform proposal--to help defray employee premium costs.

4. All Others. The benefits offered to this group will be financed out of general revenues and individual premium payments to Healthcare.

B. Administration

- The private insurance industry will administer the "employer guarantee" consistent with National Health Plan standards. It will, of course, continue its role of underwriting and marketing private coverage to employed groups and individuals both within the standards and beyond those minimum requirements.

- The Federal government will administer Healthcare but make maximum use of private industry as carriers and claims handlers on a competitive bid basis. It will take over from the States the claims processing and reimbursement function and merge this function for both the low income and aged and disabled populations in order to reduce error and waste to the greatest extent possible in Federally-financed health programs.

- The States will continue their traditional functions of certification and licensure of health facilities and personnel as well as general regulation of private insurance. They will continue to determine eligibility for those who qualify for Healthcare through AFDC.*/ The Federal government will determine eligibility for other low-income entrants to Healthcare, although States may undertake this function for the newly eligible if they meet performance standards.

C. Reimbursement

1. Hospitals. The Administration's Hospital Cost Containment legislation will establish the conditions for reimbursing hospitals and holding down costs in this most inflationary sector of the health care industry.

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*/ Long-term care is not part of Phase I. The present Medicaid long-term care program will continue as a separate State-run program for the categorically eligible with the present Federal-State matching rates.

2. Physicians

-- A mandatory fee schedule will be established in order to protect the aged and the disabled from extra physician charges and to increase physician participation in the low-income program. This schedule will be developed, in the first instance, by setting a standard fee at the Medicare average in States or Sub-State areas and then raising substandard Medicaid fees in those areas to that level over time. Physicians cannot charge--or be reimbursed--above the fees established in the schedule. A process of negotiation will be established for subsequent fee schedule changes.

-- On the private side, the Healthcare fee schedule will serve as an advisory schedule for physicians serving those covered by the "employer guarantee." The names of physicians who are willing to adhere to the schedule will be published in order to increase consumer choice. A commission will be established to look at reimbursement questions and to advise whether more stringent measures are necessary to hold down health costs and increase physician participation in the public programs.

D. System Reforms

1. The Phase I legislation will include the following system reform elements:

- Increased competition through development of HMOs and other alternative delivery and reimbursement systems, greater employee access to and incentives to use efficient health plans and greater consumer information about doctors fees.

- Limits on capital expenditures to reduce excess hospital capacity and to curb proliferation of expensive, unnecessary high technology equipment.

- Strong emphasis on prevention.

- Creation of a voluntary Reinsurance Fund that will allow HMOs and firms to buy protection against the costs (over $25,000) of truly extraordinary illness, thus providing protection for businesses to self-insure and have a direct interest in cost containment as well as giving HMO's umbrella protection in handling high risk populations.

- A five year plan to assess needs and the adequacy of Federal health programs.

2. Other Administration initiatives will complement the Phase I bill, including:

- health planning legislation
- health manpower legislation to improve physician distribution, both in terms of needed specialities and geography
- mental health legislation
- health promotion and other initiatives to prevent disease, illness and injury.

E. Fiscal Relief

There should be significant fiscal relief in the program. Approximately $2 billion dollars in fiscal relief will be distributed to State, county and local governments in each of the first two years of the program.

VI. COSTS

There will be no Federal expenditures under the National Health Plan Legislation until Fiscal 1983.

The costs of the program in the first full year of operation are as follows (this assumes 1980 population as well as 1980 dollars):

NET FEDERAL BUDGET AND EMPLOYER COSTS
(in billions: 1980 dollars)

		Federal	Employer
AGED AND DISABLED		$3.9	
-- Improved catastrophic	(1.8)		
-- Improved subsidy for poor and near poor	(2.1)		
LOW INCOME (NON-AGED)		$10.7	
-- Full coverage	(6.9)		
-- Spend down protection	(3.8)		
EMPLOYED			
-- Employer Guarantee			$6.1
-- Low income worker: premium subsidy		$ .9	
-- Small employer premium subsidy (for mandated coverage)		$ .7	
ALL OTHERS		$ .5	
-- Healthcare buy-in	(.3)		
-- Prevention	(.2)		
ADMINISTRATION		$2.1	
TAX EFFECTS		-$.6	
	TOTAL	$18.2	$6.1

Assuming 1983 dollars and 1983 population, very preliminary estimates of the Federal cost of Phase I are in the range of $23-25 billion. In the coming weeks, the Administration will work with CBO and others to refine these estimates.

VII. RELATION OF PHASE I TO A FULLY IMPLEMENTED NATIONAL HEALTH PLAN

Phase I is structured so that it can easily be converted into a universal, comprehensive plan.

- For the aged and the disabled, cost-sharing could be reduced further and a drug benefit added.

- For the poor, the low income standard could be raised from 55 percent of the poverty line to the poverty line itself, increasing the number of low income Americans who receive fully-subsidized comprehensive coverage.

- For the employed, the employer guarantee could be extended beyond full-time workers to part-time workers. Cost-sharing could be reduced and deductibles eliminated, converting catastrophic coverage to comprehensive coverage.

- For the non-aged, non-poor, non-employed, comprehensive coverage could be required, but there could be subsidized premium costs and cost-sharing for the near poor.

- For all mothers and children, the prenatal, delivery and infant benefit could be extended through the child's sixth year without patient cost-sharing.

The fully implemented National Health Plan would also meet a fundamental requirement: Total health system costs under the fully implemented plan, with both dramatically expanded coverage and effective cost containment, would be less than the present health system with its inadequate coverage and without effective cost containment.

This will result in the achievement of one of President Carter's fundamental goals. The costs of vitally needed health care benefits for those lacking adequate health insurance must, to the greatest extent possible, be offset by savings from cost containment in the inflationary health care industry.

APPENDIX:
COMPARISON OF THE COSTS OF PRESIDENT CARTER'S
NATIONAL HEALTH PLAN LEGISLATION (PHASE I)
WITH
THE HEALTH CARE FOR ALL AMERICANS ACT

The Administration's legislative proposal and the proposal announced several weeks ago present their costs in two different ways. In order to understand the differences between the two proposals it is helpful to compare them both ways. This is done below assuming 1980 dollars and 1980 population counts.

(When the Health Care For All Americans Act was announced it was costed in 1980 dollars using estimated 1983 population counts. By using 1980 population counts, the estimates below reduce the costs of the Health Care For All Americans Act slightly.)

- The Administration's approach looks primarily at net Federal budget and employer costs because taxpayers and employers are the ones being asked to shoulder the cost of new benefits. The costs to employers are especially vital in determining the employment and inflation effects of National Health Plan proposals. When viewed this way, the net costs of the two proposals are as follows:

	Phase I	Health Care For All Americans Act
Federal	+$18.2	+$30.7
Employer	+$ 6.1	+$33.1
COST	+$24.3 billion	+$63.8 billion

- The approach taken by the advocates of the Health Care For All Americans Act is to look at these and other costs now borne by individuals and state and local governments as well in order to determine the effect of National Health Plan proposals on total health system costs.

	Phase I	Health Care For All Americans Act
Federal	+$18.2	+$30.7
Employer	+$ 6.1	+$33.1
Individuals	-$ 4.0	-$25.4
State/Local	-$ 2.0	-$2.7
COST	+$18.3 billion	+$35.7 billion

* Includes reduced out-of-pocket and premium costs.

DETAILED FACT SHEET: June 12, 1979

PRESIDENT CARTER'S

NATIONAL HEALTH PLAN LEGISLATION

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NATIONAL HEALTH PLAN FACT SHEET

I. THE BASIC APPROACH: A PHASE I BILL THAT LAYS THE FOUNDATION FOR A UNIVERSAL AND COMPREHENSIVE NATIONAL HEALTH PLAN

President Carter is committed to a National Health Plan that would:

-- assure all Americans comprehensive coverage including protection against the costs of major illness;

-- eliminate those aspects of the current health system that often cause the poor to receive substandard care;

-- reduce inflation in the health care industry;

-- be financed through multiple sources; and

-- include a significant role for the private insurance industry

Following the President's instructions, the Department of Health, Education and Welfare last year developed a plan meeting these criteria. Leaders of Congress, State and local officials, consumer groups, health care providers, the insurance industry, employers and other interested parties were then consulted.

Following those discussions, Secretary Califano reported to the President that there was a general consensus among these groups that a comprehensive universal health insurance plan would not be enacted in the 96th Congress. The President accordingly directed Secretary Califano to design a Phase I Plan that could lay the foundation for a comprehensive health plan while immediately addressing the nation's most pressing health needs.

The President is now submitting to Congress:

o an outline of the universal, comprehensive national health plan which should be the goal of a national health policy; and

o a proposal for the first phase of this plan.

II. PROBLEMS: THE NEED FOR A NATIONAL HEALTH PLAN

There are three sets of problems facing our health care system today which can be effectively addressed only through a national health program.

- o Lack of Coverage. Millions of Americans lack coverage for basic health services and protection against the rising cost of major illness.

  -- 18 million Americans have no health insurance -- most of these people are poor or near-poor.

  -- 19 million Americans have inadequate health insurance coverage that fails to cover ordinary hospital and physician services.

  -- an additional 46 million Americans have inadequate insurance against large medical bills. These individuals and families may have basic coverage but they are not protected against major medical expenses.

Eligibility policies of public programs -- coupled with restrictions in private health insurance -- are largely reponsible for these gaps in coverage.

-- Medicaid fails to cover millions of poor Americans. For example, more than 10 million individuals with incomes below 55% of the official poverty standard are not covered by Medicaid.

-- Many employers do not offer insurance to their workforce. 10.1 million full-time workers have no insurance. Another 18 million are not covered by employer or union group health plans. Employees who have coverage find that, during periods of unemployment, their health insurance lapses but they are ineligible for public programs.

-- The average family often finds that common exclusions and limitations in insurance severely restrict their protection. Literally millions find their coverage restricted because they suffer from a pre-existing medical condition. Thus, people with heart trouble may find their insurance excludes all treatment of heart-related problems. Many middle-class families learn that, when a child becomes 21 years old, he or she is no longer included in the family's insurance, although the child is frequently not able to afford separate coverage.

o Inflation in the Health Sector. The costs of health care are sharply increasing, adding to inflation and threatening the stability of governmental budgets. Spending for health care -- the nation's third largest industry -- rose at an average annual rate of 12.7 percent from 1968 to 1978. Unless meaningful cost containment measures can be instituted through hospital cost containment and effective restraints in a national health plan:

-- National health costs will rise from $206 billion in 1979 to $368 billion in fiscal year 1984 -- up from 9.1% of GNP to nearly 10.2%.

-- Federal health care expenditures will rise from $62.0 billion in 1979 to nearly $110 billion by FY 1984 -- up from 12.7 cents of every Federal tax dollar to 14.5 cents under current projections for that year (without hospital cost containment).

-- The cost of individual health care will rise steeply. The average cost for a family of four will leap from $2372 in 1979 to $4064 in 1984, and the average cost for an elderly individual will soar from $2259 to $3868 during the same period.

o Inefficiency of the Health Delivery System. The health care delivery system is financed in large part through a system of third-party (insurance) payments that pay institutions on the basis of "cost" reimbursement and pay professional providers their "usual and customary" fee.

-- over 90% of hospital bills are paid by third parties

-- hospitals are reimbursed by an inefficient "cost plus" system which gives them no incentive to save on costs because the more they spend the more they get paid

-- there is no buyer/seller relationship; physicians make 70% of health care decisions but have no incentive to hold down costs.

There have been very few market incentives operating to restrain costs and encourage prudent use of resources. This system of payments has contributed powerfully to inflation in the health sector, and has also:

-- Inhibited competition among providers. Consumers frequently have no incentive to choose the most economical method of care and little information upon which to base such a choice.

-- Encouraged maldistribution of health care providers. Highly specialized practices -- almost always in urban areas -- are rewarded much more generously than primary care and rural practice, leaving rural areas and inner-cities underserved.

-- Discouraged the growth and utilization of preventive services. Insurance benefits are heavily prejudiced in favor of hospital-based care and against preventive and primary care. Very few insurance plans provide coverage for routine preventive services such as immunizations and regular check-ups for infants.

III. MAJOR PROGRAM ELEMENTS

A. An Overview

The President's Phase I NHP is designed to address the most urgent of these problems and to put into place the institutional structures necessary to guarantee comprehensive coverage for every American. It builds on the strengths of our present system -- for example, employment based coverage of the working population -- while at the same time providing new structures to make coverage universally available.

There are two major institutional features of the Phase I bill:

- HealthCare will be a new umbrella Federal insurance program that will consolidate Medicare and Medicaid in a single administrative structure, that will introduce needed economies and efficiencies and that will reduce fraud, abuse and waste in public health care financing programs.

  -- It will, to the maximum extent possible, use the private sector -- on a competitive bid basis -- to perform critical administrative functions.

  -- It will provide comprehensive coverage to the aged, the disabled and the poor.

  -- It will offer insurance against major medical expenses, on an optional basis to other individuals and small firms unable to obtain such coverage from private carriers at a reasonable price (a comparable subsidy will be provided should these employers prefer to purchase insurance privately).

- Mandated Employer Coverage (The Employer Guarantee) All employers will be required to provide full-time employees (25 hours, 10 weeks) with insurance which meets Federal standards. Premium costs can be shared with employees, (75%/25%), but employers must pay at least 75% of the total.

The majority of employers will purchase this coverage from private insurance firms which sell plans certified to meet the Federal standards. Employers for whom insurance premiums would impose significant burdens will have the option of purchasing coverage from HealthCare at subsidized rates, or of applying to HealthCare for a comparable subsidy which can be applied to private premiums.

Over time, the terms of the employer guarantee can be modified to achieve a more comprehensive level of coverage than Phase I by first reducing the maximum beneficiary cost-sharing permitted (e.g., it could be reduced to $1500 per family) or subsequently through expanding the benefit package to broaden coverage of certain services that have been limited or excluded from the initial mandate.

<u>These two insurance structures together -- HealthCare and approved private insurance plans -- together will provide every American with the opportunity to obtain insurance protection in Phase I. Equally important, it will put into place institutional structures which can be expanded -- in large or small steps -- to move toward a universal and comprehensive plan.</u>

The Phase I NHP links together HealthCare and private insurance plans so that policies of national importance can be made consistent across the public insurance plan and all private plans. For example, all private plans will cover, at minimum, the HealthCare basic benefit package, reimburse all classes of providers recognized under the HealthCare program (e.g., clinics, nurse practitioners, alcohol treatment centers), and include incentives for system reform.

Thus all Americans will understand the basic coverage to which they are entitled; providers will face more consistent policies from public and private insurance plans, and both public and private incentives for cost control and system efficiency will work in tandem, not in opposition to each other. An example of consistent cost containment policy across public and private plans is the hospital cost containment plan which will limit payments to hospitals by both public and private insurance programs.

B. <u>HealthCare</u>

HealthCare will be a new Federal insurance plan which expands Medicare for the aged and disabled and replaces Medicaid as an insurance program to pay for acute care services used by poor families.

HealthCare is a new insurance structure which can be flexibly adapted over time to solve a number of special coverage problems which do not readily lend themselves to solution through the private sector. HealthCare will:

- o Establish uniform and consistent policies governing eligibility, benefits, cost-sharing, reimbursement and quality assurance for the beneficiaries of Federal health insurance: the aged, low-income and disabled. This will improve program performance for each beneficiary group:

  - -- the aged and disabled will have an expanded, integrated benefit package which removes the current dichotomy between Medicare "Part A" (hospitalization) and "Part B" benefits (physician services) and does away with limits on hospital coverage.

  - -- aged and disabled beneficiaries currently enrolled in both Medicare and Medicaid (4 million individuals) will deal with a single program -- HealthCare. This will simplify enrollment and program contacts for the beneficiaries and will enable the program to handle their claims more efficiently and expeditiously. At present, claims for these beneficiaries are paid by both State Medicaid programs and Medicare. Co-ordination of claims payment between the State and Federal programs often results in long payment delays for physicians and other providers.

  - -- the low-income will benefit from national minimum eligibility standards for acute care services. At present, there are 53 separate Medicaid programs, each with differing standards governing eligibility and benefits.

  - -- the low-income as well as the aged and disabled will benefit from the new provider payment policy. The low-income will have greater access to mainstream medicine because HealthCare will pay physicians a higher fee than most Medicaid programs. The aged will be protected against excess physician fees that are higher than the HealthCare approved rate.

- o Increase administrative efficiency and improve quality assurance activities by establishing single claims processing agents in wide geographic areas. At present, multiple private insurance firms may handle Medicare

claims processing in a single area. The State or a private contractor handles Medicaid claims. HealthCare will select one private contractor -- for example, an insurance company or data processing firm -- to handle all claims in a State or multi-State area. This will:

-- reduce contracting costs by the award of contracts on the basis of competitive bids. At present, Medicare must honor the claims agent designated by providers. However, experiments in several areas show that contracts awarded on the basis of competitive bids are significantly less costly.

-- enable economies of scale in bill processing. One contractor in a geographic area will be able to utilize efficiently advanced claims processing technologies such as on-line computer terminals for billing in every hospital. Hospitals, physicians, and other providers will also realize efficiencies in billing. Use of one agent and a single claims form will permit bulk billing and faster cash flows to physicians.

-- enhance program ability to identify fraud and abuse problems by establishing a single identifying number for all participating providers. Computer profiles maintained by the claims processing agent should permit ready identification of those providers whose billing patterns indicate an abnormal volume of claims or other questionable practices.

These management improvements are not feasible under current law because Medicare requires DHEW to employ the fiscal agent designated by providers in the area and because there cannot be administrative integration of Medicare with the 53 separate Medicaid programs. The State-by-State variations in benefits, provider participation policy, reimbursement policy and other administrative features makes integration of the two programs almost impossible even if the hurdle of Federal/State management control could be surmounted.

o <u>Establish a new national insurance structure which can provide assistance to those individuals and employment groups whose special problems make it difficult for them to be adequately served by the private insurance market.</u>

-- Non-employed, non-aged or non-low-income individuals whose health is poor or who have a history of serious medical problems in the past (a "pre-existing" medical condition).

These individuals cannot generally obtain insurance in the private market or, if it is available, must pay exorbitantly high premiums or accept a policy which excludes the pre-existing condition.

-- Non-aged spouses of workers who have reached age 65. Once the worker enters HealthCare, or today, Medicare, spouses often have great difficulty in obtaining private insurance. This problem is most troublesome for women in their late 50s or early 60s who are not employed outside the home. They will be able to buy HealthCare.

-- Individuals who work intermittantly and in hazardous occupations. Private insurance plans are customarily reluctant to insure these individuals. They will be able to buy HealthCare.

-- Employment groups which have a concentration of high-risk individuals or those in which the nature of work is so hazardous that private plans are not available or available only at an exorbitant premium. They will be able to buy HealthCare.

For these kinds of individuals and groups, HealthCare will be available to make adequate coverage available at a reasonable premium.

Specific features of the HealthCare plan are summarized below:

1. Eligibility

o Aged and disabled. Medicare eligibility standards would continue under HealthCare for all persons over age 65 and those persons under age 65 who meet the Social Security test of total and permanent disability, or who suffer chronic renal failure. The 500,000 aged persons who do not have sufficient quarters of coverage to gain entitlement but whose incomes are less than 55% of poverty will also be enrolled in HealthCare.

- The Low-Income. There are three eligibility gates into HealthCare for the low-income:

  -- Through cash assistance eligibility. All persons who qualify for cash assistance under the program for Aid to Families with Dependent Children (AFDC) or Supplementary Security Income (SSI) will be automatically enrolled in HealthCare at the time they qualify for cash assistance payments. Eligibility will extend to all cash assistance recipients including those who do not currently qualify for Medicaid because of optional State restrictions and those who would not automatically qualify for Medicaid under the Administration's Welfare Reform proposal (newly mandated AFDC-U families). Eligibility levels for AFDC and SSI families will vary by State, mirroring the cash assistance standard in that State.

  -- Through the national low income standard. Other individuals or families whose incomes are less than the HealthCare low income standard -- equivalent to 55% of povertyin Phase I -- will also be eligible for HealthCare. This is an important extension of entitlement to 10.5 million non-aged low-income perons not now on Medicaid.

  -- Through the spend-down standard. Any individual or family whose health expenses exceed the difference between their income (minus a 20% of earnings work expense deduction) and the 55% of poverty can apply to HealthCare for complete coverage of all further expenses for a year. This is an important extension of spend-down protection, now provided by only 30 States, but available nationally under HealthCare. Thus, for example, a family of four with earnings of $7000 per year could apply for HealthCare coverage through the "spend-down" if their medical, if applicable, expenses (plus certain allowances for child care) exceed $1400 (55% of poverty equals $4200 -- $7000 - $1400 = $4200).

    This will provide critical assistance to 4 million additional people. In States where spend-down standards for Medicaid exceed the HealthCare standard, HealthCare will maintain the higher standard for single parent families with children and aged, blind or disabled individuals.

- o Others. All other persons can buy into HealthCare by paying the premium for individuals and small groups. The benefits purchased under this buy-in are the same as those provided to other HealthCare beneficiares, subject to a $2500 deductible on all services.

- o Employment Groups. Although employers will generally fulfill their obligations under the employer guarantee by purchasing private insurance, HealthCare will serve as a back-up insurance plan for those who find private coverage difficult to obtain or unreasonably expensive. Any employer can buy into HealthCare for the mandated coverage (HealthCare benefit package but with a $2500 deductible on all services except prenatal, delivery and infant care.)

2. Benefits

The HealthCare benefit package includes a comprehensive range of acute care services, and complete preventive as well as acute care benefits for pregnant women and infants. The benefits are similar to those provided under Medicare, with some improvements. HealthCare benefits are more generous than Medicaid benefits in about half the States, but more restrictive than in certain high-benefit States. The most significant exclusions from current Medicaid benefits are drugs, dental care, eyeglasses and hearing aids, and long term care. Drugs, dental care, eyeglasses and hearing aids will continue to be provided in a residual Medicaid program, with administration handled by HealthCare or by State governments, at the State's option. Specific benefits included in HealthCare are:

- o Inpatient hospital services (unlimited)

- o Physician and other ambulatory services (including laboratory and excluding dental and psychiatric care) (unlimited)

- o Skilled nursing service (100 days per year). These skilled nursing home benefit days are intended to permit patients who still require the support services of an institution -- but no longer the range and intensity of services provided by a hospital -- to be released from the hospital to a less costly level of care. The skilled nursing benefit will reduce the length of hospital stays for many admissions.

- o Home health visits (100 visits per year)

- o Mental health (20 days of inpatient hospital care; $1000 in ambulatory services)

- o Preventive Care. HealthCare covers two important preventive care packages

  -- complete prenatal, delivery, and total infant care (preventive and acute services) for all mothers and children

  -- a schedule of preventive services for all children up to age 18

Except as noted above, long term care services will be continued as a separate program under State Administration, financed under the current Title XIX program grant system.

3. Cost-Sharing

Different cost-sharing requirements apply to persons who enter HealthCare through the various eligibility standards.

- o Aged/Disabled. At present, the aged and disabled pay a single day hospital deductible of $160 (July 1, 1979) for each admission per "spell-of-illness" plus a $60 deductible and 20% co-insurance on non-hospital services. There is no limit on coinsurance payments. In addition the aged pay fees charged by physicians which exceed the Medicare maximum payment rate. In combination, these requirements leave the aged exposed to high and unpredictable out-of-pocket costs. That will change under HealthCare.

  Medicare cost-sharing requirements are extended to HealthCare with the following important modifications:

  -- there will be an annual hospital deductible rather than a new hospital deductible applicable to each spell-of-illness. The annual deductible will be the same.

-- no cost-sharing will be required after an individual has paid $1250 in out-of-pocket costs

-- aged persons whose income is below 55% of poverty standard have no cost-sharing. Neither do those who spend down the 55% standard.

-- All physicians bills will be assigned -- that is, physicians will be required to bill HealthCare, not the beneficiary, and to accept HealthCare's payment rate as full compensation for the service. No extra billing will be permitted.

o The Low-Income. Persons eligible because they are entitled to cash assistance or because their income is less than the low-income standard do not face any cost sharing. Individuals who enter HealthCare through the "spend-down" do not face cost-sharing after they spend-down below low-income standard. Only expenses related to services covered under the HealthCare mandate will be counted toward the spend-down.

o Others

-- Individuals or employer groups who buy into HealthCare by paying a premium, face a deductible of $2500 on all services. However, because of the importance of good pre-natal care and comprehensive health care services for all infants, a special maternity and infant benefit is provided under the HealthCare buy-in. All pre-natal care services, the costs of delivery, and total preventive and treatment costs for an infant in the first year of life will be covered under the buy-in without cost-sharing. This will remove all financial barriers to seeking care for pregnant women and infants.

4. Financing

- o Aged and disabled. The current Medicare payroll tax (1.05% on employer and employee, applied to a $22,900 earnings base) will be continued. In addition, all aged and disabled persons with incomes above the 55% of poverty standard will be required to pay a premium equivalent to the Medicare Part B premium, which is now $98. Additional subsidies will be provided through Federal general revenues to pay the cost of protecting the aged against catastrophic expenses.

- o The Low-Income

  State and local governments will continue to share with the Federal government in the costs of financing HealthCare covered services for the low-income population in a manner that will retain State incentives to restrain health cost inflation. State fiscal liabilities under HealthCare will approximate those which would have occurred under Medicaid reduced by fiscal relief

- o Others

  Individuals who buy into HealthCare will pay a national community rated premium which is based on the average per capita costs for all individuals and groups of less than 50. It will cover about 75% of their actual costs. The remaining costs will be provided through a Federal general revenues subsidy.

5. Administration

HealthCare will be a new national insurance program with uniform standards governing benefits, eligibility, provider reimbursement, quality assurance, and other aspects of law and regulation which determine the adequacy, equity, and performance of the program. As such, it will be quite similar in concept to Medicare.

Under Medicare, the same eligibility standards apply to aged and disabled persons throughout the country. All Medicare enrollees have the same benefits, cost-sharing obligations, and rights under the program, no matter where they live. Although Medicare is governed by national law and policy, it is in large measure, administered locally -- all claims processing is contracted out by HEW to "fiscal intermediaries" and "carriers", most often the local Blue Cross and Blue Shield plans.

Medicaid, by contrast, is not a national program. Eligibility standards, benefits, provider participation policy, and reimbursement rates differ among the States. Thus, equally poor individuals may be entitled to benefits if they live in one State but not entitled in another. Providers are also treated unevenly. Some States so drastically limit payments that only 25% of physicians accept Medicaid patients, while other States pay adequately. Payment error rates are high and payments are generally slow. For these and similar reasons, the program is widely criticized by beneficiaries who use it, providers who are paid by it and the taxpayers who finance it.

One of the most important objectives of the Phase I NHP is to create the framework for a national health insurance plan which is viewed as a valued part of our social insurance system. It should be equally available to all Americans -- no matter where they live. It should be viewed as treating both beneficiaries and providers fairly, equitably, adequately, and efficiently. It should be seen by the public as operating efficiently, and with accountability -- minimizing problems of fraud and abuse by providers or beneficiaries.

These are ambitious goals, and cannot be accomplished within the framework of multiple Federal and State insurance programs in which accountability is diffuse and standards variable.

Instead, HealthCare creates a new administrative structure which permits the implementation of national standards governing benefits, provider participation, reimbursement policy, quality assurance and fraud control. It will closely resemble Medicare in the sense that claims administration will continue to be handled under contract with private fiscal agents. However, because of

the multiple gates into HealthCare -- through Social Security, through cash assistance, or through the spend-down -- there will be several different agencies determining eligibility, not a single agency (as the Social Security Administration now determines eligibility for Medicare.) Regardless of how they enroll initially, however, all beneficiaries will enter the same program. Providers can be assured consistent treatment and fair reimbursement on behalf of all HealthCare patients.

Specific functions will be handled as follows:

- o All claims processing will be handled by private fiscal agents (insurance companies, data processing firms or others) covering a specified geographic area. Today, there are multiple claims agents in an area -- the Medicare intermediary and carrier and the Medicaid claims processing agent (either a State or its designee). HealthCare will shift all responsibility for management of claims processing to the Federal level. This will permit merger of this function for all aged and low-income beneficiaries, and should reduce error and waste to the greatest extent possible in Federally-financed health programs. Contracts will be awarded on the basis of competitive bids. This will reduce administrative costs, and improve speed of payment to providers. Use of a single fiscal agent will enhance our ability to detect problems of fraud and program abuse.

- o Eligibility determination will be handled by the Federal government for aged and disabled persons. States will handle eligibility determination for categorically eligible families (AFDC). The Federal government will determine eligibility for other low-income entrants to HealthCare, although States may undertake this function for the newly eligible if they meet performance standards.

6. Reimbursement

- o Hospital. Payment for hospital services under the Phase I NHP will be governed in both HealthCare and private plans by the Administration's hospital cost containment program.

- o Physicians and other providers of ambulatory care services. Physicians and others who provide ambulatory (non-institutional) services to HealthCare patients will be paid on the basis of a fee schedule. The fee schedule for physicians will be based on average Medicare physician payment levels. Medicaid fees will be brought up to the Medicare level in the three years prior to implementation of the schedule. After the first year implementation of the fee schedule, subsequent alterations in the schedule will be developed through a process of negotiation between HealthCare and physician representatives.

  All physicians who accept HealthCare patients will be required to take assignment of claims -- that is, to accept the HealthCare fee as payment in full for the service rendered. This is one of the most important new protections extended to the aged and disabled and will save them approximately $1 billion in charges now billed by physicians. This will protect all HealthCare beneficiaries from being billed for excess physician fees. Private plans will be encouraged use the HealthCare fee schedule as a guide in determining their rates of payment.

7. System Reform

Many serious problems in the U.S. health care system will not relieved by insurance changes alone. NHP is designed as an umbrella, incorporating important non-insurance system reform supplements to guarantee access to care, redirect and improve distribution of resources and promote efficiency and competition.

- o A new process for assessing health needs and determining the adequacy of federal programs. This program will require a five-year plan for each relevant federal program.

- o Strengthening the health planning by imposing national and State limits on hospital capital spending, as noted.

- o Measures to increase competition by encouraging HMO enrollment, as also noted.

- o Expanding utilization review

In addition, the following legislative and administrative initiatives already under way will be part of the NHP system reform effort:

- o Revising federal health manpower policy to prevent a potentially costly physician surplus and to provide incentives for change in specialty and geographic distribution.

- o Seed money to expand HMOs and other innovative settings, helping to ensure consumers a wider choice among delivery systems.

- o Improving efficacy and productivity through assessment of new technology and procedures.

- o Expanding programs that provide basic primary care for the neediest of the nation's underserved areas.

- o Implementing fully the proposed Mental Health Systems Act now before the Congress.

- o Continuing to build disease prevention and health promotion through preventive dental services in Title I schools; anti-smoking, drinking moderation, nutrition and exercise campaigns, effective screening programs, community based health fairs and environmental improvements, WIC, occupational health and safety and other relevant programs throughout the government.

C. The Employer Guarantee

All employers will be required to provide full time workers (persons who have worked at least 25 hours per week for 10 consecutive weeks) and their families with a health insurance plan which meets Federal standards. For the 100 million workers and their families who now have coverage the effect of the guarantee generally will be to enrich their benefit package by adding important new protections such as mental health coverage and skilled nursing care. But for the 56 million workers and their families who do not now have insurance providing comprehensive protection against catastrophic costs, the guarantee will provide important new financial security against bankruptcy.

Insurance companies marketing plans to meet Federal standards and clearly designate those policies which meet Federal requirements.

The requirements of the mandate encompass benefits, cost-sharing liability, extensions of coverage after termination of employment, to spouses and dependents in the event of death of the wage earner or divorce; plus other consumer protection standards. All employers must offer their employees a choice between an insurance plan meeting Federal standards and enrollment in any Federally qualified HMO (or Independent Practice Association -- IPA) in the area.

1. Eligibility. All full-time employees, their spouses and dependents. Dependents include children through their 22nd birthday or through age 26 if enrolled in school on a full-time basis or otherwise a dependent of their parent. Children disabled before their 22nd birthday are continued as dependents as long as they live with their parents. Any employer who fails to meet his obligations under the mandate will be subject to a fine. The self-employed will be treated like any other employer.

2. Benefits and Cost-Sharing: The benefit package in the employer plans must include the same services as those insured under HealthCare. The employer may agree to provide broader benefits, but cannot provide a smaller package. For most employed persons and their families, cost-sharing under the plan will be relatively limited because employers will continue and improve coverage now in force. However, no individual or family will face cost-sharing in excess of $2500 per year for services covered under the mandate. Within this constraint, employers (and unions) may arrange any combination of cost-sharing ranging from complete coverage without cost-sharing to a $2500 deductible on all services. One exception will be applied: there can be no cost-sharing on pre-natal and delivery services for a pregnant woman or for all acute care provided to an infant in the first year of life. These special preventive services are recognized to have extremely high pay-off in terms of improved delivery outcome, lowered infant and maternal mortality, and long term child health. Therefore, all financial barriers to seeking these services will be eliminated.

3. Financing and Special Subsidies. Employers will be required to pay at least 75% of the premium cost for a plan meeting the Federal mandate standards. Higher employer premium shares can, of course, be agreed to in collective bargaining. Today more than 85% of workers with employer-financed insurance are covered in plans where the employer pays at least 75% of the premium. Any collective bargaining agreements in force that call for higher employer shares when Phase I NHP is implemented will be protected for the life of the contract.

   Because premiums are assessed by private insurance companies on the basis of the health risk presented by an employment group and the composition of that work force -- e.g. the number of workers with families -- a traditional premium will create problems for marginal firms andlow-wage workers, particularly workers with families. In order to protect employers and low-wage workers from undue hardship resulting from premium payments, several special subsidies are included:

   - Employers will not be required to spend more than 5% of payroll on a mandated plan. (On average, employers who now provide no coverage will be able to buy the mandated package from insurance firms for 2.5% of payroll.) Subsidies for costs in excess of 5% will be available by buying coverage from HealthCare at a premium rate equal to 5% of payroll or by applying for an equivalent subsidy to purchase coverage from private insurance firms. Data limitations prevent a precise estimate of the number of firms that would be likely to take advantage of this subsidy provision. However we are able to estimate that firms employing approximately 7 million workers (out of a work-force of 73 million full-time workers) might take advantage of one of the two subsidy options.

   - The Earned Income Tax credit which assists low-income working families will be expanded to provide a maximum benefit of an additional $150 to largely offset the cost of the employee premium share for such families.

5. Administration. Phase I NHP establishes national minimum standards for all health insurance plans provided to meet the employer mandate. To assure uniform application of these standards, the certification process will be Federally administered. The Federal government will also offer a reinsurance program to health maintenance organizations, employers and small insurance companies.

   o Standards for employer plans: All employers will be expected to provide coverage conforming to Federal standards, whether they obtain this coverage through private insurance companies, HealthCare, provide it by self-insuring or through multi-employer trusts. The purpose of the standards is to assure consumers adequate protection and information about their insurance coverage, and to link private coverage standards with HealthCare to achieve a national guarantee of basic protection. To meet the conditions of the employer mandate a plan must:

   -- provide, at a minimum, the HealthCare benefit package with a maximum out-of-pocket liability of $2500 policy. Plans may include any cost-sharing configuration desired, so long as the out-of-pocket limit is retained. However, there will be no cost-sharing for pre-natal and delivery services for pregnant women or preventive and acute care services provided to an infant in the first year of life.

   -- provide the same benefits to all persons. There will be no waiting period for coverage after the 10th week of employment, and coverage must continue at least 90 days after termination of employment, or after the death of a worker or divorce of a worker and spouse.

   -- not limit or exclude coverage due to pre-existing conditions; provide care for newborns and have no restrictions on coverage or benefits for those in poor health.

-- cover spouses, dependents, including children (and adopted children) up to age 22, (or age 26 if a full-time student or otherwise a dependent of the wage-earner) and children disabled prior to age 22, if living with their parents. Employees and/or their dependents must be given the right to continue to buy comparable individual plan from the insurance company after termination of employment, regardless of their health risk.

-- provide adequate, clear information regarding policy provisions, benefits, costs and conform to any further public disclosure requirements or standards for policies.

-- publish a reasonable relationship of premiums charged for qualified plans to benefits paid to policyholders.

o Enforcement of Standards. DHEW will review and certify all private plans. Similar standards and certification processes will be applied to insurance companies seeking to market to employer groups and to self-insured plans of a single employer or a multi-employer employer trust. States will continue most of their insurance regulatory activities (e.g., review of premiums and plans for financial solvency). While traditional State roles in insurance regulation will be largely preserved, the Federal government has a responsibility to assure that plans purchased under the mandate are uniform and meet minimum standards. In the event of a conflict between the Federal mandate and State requirements, the Federal standards will be primary.

An insurance company which alters a previously qualified health insurance plan -- or otherwise misrepresents a plan as conforming to Federal standards when it does not -- will be liable for several penalities:

-- The company will not be allowed to market any health insurance under the Federal program for a specified period.

-- The company will be assessed a financial penalty.

-- The company will be liable for civil suit and subject to criminal penalties.

o Reinsurance Program. Creation of a voluntary Reinsurance Fund that will allow HMOs and firms to buy protection against the costs (over $25,000) of truly extraordinary illness, thus providing protection for businesses to self-insure and have a direct interest in cost containment as well as giving HMOs umbrella protection in handling high risk populations.

6. Reimbursement

o Hospitals. Payment for hospital services in approved private plans, as in HealthCare, will be based on implementation of the Administration's hospital cost containment program.

o Physicians and other ambulatory care services. The issue of what -- if any -- restraints should be placed on payment to physicians under participating private insurance plans was one of the most difficult questions to resolve in designing Phase I of NHP. Clearly, fee schedules and mandatory assignment are essential components of HealthCare plan; needed to control costs, protect beneficiaries, and institute more equitable reimbursement rates for primary care physicians than exist in Medicare and Medicaid today.

Extension of the same fee schedule to private plans and requirement of mandatory assignment plans were considered, but rejected, for Phase I NHP. Instead, the Phase I, NHP will attempt to stimulate competition among providers and assist beneficiaries in knowing which physicians accept insurance payments as full compensation for a service.

-- The HealthCare fee schedule will be furnished on an advisory basis to all insurance plans marketing coverage to meet the employer mandate. Plans may use -- or not use -- the schedule in guiding the rates they will pay for a given service.

-- Insurance plans will furnish enrollees with lists of physicians in the State who agree to accept the insurance plan's reimbursement as full compensation for their services. This will enable consumers to make a better-informed choice of physicians.

-- The various incentives to establish or expand pre-paid practice systems (HMOs, IPAs) may serve to restrain fee increases by physicians, who must compete with the pre-paid plans for patients.

The success of these incentives to restrain physician fees through competition and consumer information will be studied for three years by a Presidential Commission. Following that study, the Commission will make recommendations.

7. System Reform: Competition

A number of incentives to increase competition among providers have been included in the private mandate provisions. The most important of these include:

o The requirement that employers make equal dollar premium contributions to (all plans offered by the employer (e.g., an insurance plan or plans and HMOs or IPAs). This will encourage employees to seek out lower-cost plans because the employer's relative contribution would be greater. It will encourage employers to help establish HMOs in order to hold down their premium liabilities.

In the event the employer's contribution would exceed 100% of the premium cost for a low-cost plan, alternative fringe benefits or other compensation to the employee would be required.

- Improved consumer information will be available including:

  -- the list of participating physicians furnished by private insurance plans

  -- information regarding area HMOs or IPAs (available from HealthCare Office.)

IV. CONSEQUENCES

Phase I of the National Health Plan will be universal, reaching every American. For the most vulnerable in our society -- the aged, the poor, the disabled, mothers and infants -- it will provide comprehensive care, that is a full range of benefits subject to either limited or no cost-sharing. For all others, it will at minimum provide protection against the cost of major illness, while establishing a framework upon which comprehensive protection can be built through voluntary improvements and through statutory enlargement of the employer guarantee. The consequences of NHP Phase I for beneficiaries, employers, State and local governments, the private insurance industry and employers is described in the following sections.

A. Beneficiaries

1. Aged and Disabled: HealthCare will continue and expand the coverage now available under Medicare.

   - For the first time, 24 million aged and disabled Americans will have a limit on their out-of-pocket medical expenses. No enrollee will pay more than $1,250 for covered medical services. The poor aged and disabled will pay nothing.

   - Current Medicare benefits will be improved through providing unlimited days of hospital care and expanded benefits for mental health and alcoholism services

   - One-half million of our poorest elderly citizens, who do not now have sufficient Social Security coverage to be eligible for Medicare, will receive insurance for the first time under HealthCare.

- o About 20,000 disabled individuals, who now lose Medicare benefits when they return to work, will retain their health insurance coverage for three additional years.

- o In total, the elderly will save almost $1 billion in out-of-pocket payments for physician services, because physicians will not be allowed to bill at more than the approved rate.

2. The Low-Income: Medicaid coverage will be significantly altered and expanded.

   - o 15.7 million non-aged poor now on Medicaid will be automatically converted to full subsidy coverage under HealthCare. This includes SSI recipients who live in the 15 States that do not provide Medicaid to all these individuals.

   - o Current Medicaid recipients will receive a similar package of acute care services through HealthCare. They will continue to receive long term care services through State-run programs.

   - o An additional 10.5 million persons with family incomes under 55 percent of poverty will, for the first time, be brought into a health care financing program. These people will receive fully-subsidized coverage through HealthCare.

   - o An estimated four million additional individuals will obtain HealthCare coverage because their medical expenses are so high as to reduce their effective family income to 55% of the official poverty level.

   - o Another 7 million people who are within $3000 of the 55% of poverty level are thus insured by the spend-down even if their expenses in a given year are not sufficiently high to qualify them for HealthCare coverage.

3. The Employed: Under Phase I NHP all full-time employees and their families will be guaranteed a minimum level of health insurance coverage.

   - o 156 million workers and their families will finally be protected against the devasting costs of catastrophic illness. None will have to pay more than $2500 per family on out-of pocket expenses.

- o Every worker will have coverage for prenatal, delivery and infant care with no cost-sharing requirements.

- o No worker will have to pay more than 25% of the premium for mandated coverage.

- o All workers will be assured extension of health benefits during short periods of unemployment, and their families will be similarly protected if the wage-earner dies or if the family is separated. Workers and their families will have an opportunity to convert their health insurance to an individual policy if they desire after leaving employment.

- o For many workers and their families, the scope of benefits will be improved through coverage of physician services and home health visits.

- o Low-income workers and their families will receive subsidies for their share of the premium through an expanded Earned Income Tax Credit.

- o Employees will be able to join any qualified Health Maintenance Organization or Independent Practice Association in their area, if they desire.

4. All Others: About 9 million Americans will not automatically be insured under HealthCare or through mandated employer coverage. These people are unemployed or work part-time, but are not over age 65 nor poor enough to be entitled to fully-subsidized care. HealthCare offers a basis of catastrophic protection for this group in two ways:

   - o Any non-employed person can purchase HealthCare coverage at a national community-rated premium. (Federal subsidies will hold the premium rate to no more than the average per capita health expenditure for all individuals and persons in small groups in the country. Because the nine million individuals in this group have much higher than average health costs -- approaching $3000 each -- a subsidy is required to make coverage affordable.) About 1 million are likely to buy a plan including the complete HealthCare benefit package, with a deductible of $2500.

B. Employers: Under Phase I NHP employers will be required to provide coverage meeting Federal standards to all full-time employees and their dependents.

- Most firms in well-insured industries (manufacturing, transportation) will have to make only small changes in their current plans - e.g., adding physician office visits or the mental health benefit. In poorly-insured industries, such as agriculture and retail trade, many will for the first time provide at least catastrophic protection for their employees. Various measures have been included in the Phase I NHP to assure that meeting the terms of the guarantee will not cause undue hardship to employers and will not result in substantial job loss.

  -- the guarantee requires only that the employer purchase insurance covering costs in excess of $2500. This holds the average premium rate for the mandated plan to $450 per worker.

  -- For those employers whose work force includes a large proportion of workers with higher than average health costs (older workers, a high proportion of women in their childbearing years, or those with large families) subsidies have been included as part of the Phase I package.

- Any employer will be able to buy the mandated insurance from HealthCare by paying a premium equal to 5% of payroll. Or, if the employer prefers to purchase coverage privately, a similar subsidy will be provided to pay private premiums.

- Within the framework of Federal requirements for certified plans, employers will continue to negotiate coverage with insurance companies as they do today. Large firms, (with over 50 employees) will be able to purchase experience-rated contracts whereby premiums are set according to individual utilization experience. Firms of 10-50 workers will pay a community-rated premium for firms of that size. This will protect a small firm (10-50 workers) with exceptionally high-risk employees from paying a premium which is substantially higher than that paid by other firms of a comparable size.

- The availability of the voluntary Federal Reinsurance Fund will enable many medium-size firms to self-insure. Because the Reinsurance Fund will insurance exceptionally large claims (over $25,000) many employers may find it cheaper to self-insure for claims under that amount.

C. State and local governments

Because the Phase I NHP is putting into place a national health program the current responsibilities of State and local governments will be altered in several respects.

1. As Employers

State and local governments in their capacity as employers will be required to provide insurance coverage to their workers which meets the standards of the mandate.

2. Administration

States will conduct eligibility determinations for those families who enter the program because of eligibility for cash assistance. They also will have the option, subject to meeting appropriate performance standards, of contracting with the HealthCare program to conduct eligibility determinations for all persons entering through the national low-income standard or through the spend-down provisions. States will retain administrative responsibility for financing services not covered by HealthCare (primarily long term care), although provision would be made at State option for administration through HealthCare of the non-covered acute services that some States now provide through HealthCare at State option.

3. Other Continued Functions

States will continue their traditional functions in certification and licensure of facilities and personnel and the regulation of private health insurance. However, to the extent that federal regulations governing the employer mandate plans conflict with State regulations, the federal regulations will be primary.

4. Fiscal Responsibility/Fiscal Relief

State and local financial responsibilities for public health care programs will be affected in two major ways by this proposal: (see following table)

- The NHP Phase I will provide $2 billion in fiscal relief for State and local governments (see tables at end of fact sheet for the geographic distribution of this fiscal relief). This fiscal relief will result from:

-- A $0.5 billion decrease in the State share for current Medicaid services

-- The fact that HealthCare provides low-income individuals and families with additional insurance coverage which will help pay bills to State and local hospitals or replace payments made by other State and local programs - $1.5 billion.

o States will continue to share with the Federal government in the costs of financing HealthCare covered services for low-income population in a manner that will retain State incentives to restrain inflation in health care costs. State liabilities will approximate those they would face under Medicaid, (less the fiscal relief, indicated above). To insure no State faces a greater liability there will be a five year hold-harmless provision for any increased health care costs (relative to Medicaid) resulting from expansion of coverage, improved benefits or upgrading of physician fees.

o Federal and State Financial Responsibilities During the Transition Period

Currently the States share in Medicaid costs according to a formula that yields a range from a low of 22% to a high of 50%, depending on State per capita income. At present the States have a great deal of flexibility to influence total Medicaid costs in the State by modifying plan provisions such as benefits covered (except for those required in the core benefit package necessary to meet the conditions of the Federal grant-in-aid program), reimbursement levels, and other provisions including income eligibility levels for entering the program.

During the first two years subsequent to the implementation of HealthCare, the Medicaid matching formula would continue to determine the States share for financing those services not covered by HealthCare. However, in order to hold States harmless for the anticipated increased costs for expansions in full subsidy and spend-down coverage, improved benefits and fee upgrading for HealthCare covered services, and to provide some fiscal relief, the State share in HealthCare costs will be calculated as follows:

- the Medicaid expenditures that each State would have incurred during these two years for HealthCare covered services will be projected by indexing actual Medicaid costs in the prior year to the average growth rate of State Medicaid expenditures during the prior three years. (Maintenance-of-effort of the current State Medicaid plan would be required from the time of enactment of NHP Phase I until implementation of HealthCare.)

- States will be required to pay 90% of these estimated expenditures which, in the aggregate, are expected to be about $5.5 billion.

This procedure will guarantee States fiscal relief during the first two years of the program and produce a predictable HealthCare expense for them. It also will maintain their incentives to hold down inflation in medical care costs after the enactment of NHP Phase I.

- Federal and State Financial Responsibilities After the Transition Period

In the third and subsequent years after implementation of the program, States will share in the actual costs -- excluding that portion attributable to the eligibility expansion, benefit improvement and fee upgrading -- of providing HealthCare covered services to the low income population on the basis of the Medicaid matching formula.* However, this formula will be adjusted to provide a 5% reduction in all States' matching rate as it applies not only to their new HealthCare cost-sharing, but also their continued Medicaid service expenditures for non-HealthCare covered services. This will provide additional continuing fiscal relief

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* Estimated Medicaid expenditures will be subtracted from total HealthCare costs for the low-income population in year two. The remainder will reflect those costs attributable to the eligibility expansion, benefit improvement and fee upgrade which are being borne 100% by the Federal government. This figure, indexed by the rate of growth of the nominal GNP, will be subtracted from the subsequent years' costs of HealthCare for the low-income population in order to arrive at that portion in which the States would share.

for the States which is estimated to be about $.5 billion in the third year. Furthermore, a general hold-harmless will remain in effect through the fifth year of HealthCare based upon projections of what the States otherwise would have paid under Medicaid for HealthCare covered services (calculated in the same manner as described above for the transition period).

These cost-sharing arrangements will insure that States, as well as the Federal government, are sensitive to the need to restrain health care cost increases. States will continue to enjoy substantial fiscal relief beyond the third year as long as the rate of growth of HealthCare program costs increases for the low-income population does not substantially exceed that of the GNP.

States also will be protected from the costs of any future eligibility and benefit expansions in the program in subsequent phases.

o Savings in State and Local Public Facilities and Grant Programs

There will be additional immediate fiscal relief for State and local governments in the amount of $1.5 billion.

This fiscal relief results from the extensions of insurance protection in HealthCare (the new coverage for 10.5 million low-income persons and 4 million through spend-down) and through the employer guarantee. These insurance plans -- HealthCare and private plans -- will reimburse municipal, county and State hospitals for services that must now be financed through tax revenues. Insurance payments will also replace payments to providers made by State and local grant programs such as those for crippled children. Approximately half of the $1.5 billion in fiscal relief will flow to State governments. The table which follows details fiscal relief by State.

D. The Insurance Industry

The decision to provide insurance coverage for the working population primarily through private insurance companies will create an initial increase in insurance premiums paid by employers and employees of $8.5 billion. These are not voluntary premium payments, they are made by employers and employees as a result of Federal law.

A government requirement that all working people purchase protection against major medical expenses imposes a corollary obligation on the Federal government to assure the value and availability of protection offered to meet the guarantee. For this reason, new Federal regulations will be established to qualify insurance plans which are sold to meet the conditions of the guarantee. These regulations will supercede any similar regulations imposed by States. States will, however, continue to regulate private health insurance for solvency and other aspects of insurance sales which are now regulated by State law.

E. Providers

The combination of HealthCare and extended private insurance as a result of the employer guarantee will effect major health care provider groups in the following ways:

- o Hospital revenues will be contained through the provisions of the Administration's hospital cost containment plan. However, as a result of extending coverage to persons now either uninsured or inadequately insured, revenues to hospitals and skilled nursing facilities will increase by $5.5 billion.

- o Physicians and other providers of ambulatory care services will continue to operate their practices just as they do under current law and programs. Nothing in the NHP Phase I will alter the professional relationship between physician and patient. Nothing in the NHP Phase I will restrict the right of individual patients to choose their own physician.

The most significant change from current law for physicians is the requirement that any physician treating HealthCare beneficiaries agree to submit their bill to the HealthCare program rather than billing the patient directly, and to accept the HealthCare payment as full compensation for the service -- not to bill the patient for any additional amount. As a result of the extension of coverage to those not previously insured for physician services and because of the upgrading of Medicaid fees, total payments to physicians and other providers of ambulatory care services will increase by $10.3 billion under NHP Phase I.

V. Cost of the Phase I NHP and Economic Impact

Expansion of coverage and benefits under the Phase I plan will not begin until FY 1983. This provides time for administrative planning; gives initial cost controls and system reform incentives an opportunity to slow increases in health care costs prior to the expansion of coverage, and gives employers an opportunity to plan for proposed standards on health insurance coverage for employees.

The actual first year cost of the program will depend, in part, upon the restraint in health care costs brought about by other Administration initiatives prior to 1983 such as:

- o hospital cost containment
- o strengthening of health planning and utilization review under the Professional Standards Review Organizations (PSROs)
- o emphasis upon technology assessment
- o expansion of health maintenance organizations

The uncertainty as to the magnitude of savings brought about by these types of system reforms and cost costraints makes any projection of first year costs more problematic the further out in time the estimates are presented. To reduce this uncertainty, all cost figures are for FY 1980, assuming that the Phase I plan were in effect in that year. In addition, estimating change in Federal expenditures and total health system costs due to Phase I is a complex technical task. We will work with CBO over the next few months to further refine these estimates.

A. Total Health Spending

As shown below, the Phase I plan will increase total health spending for the covered benefit package (hospitalization, physician services, lab and X-ray, and prenatal, delivery, and infant care) by $17.8 billion (in 1980 dollars and population) or 0.7% of GNP.

EXPENDITURES FOR COVERED SERVICES, CURRENT LAW AND UNDER NHP-PHASE I
(FY 1980: AMOUNTS IN BILLIONS)

	CURRENT LAW	NHP PHASE I	CHANGE
TOTAL SYSTEM SPENDING*	$148.0	$166.3	$18.3
FEDERAL	45.0	63.2	+18.2
EMPLOYER	42.6	48.7	+ 6.1
INDIVIDUAL	52.0	48.0	- 4.0
STATE	8.4	6.4	- 2.0

*For NHP covered services

The net impact on total health spending during the 1980s, however, will depend upon total system savings from hospital cost containment, reimbursement reforms for physicians and other health care providers, and other health system reform measures included in the Phase I plan or other Administration initiatives. Reductions from cost controls and system reform incentives are estimated to more than offset the expanded utilization and expenditures generated by the Phase I plan after the third year of operation. Even with the expansion to the fully implemented universal, comprehensive plan, total health spending is expected to be lower than it would be under the current system.

B. Federal Budget

The net effect on the federal budget of the Phase I plan will be $18.2 billion (FY 1980 dollars and population). Federal tax revenues are used to:

- Improve major medical protection for the aged and disabled
- Subsidize coverage for the poor and near-poor
- Provide financial protection for selected low-wage and/or high-risk workers and unemployed persons; and
- Guarantee access to adequate prenatal, delivery, and infant care to non-employed families

1. Aged and Disabled -- $3.9 billion

Coverage for the aged and disabled is improved in two major respects:

- A ceiling on cost sharing of $1250 per person is imposed, and the limits on covered hospital days are removed -- Net cost $1.8 billion
- All aged below 55% of poverty are fully subsidized, and spend-down protection is provided for all aged with incomes above this level -- Net cost $2.1 billion

2. Low-Income (Non-Aged) -- $10.7 billion

All cash assistance recipients and person below 55% of poverty receive fully subsidized care. Others above this income may "spend-down" and receive coverage. Major costs for this group are allocated as follows:

- Improved coverage for current cash assistance recipients (primarily an upgrade in physician fees under the Medicaid program) -- $1.4 billion
- Expansion of coverage to all below 55% of poverty -- $5.5 billion
- Spend-down coverage -- $3.8 billion

3. Employed -- $1.6 billion

Federal revenues are used to subsidize care for selected low wage and/or high risk workers:

- o An Earned Income Tax Credit provides relief from additional mandated premiums for low wage workers -- Net cost $0.9 billion

- o Any firms may purchase HealthCare at a subsidized premium if their costs for the mandated benefit would otherwise exceed 5% of payroll (a comparable subsidy will on the experience of individuals and firms be provided if they buy private). Federal general revenues are used to subsidize the difference between premium payments and benefit payments -- Net Cost $0.7 billion

4. Others -- $0.5 billion

-- Financial protection and access to prenatal, delivery, and infant care services are guaranteed for the non-employed through the purchase of HealthCare coverage:

- o Such individuals may purchase a $2500 deductible plan covering hospitalization, physician services, lab, X-ray -- by paying a premium set at the average community rate equivalent to the average cost for individuals and firms with fewer than 50 employees. Federal general revenues are used to subsidize the difference between premium payments and benefit payments (premiums cover 75% of benefit costs) -- Net Cost $0.3 billion.

- o Non-employed families may also enroll once a year for comprehensive prenatal, delivery, and infant care up to age 1 by paying a premium set at one-fourth the cost of this coverage for employed families. Federal general revenues are used to subsidize the difference between premium payments and benefit payments -- Net Cost $0.2 billion.

5. Administrative Expenses -- $2.1 billion

The additional federal administrative costs are $2.1 billion. The greatest proportion of this increased cost is for intake and eligibility determination of the approximately 15.7 million newly covered persons (1.2 million aged, 10.5 million fully subsidized low-income non-aged, and 4 million spend-down into fully subsidized coverage).

6. Tax Effects -- $ -0.6 billion

The Phase I will also affect the federal budget indirectly through its impact on federal tax receipts. There are three important effects:

- Out-of-pocket payments will be reduced, and itemized deductions under the personal income tax will be lowered. This will increase federal tax payments, and reduce the net deficit to be financed. Net Cost -- $ -0.5 billion.

- The personal income tax provisions for health insurance premiums and medical expenses will be changed. A deduction will be provided only to the extent that premium and medical expenses exceed 10 percent of adjusted gross income (rather than 3 percent as in current law). This will increase federal tax payments, and reduce the net deficit to be financed. Net Cost -- $ -1.3 billion.

- Employers will be required to spend $6.1 billion more under the employer guarantee plan than they would under current law. To the extent that employers substitute these premium payments for wage payments, taxable income of employees will be reduced (or, in practice, increased less than they otherwise would have increased). This will reduce federal tax payments, and increase the net deficit to be financed. Net Cost -- $1.2 billion.

C. Other Financial Flows

Some provisions of the Phase I plan will increase both federal receipts and expenditures, with no net effect on the deficit. These include:

- o A voluntary reinsurance plan will be provided to any insurance company, health maintenance organization or other organized delivery setting, or employer choosing to self-insure employees. This reinsurance plan will be self-financing through the assessment of premiums sufficient to cover expenses. It is estimated that premium payments of $0.3 billion will be made to the plan.

- o Individuals and employers may purchase HealthCare coverage by paying a premium set at the community-rated premium for individuals and firms with fewer than 50 employees. Premium payments which will go to cover benefit payments will be $0.9 billion.

In total, these provisions will increase both federal outlays and federal receipts by $1.2 billion, with no net effect on the federal budget deficit.

D. Impact on Employers and the Economy

The Phase I plan takes care to minimize the impact on employers to avoid any serious economic effects on employment or inflation. The net increase in employer premiums, over and above current health insurance premium payments is expected to be $6.1 billion (in 1980 dollars). If the plan were implemented immediately upon enactment, it might be expected to cause a one-time increase in the CPI of 0.2 percentage points (assuming all new employer costs were reflected in higher prices) and result in the loss of about 50,000 jobs. However, no changes in employment-based insurance are proposed until FY 1983. This should provide time for employers to make adjustment in their wage and fringe benefit packages to accommodate the standards set by the plan and, as a result, cause only inconsequential employment and inflation effects.

Also, in order to ameliorate any adverse impact on selected firms, subsidies are provided to small firms and to firms with unusually high premiums as a percent of payroll (either because workers have low wages or are high risks). Any firm with premiums exceeding 5 percent of payroll will be eligible for a subsidy to purchase HealthCare coverage or comparable coverage from a private insurance firm.

VII. RELATION OF PHASE I TO A FULLY IMPLEMENTED NATIONAL HEALTH PLAN

Phase I is structured so that it can easily be converted into a universal, comprehensive plan.

- For the aged and the disabled, cost-sharing could be reduced further and a drug benefit added.

- For the poor, the low income standard could be raised from 55 percent of the poverty line to the poverty line itself, increasing the number of low income Americans who receive fully-subsidized comprehensive coverage.

- For the employed, the employer guarantee could be extended beyond full-time workers to part-time workers. Cost-sharing could be reduced and deductibles eliminated, converting catastrophic coverage to comprehensive coverage.

- For the non-aged, non-poor, non-employed, comprehensive coverage could be required, but there could be subsidized premium costs and cost-sharing for the near poor.

- For all mothers and children, the prenatal, delivery and infant benefit could be extended through the child's sixth year without patient-cost sharing.

The fully implemented National Health Plan would also meet a fundamental requirement: Total health system costs under the fully implemented plan, with both dramatically expanded coverage and effective cost containment, would be less than the present health system with its inadequate coverage and without effective cost containment.

This will result in the achievement of one of President Carter's fundamental goals. The costs of vitally needed health care benefits for those lacking adequate health insurance must, to the greatest extent possible, be offset by savings from cost containment in the inflationary health care industry.

JUNE 12, 1979

President Carter's

NATIONAL HEALTH PLAN LEGISLATION:

CHARTS

1. National Health Plan: The Basic Approach
2. National Health Plan: Problems with the Current System
3. Phase I: Goals
4. Phase I: Structure
5. Phase I: Benefits for the Aged and Disabled
6. Phase I: Benefits for the Poor and the Near Poor
7. Phase I: Benefits for the Full-Time Employed
8. Phase I: Benefits for Others
9. Phase I: Benefits Summarized
10. Phase I: HealthCare
11. Phase I: The Role for Private Insurance
12. Phase I: State Role and Fiscal Relief
13. Phase I: Payment to Providers
14. Phase I: System Reform
15. Phase I: Net New Costs
16. The National Health Plan: Steps Beyond Phase I

NATIONAL HEALTH PLAN:
THE BASIC APPROACH

Describes Ultimate Goal: Universal and Comprehensive Plan that —

- Provides Basic Health Care to All Americans
- Systematically Contains Health Cost Inflation

Proposes Phase I Legislation that:

- Lays Foundation for Long-Term Plan
- Improves Coverage for Those Most in Need: Poor, Aged and Disabled
- Provides All Americans with Protection against Cost of Major Illness
- Initiates Key Cost Containment and Other Health System Reforms

NATIONAL HEALTH PLAN:
PROBLEMS WITH THE CURRENT SYSTEM

Inadequate Coverage

- 18 Million Americans with No Health Insurance
- 19 Million Americans with Inadequate Basic Health Insurance (Hospital, Physician and Diagnostic Services)
- An Additonal 46 Million Americans with Inadequate Catastrophic Health Insurance

Escalating Costs

- Health Costs Are 9.1 Percent of GNP ($206 Billion), Federal Health Costs 12.7 Percent of the Federal Budget ($62 Billion) — and Rising Steeply
- Total Health Costs Will Jump to $368 Billion in 1984 without Hospital Cost Containment

Other Health System Failures

- Lack of Competition: Only 4 Percent of Population in HMOs
- Insufficient Emphasis on Prevention: Often Not Covered by Insurance
- 51 Million Live in Underserved Areas

PHASE I: GOALS

Expand Coverage to Achieve —

Universality In:

- CATASTROPHIC PROTECTION: **$2500 Limit on Out-of-Pocket Expenses for Major Illness Available to All Americans**
- PREVENTION SERVICES: **Prenatal, Delivery and 1st Year Services Available for All Mothers and Children without Cost Sharing**

Equity:

Expanded Comprehensive Coverage for Aged, Disabled, Poor and Near Poor

Hold Down Costs

- Hospital Cost Containment
- Physician Reimbursement Reforms
- Limits on Capital Expenditures

Reform the Health Care System

- Enhance Competition among Insurers, Physicians, Suppliers
- Provide Care in Underserved Areas
- Improve Management of Public Programs

Major Step Toward Universal, Comprehensive National Health Plan

PHASE I: STRUCTURE

HealthCare

— The Umbrella Federal Insurance Program for Aged, Disabled, Poor, Near Poor, Small and High Risk Businesses and Others Not Served by Private Insurance

Employer Guarantee

— All Employers Must Provide Insurance against Major Medical Expenses for Full-Time Workers (25 Hours Per Week, 10 Weeks) and Their Families

System Reforms

— Capital Controls, HMOs, Competition, Reimbursement Reform, Voluntary Reinsurance Fund

PHASE I:

BENEFITS FOR THE AGED AND DISABLED

Improve Coverage for All 24 Million Non-Poor Aged and Disabled

- Limit Cost-Sharing to $1250 Per Person ($2500 Per Couple)
- Physicians Can only Charge Publicly Set Fee — Aged and Disabled Won't Face Extra Bills
- Remove Limit on Fully Subsidized Hospital Days
- Ambulatory Mental Health Coverage Increased from $500 to $1000 Annually

Provide Fully Subsidized Care for an Additional 1.2 Million Poor Aged and Disabled

- A Total of 5.2 Million Poor Aged and Disabled Will Be Covered under HealthCare

PHASE I:
BENEFITS FOR THE POOR AND THE NEAR POOR

Provide Fully Subsidized Coverage for an Additional 14.5 Million Poor

- Those under 55 Percent of Poverty Standard not Covered by Medicaid Now: 10.5 Million
- Those Who "Spend-Down" to 55 Percent of Poverty: 4 Million

Improve Care for 30.2 Million Covered Poor — Including 15.7 Million Currently on Medicaid

- Unlimited Hospital and Physician Services
- Complete Coverage for Prenatal, Delivery and 1st Year of Care
- Physician Participation Increased

PHASE I:
BENEFITS FOR THE FULL-TIME EMPLOYED

Mandate Coverage of 156 Million Full-Time Employees and Families under Private Group Plans

Essential Improvements for Workers and Their Families

- Limits Out-of-Pocket Expenses to $2500
- Mandates Prenatal, Delivery, and 1st Year Care with No Patient Cost-Sharing
- Mandates Other Important Standards: e.g.,
  - Basic Benefit Package (Hospital, Physician, Lab and X-Ray, Preventive and Mental Health Services) *and* Full Coverage After $2500
  - 90-Day Insurance after Termination of Employment
  - No Exclusion of Pre-Existing Conditions
- Requires Employer to Pay at Least 75 Percent of Premium
- Provides Subsidies for Low-Income Workers and Small Employers

Result

Catastrophic Coverage for 56 Million with Inadequate Protection

Better Basic Coverage for These and Tens of Millions More

PHASE I:
BENEFITS FOR OTHERS

Makes HealthCare *Available* for Those Non-Aged, Non-Poor, Non-Employed Who Often *Cannot Obtain Individual Insurance*

- **Can Buy HealthCare Catastrophic Plan: $2500 Deductible**
- **Prenatal, Delivery, and Infant Care with No Patient Cost Sharing**
- **Can Spend-Down into Comprehensive Full Subsidy Plan**

PHASE I:
BENEFITS SUMMARIZED

	Phase I Coverage	Improvement Over Present
Aged/ Disabled	24 Million Non-Poor Get Limit on Cost Sharing 5 Million Poor Aged Receive Full Subsidy Coverage	— New Catastrophic Protection for 24 Million Non-Poor — Additional 1.2 Million Poor Aged Get Full Subsidy Coverage
Low-Income	37 Million Receive Full Subsidy Coverage or Eligible for Spend-Down	— 14.5 Million Additional Poor Get Full Subsidy Protection
Employed	156 Million Covered through Employer Mandate	— 56 Million Get New, Adequate Catastrophic Protection — 10s of Millions Get Improved Basic Coverage
Others	9 Million (7.5 Million Already Self Insure) — 1.5 Million Can Buy HealthCare Catastrophic	— 1.5 Million Hard to Insure Have Major Medical Protection Available
U.S. Population (1980)	231 Million Total	**Reaches All Americans**

PHASE I:
HEALTHCARE

Establishes a New Consolidated Federal Insurance Program

- Continues and Improves Coverage for the Aged and Disabled
- Expanded Coverage for the Poor/Near Poor
- Makes Insurance Available to Other Individuals and Small Firms on an Optional Basis
- Consolidates Administration of Medicare/Medicaid with Major Expansion of Private Sector Role —Especially in Billing and Collection

Impact

- Makes Protection against Cost of Major Illness Universal
- Uniformity in Eligibility, Benefits, and Reimbursement for Poor
- Increased Program Accountability
- Efficiency and Economy of Operation: Reduction of Fraud, Abuse and Error

PHASE I:

THE ROLE FOR PRIVATE INSURANCE

- Continue Underwriting and Marketing Private Coverage to Employed Groups and Individuals
- Expand Private Group Coverage of 56 Million Employees and Their Families
- Compete for Claims Processing under HealthCare

PHASE I:
STATE ROLE AND FISCAL RELIEF

Under Phase I State Governments Will:

- Share with the Federal Government the Cost of Providing HealthCare Coverage for Low Income Eligibles

- Determine HealthCare Low Income Eligibility for
  - — AFDC Recipients (Mandatory)
  - — Newly-Eligible Poor (Optional under Performance Contracts)

- Continue Traditional State Activities in Certification and Licensure of Health Personnel and Facilities, and in Regulation of Private Health Insurance

Phase I Will Provide: About $2 Billion in Fiscal Relief to States and Localities in Initial Years

PHASE I:
PAYMENT TO PROVIDERS

HealthCare

- Hospitals Will Be Reimbursed under the Administration's Hospital Cost Containment Program
- Physicians Will Be Paid According to a Schedule Based on Average Medicare Fees in Area; Physicians Cannot Charge Extra

Employer Mandate Plans

- Hospitals Will Be Reimbursed under the Administration's Hospital Cost Containment Program
- The Names of Physicians Who Agree to HealthCare Fee Schedule Will Be Published for Consumer Use

PHASE I:
SYSTEM REFORM

Elements in the Plan

- **Preventive Services for Pregnant Women and Young Children**
  - — Shift Emphasis from Curing to Caring
- **Enhance Competition**
  - — Incentives for HMO Enrollment
  - — Greater Consumer Choice
- **Capital Expenditure Limits**
  - — Reduce Excess Hospital Capacity and Curb Proliferation of Equipment
- **Voluntary Reinsurance Fund**

Elements in Other Administration Initiatives

- **Increase Technology Assessment and PSRO Review**
  - — Ensure Effectiveness and Productivity
- **Redirect Manpower Incentives**
  - — Improve Geographical and Specialty Distribution
- **Provide Access to Care in Underserved Areas**
- **Mental Health and Health Education Programs**
  - — Avoid Illness: Promote Appropriate Use of Care

PHASE I:
NET NEW COSTS (1980 Population and Dollars)

		Federal	Employer
Aged and Disabled		$3.9 Billion	
• Improved Catastrophic	(1.8)		
• Improved Subsidy for Poor and Near Poor	(2.1)		
Low Income (Non-Aged)		10.7	
• Full Coverage	(6.9)		
• Spend Down Protection	(3.8)		
Employed			
• Employer Guarantee			$6.1 Billion
• Low Income Worker Premium Subsidy		0.9	
• Employer Premium Subsidy (For Mandated Coverage)		0.7	
All Others		0.5	
• HealthCare Buy-In	(0.3)		
• Prevention	(0.2)		
Administration		2.1	
Tax Effects		—0.6	
	Total	$18.2 Billion	$6.1 Billion

THE NATIONAL HEALTH PLAN:
STEPS BEYOND PHASE I

Aged/Disabled

- Reduce Cost-Sharing from $2500 to $1500 for Non-Poor Family ($750 Per Person)
- Add Drug Benefit

Poor

- Raise Low-Income Standard from 55% to 100% of Poverty Line
- Increase Poor Receiving Full-Subsidy Coverage from 30 Million to 37 Million

Employed

- Include Part-Time Employed, Increasing Workers and Their Family Members Covered by Employer Guarantee from 156 Million to 160 Million
- Provide Comprehensive Coverage with 25% Coinsurance and Maximum Cost Sharing of $1500 Per Family

All Others

- Require All to Purchase Comprehensive Coverage
- Subsidized Premiums and Cost-Sharing for Near Poor

Results: — Universal, Comprehensive Plan

— Total Costs Less Than Growth of Present System Due to Cost Containment

To: Legislators and Staff Concerned about Welfare Reform

From: Diana Scully Diana

Re: Yet Another Resurrection of "Reform"

Date: June 28, 1978

No sooner do I get out a memo telling you that welfare reform is off the agenda for the 95th Congress, when a new proposal appears before that august body.

Enclosed for your information, review and comment, is a description of the "State and Local Welfare Reform and Fiscal Relief Act of 1978", which has been introduced by Senators Moynihan, Cranston and Long.

What do you think????

Happy 4th of July.

FROM THE OFFICE OF

Senator Daniel Patrick Moynihan

New York

For Immediate Release
Wednesday, AM
June 28, 1978

Contact: Tim Russert
202-224-4451

STATEMENT BY SENATOR DANIEL PATRICK MOYNIHAN (D., N.Y.)

STATE AND LOCAL WELFARE REFORM

AND FISCAL RELIEF ACT OF 1978

An opportunity is at hand for the 95th Congress to take a long step toward the constructive revision of the American welfare system. The bill that Senators Cranston, Long and I are introducing is based on three simple concepts:

-- Welfare is a national responsibility, and the national government should bear the primary burden of paying for it. The states should have the ability to design and administer appropriate programs and should retain a limited financial involvement. But as promised in the 1976 platform of the Democratic Party -- "local governments should no longer be required to bear the burden of welfare costs." It is inappropriate to devote local tax revenues, particularly those derived from property taxes, to such national social purposes as public assistance.

-- Inasmuch as having a job is far preferable, from practically every standpoint, to being on welfare, strong incentives should be provided to employers to hire persons who are -- or would otherwise be -- on welfare. Such incentives to private employers add to the various public service jobs programs already in place.

-- People who are willing and able to work, but who have very low earnings, should receive supplements through the federal income tax system.

Our proposal embodies these ideas in a measure that we expect the Senate to be able to consider and adopt this year. It is uncomplicated and it is direct. It draws heavily on important principles found in the major welfare reform bills previously introduced in the 95th Congress, notably including the Baker-Bellmon-Ribicoff-Danforth proposal. Our bill is similar to theirs in its emphasis on incentives for private employers of welfare recipients, its expanded Earned Income Tax Credit, and its setting 65 percent of the national poverty line as an appropriate target for welfare benefit levels in states presently below that line. Our proposal also owes much to the impetus given welfare reform by President Carter's earlier comprehensive proposal, by Chairman Al Ullman s

(more)

proposal, and by the fine work of Congressman James C. Corman and his special welfare reform subcommittee. Although it appears impossible to reach agreement this year on such sweeping changes in the present welfare system, we are assured by the Senate Majority Leader that there is time on the Senate calendar to allow full consideration of a measure of the magnitude we propose.

This is a fiscally responsible bill. Its total cost -- less than $5 billion per annum when fully implemented -- is below that originally estimated by the President for the Administration's bill, and just one-fifth of the cost of the measure reported by the House special subcommittee.

Yet the fiscal relief it would bring to state and local governments across the nation is very substantial. In New York, for example, all the counties (and New York City) would be entirely relieved of their share of A.F.D.C. payments. If the local government chose to pass this relief through to taxpayers, it could do so in the form of reduced property taxes. In fact, most county property taxes could be cut by 10 to 20 percent. Alternatively, the county might choose to accelerate its debt service payments, to maintain and improve its physical plant and infrastructure, or to provide other needed services to its citizens.

This bill is in the liberal tradition. It would allow significant improvement in welfare benefits in states where they are presently low. In every state, it would allow benefit levels to keep pace with the rising cost of living. This is particularly important in New York City where the benefits "freeze" occasioned by the city's severe fiscal problems has resulted in a 28 percent decline in the purchasing power of an A.F.D.C. recipient's grant during the past four years.

I would ask persons concerned, as I have been, with the welfare of welfare recipients to consider that in New York State these past four years, for the first time in our history, our provision for the poor has been cut. Inflation has cut payments -- by one quarter -- just as surely as the most punitive administrative or legislative measures might have done. Stalemate on welfare reform has punished the poor.

The employment provisions are also highly significant. The tax credit for employers of welfare recipients (and disabled S.S.I. recipients) provides a powerful incentive for the creation of jobs that will enable hundreds of thousands of persons to be employed and earn their own livings. There are protections built into the law to ensure that these are additional jobs and do not displace other workers.

For low-income wage earners, the expanded Earned Income Tax Credit will provide an income supplement of up to $600 per family. This form of assistance is refundable, which means it is available even to those with limited tax liability, and it would be reflected

(more)

in each week's or month's paycheck. Moreover, it would provide at least some help to families with incomes up to $12,000.

Welfare reform is not dead in the 95th Congress. It is alive and well in the United States Senate. We expect this bill to provide the necessary catalyst to action. We are ready to move.

-30-

STATE AND LOCAL WELFARE REFORM AND FISCAL RELIEF ACT OF 1978

Fact Sheet

The proposal has three major elements:

1. Fiscal relief for States and localities with:

   -- incentives for improvement in the administration of welfare programs

   -- incentives for States to place employable welfare recipients in jobs

   -- replacement of local funds for welfare payments by Federal funds, in those States where there is a local share

   -- additional funding if low-benefit States raise payment levels

   -- additional funding to assist States in raising payment levels as the cost of living rises

   -- additional funding when unemployment in a State rises to unusually high levels

2. Incentives for employers to hire welfare recipients:

   -- a tax credit for an employer for each welfare recipient hired, with a maximum credit of $3,000 in the first year, $2,000 in the second year, and $1,500 in the third year

   -- the credit would be available to all employers, including nonprofit organizations and individuals not engaged in a trade or business

3. Additional funds for low-income workers with families via increases in the earned income tax credit

A more detailed description is provided below.

1. Fiscal Relief

Under present law, States are entitled to Federal matching of from 50 percent to 83 percent for Aid to Families with Dependent Children (AFDC), depending on State per capita income. Generally, 50 percent Federal funds are available for administrative costs.

Under the proposal, the present matching provisions would be replaced by a block grant approach, effective October 1, 1979. The block grant for the first fiscal year (i.e. fiscal year 1980) would equal the Federal share of welfare payments plus administrative costs under present law for the 12-month base period July, 1977 through June, 1978 plus one-half of the matchable State and local share for this same period. (Thus for a State now receiving 50 percent Federal matching, the block grant would be 75 percent of total costs during the base period.)

In States where localities pay part of AFDC costs, the savings would have to be passed through to them (but would not exceed 100 percent of their base period share).

After fiscal year 1980, the block grant amount would be adjusted at the beginning of each fiscal year by the increase or decrease in the population of the State.

In addition, a State's block grant amount would be adjusted by the increase in the consumer price index over the preceding year to enable the State to maintain the purchasing power of welfare benefits for recipients.

For most States, when insured unemployment in a State rises above 6 percent, the block grant would be increased. If the average rate of insured unemployment during the base period in a State is higher than 6 percent, the increases in the block grant would be related to the increase in insured unemployment above the rate in the base period. (Insured unemployment, which measures the number of persons receiving unemployment benefits as a percentage of all insured workers, is generally about 2 percentage points below total estimated unemployment.)

In some States, the AFDC payment to a family with no other income when combined with the value of food stamps adds up to less than 65 percent of the 1977 national poverty level (in round numbers, 65 percent of the poverty level for a family of four was about $4,000 in 1977). In those States, the block grant would be increased if payment levels are increased.

Any savings achieved by the State by placing welfare recipients in jobs or by reducing the number of ineligible recipients and overpayments would be retained 100 percent by the State since the block grant would not be reduced.

(It is assumed that the Congress will enact $400 million in interim fiscal relief in fiscal year 1979 along the lines of the Finance Committee provisions included in H.R. 7200.)

2. Welfare Recipient Employment Tax Credit

Under present law, an employer engaged in a trade or business is eligible for a tax credit if he hires a person, who has been receiving AFDC at least 90 days, to work on a substantially full-time basis. Present law requires that the AFDC recipient not have displaced any other individual from employment. The credit is equal to 20 percent of the wages during the first 12 months of employment, with a maximum credit of $1,000.

Under the proposal, the credit would be:

-- 50 percent for the first 12 months of employment (with a maximum credit of $3,000)

-- 33 1/3 percent for the second 12 months (maximum credit, $2,000)

-- 25 percent for the third 12 months of employment (maximum credit, $1,500)

The maximum credit would be increased as follows (approximately as the Federal minimum wage rises):

	First 12 mos.	Second 12 mos.	Third 12 mos.
1979	$3,000	$2,000	$1,500
1980	3,300	2,200	1,650
1981 and after	3,600	2,400	1,800

The credit would be available to employers hiring AFDC recipients as well as disabled recipients of Supplemental Security Income (SSI).

The credit would be available to all employers, not only those engaged in a trade or business. Appropriations would be authorized for payments in lieu of the credit to nonprofit organizations that hire welfare recipients.

3. Increase in the Earned Income Tax Credit

Under present law, low-income workers with families are eligible to receive an earned income tax credit. The credit is equal to 10 percent of their earnings up to $4,000; the $400 maximum credit is reduced 10 cents for every dollar by which family income exceeds $4,000. The credit is refundable, that is, it is paid to persons who pay no taxes or whose tax liability is less than the amount of the credit.

Under the proposal, the credit would equal 10 percent of earnings up to $6,000 in 1979 (maximum credit $600), $6,500 in 1980 ($650 maximum), and $7,000 in 1981 ($700 maximum). The maximum credit would be reduced 10 cents for every dollar by which family income exceeds $6,000 in 1979, $6,500 in 1980, and $7,000 in 1981. In effect the increases in the maximum credit represent an adjustment of the existing credit to changes in the Federal minimum wage.

Under present practice, an employee does not receive the credit in his paycheck because the value of the credit is not reflected in the withholding tables his employer uses. Under the proposal, the employee would receive the value of the credit as part of his regular paycheck.

* * * * *

ADDITIONAL INFORMATION

1. Cost of Aid to Families with Dependent Children

(in billions of dollars)

	FY 1977	FY 1978(est)	FY 1979(est)
Welfare payments:			
Federal share	$5.6	$5.8	$6.1
State and local share	4.7	4.9	5.1
Total	10.3	10.7	11.2
Administrative and other costs:			
Federal share	0.6	0.7	0.7
State and local share	0.6	0.7	0.7
Total			

Source: 1979 President's Budget, p. 448

2. Federal block grant total under bill in FY 1980: about $8.4 billion (a probable net increase of about $2.2 billion above present law)

3. States in which local jurisdictions pay more than 5 percent of the cost of Aid to Families with Dependent Children:

California	Montana	North Dakota
Colorado	New Jersey	Wyoming
Indiana	New York	
Minnesota	North Carolina	

4. States whose AFDC payment to a family of 4 with no other income in July, 1977 plus the value of food stamps was less than $4,000:

Alabama	Mississippi	Texas
Georgia	South Carolina	
Louisiana	Tennessee	

5. If in the fifth year of the program the employer tax credit reached a level of $1.5 billion, it would relate to an average of more than 600,000 jobs.

6. In 1978, an estimated 4.9 million families are eligible for earned income tax credits totalling $0.9 billion. The proposed increase in the credit would make an estimated 7.5 million families eligible in 1979 at a total program cost of $2.0 billion (an increase of $1.1 billion over 1978).

National Conference of State Legislatures

Office of State Federal Relations

444 North Capitol Street, N.W. 2nd Floor Washington, D.C. 20001 202/624-5400

President
Fred E. Anderson
President of the Senate
Colorado

Executive Director
Earl S. Mackey

To: Members of the NCSL Subcommittee on Aging

From: Diana Scully, NCSL Washington DS

Re: Annual Meeting Activities

Date: June 23, 1978

In my memo of June 10, I told you that I would get back to you with room numbers for various sessions relating to aging issues and business. The NCSL office in Denver has informed me that we will all have to wait to find out room numbers at the Registration Desk at the Annual Meeting or from the agendas that will be handed out at the Annual Meeting. Most meetings will be held in the Denver Hilton Hotel. The Registration Desk will be located there.

The following is a reminder about the meetings which should be of particular interest to the members of the Subcommittee on Aging:

1. Meeting of the Human Resources Committee of the State/Federal Assembly. (See enclosed agenda.) Please note that proposed policy resolutions for 1978-79 will be considered by the full Committee from 11:00-12:30 PM on Wednesday, July 5. As I stated previously, it is important for at least some members of the Subcommittee on Aging to be present to advocate for those resolutions relating to aging.

2. Meeting of the NCSL State-Federal Assembly. The Assembly will be held from 3:30 until late afternoon on Wednesday, July 5. Policy resolutions adopted by the Committees, will be voted on by the entire State-Federal Assembly.

3. Meeting of the NCSL Subcommittee on Aging. The Subcommittee on Aging will meet from 2:30-5:00 PM on Thursday, July 6. The purpose of this business meeting will be to discuss future activities of the Subcommittee.

4. Concurrent Session on Alternatives to Nursing Home Care. The Concurrent Session on State-initiated alternatives to nursing home care will be held from 1:45-3:30 PM on Friday, July 7. Participating in the Session as faculty will be Senator Jim Caldwell (Ark.), Senator Tarky Lombardi (N.Y.), Delegate Mary Marshall (Va.), and Representative Gregory Cusack (Iowa).

5. Annual Business Meeting. It is my understanding that any policy resolution that has not been reviewed and voted on by the State-Federal Assembly, must be submitted 48 hours prior to the Annual Business Meeting, and may be offered from the floor of this meeting. The Annual Business Meeting will be held from 9:30-11:30 AM on Saturday, July 8.

If you have any questions about anything at all, please don't hesitate to call me at 202/624-5410.

National Conference of State Legislatures

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President
Fred E. Anderson
President of the Senate
Colorado

Executive Director
Earl S. Mackey

To: Members of the NCSL Subcommittee on Aging

From: Diana Scully, Policy Analyst

Re: Sessions during the Annual Meeting; submittal of policy resolutions

Date: June 10, 1978

Meeting of Subcommittee:

The next meeting of the NCSL Subcommittee on Aging will be held on Thursday, July 6 in Denver, Colorado from 2:30-5:00 P.M. during the Annual Meeting (July 5-8). The purpose of this business meeting will be to discuss future activities of the Subcommittee. The session will be held in the Hilton Hotel (room to be specified at a later date).

Concurrent Session:

The concurrent session on state-initiated alternatives to nursing home care will be from 1:30-3:30 P.M. on Friday, July 7. The place will be specified at a later date. Participating in the session as faculty will be Senator Jim Caldwell (Arkansas), Senator Tarky Lombardi (New York), Delegate Mary Marshall (Virginia), and Representative Gregory Cusack (Iowa).

Policy Resolutions:

Members of the Subcommittee who wish to present policy resolutions for consideration during the Annual Meeting, should submit their ideas to me by no later than Friday, June 23, so that I can draft them up in time for the meeting. Feel free to submit your resolutions in writing or via telephone. My number is (202) 624-5410.

All resolutions must be voted on during the Human Resources Committee meeting to be held on Wednesday afternoon, July 5, in the Denver Hilton. It is important that at least some of the Subcommittee members participate in this meeting, so that the aging resolutions get a full hearing before the full committee. I will inform you of the exact time and place of this meeting in my next notice.

It is my understanding that any proposed resolution that has not been reviewed and voted on by a State-Federal Assembly Committee, must be submitted 48 hours prior to the Annual Business Meeting. This will be held from 9:30 to 11:30 A.M. on Saturday, July 8.

As you think about policy resolutions, please bear in mind that the Subcommittee's activities for the coming year will be defined in large part by these resolutions. I have enclosed for your review the existing resolutions related to aging.

Talmadge Bill - Requires State legislative oversight
NHS - New Coalition - NCSL - Govs - Counties/Cities. to
develop common principles

HEALTH BULLETIN

SUMMARY OF NURSING HOME WITHOUT WALLS LAW
(CHAPTER 895, NEW YORK STATE LAWS OF 1977)

Senator Tarky Lombardi, Jr., Chairman
New York State Senate Health Committee

Room 612, Legislative Office Building
Albany, New York 12224

Chapter 895 of the Laws of 1977, "The Nursing Home Without Walls" Law, which became effective April 1, 1978, authorizes the establishment of long term home health care programs as an alternative to institutional care. This Law, which was three years in development, was conceived as a means of providing long term care tailored to meet the needs of the patient rather than the usual method of the patient meeting the requirements of a program.

In addition, the occupancy rate in New York's nursing homes exceeds 96%, and in some areas there are no nursing home beds for patients who could be discharged from much more costly acute care beds.

In 1976 long term care in New York State took one-third of the Medicaid budget while in 1967 the same care consumed 12% of the Medicaid budget. As a result of the increasing elderly population it is expected that the portion of the health care dollar devoted to long term care will continue to rise.

Rather than meet the increasing demand for long term care through construction of more nursing homes, thus paying for bricks and mortar, available funds should be more appropriately used to provide patient care. Social as well as fiscal reasons dictate that we develop alternative, non-institutional methods of providing long term care. Although a nursing home is now authorized to care for a certain number of patients within a facility, there is no reason that same nursing home could not also provide the same level of care to people in their own homes. The nursing home would manage the patient's case but the patient would not physically reside in the facility.

The "Nursing Home Without Walls" program has three key elements: 1) the selection of the provider; 2) the financing mechanism; and 3) the selection and management of the patient.

SELECTION OF PROVIDERS

Long term home health care may be provided by certified home health agencies and by public or voluntary non-profit residential health care facilities and hospitals which have received the authorization of the State Health Commissioner. The Commissioner's determination is made on applications submitted by potential providers after considering the recommendations of the appropriate Health Systems Agency and the State Hospital Review and Planning Council. In approving an application, the number of patients for which a program may provide care must be specified.

A detailed application is first submitted to the Commissioner, who forwards it to the appropriate HSA and the State Council. The application must include a description of the need for the proposed program, the geographical area to be covered, the estimated number of patients, and projected common diagnoses of the caseload. Policies for admission and discharge of patients from the program must also be described. Additional information required includes the relationship of the proposed program to the organizational structure of the parent facility; arrangements for coordination of services with other providers; arrangements to ensure the availability of 24-hour-per-day, 7-days-per-week professional assistance; provision of emergency care; availability of additional community support; anticipated staffing requirements; mechanisms to assure the provision of quality care; long range operational plans; available financial resources and the general financial stability of the applicant; and the adequacy of procedures for patient identification and entry into the program.

A provider of "nursing home without walls" care must make available, either directly or through contract arrangements, the following services: Nursing; home health aides; physical, occupational, respiratory, and speech therapy; audiology; medical social work; nutritional services; personal care, homemaker and housekeeper services; and medical supplies, equipment and appliances. Nursing, home health aide, personal care, and homemaker services must be available 24 hours per day, 7 days per week.

(over)

The "nursing home without walls" program is to be a distinct part of an agency or facility with a full time director. Each provider must have a physician advisory committee with the responsibility of developing and approving standard medical regimens and policies. A professional advisory committee, comprised of the agency administrator, a practicing physician, a representative of the community, a consumer representative, and a representative of the nursing and other professional staffs, is to be responsible for reviewing policies on the delivery of care; developing agreements with other facilities in the area for the acceptance of patients referred for long term home health care; reviewing the quality of services; and advising the program on any needed or unneeded services.

FINANCING MECHANISM

Payment for "nursing home without walls" care will be made under the Medicaid program. A county social services department will develop an individualized monthly budget to pay for the services deemed necessary for each patient. The monthly budget is limited to 75% of the average monthly SNF or HRF rate, as appropriate for the level of care required by the patient, in the county in which he resides. If the patient does not use the total amount available to him, the balance accrues to him as a "paper credit" and can be used at a later date to provide additional care if required.

For example, if the average skilled nursing facility rate in a county is $1200 per month, up to $900 per month is available for a "nursing home without walls" patient. If the patient requires health services costing $600, the $300 balance accrues to his account, and can be used at a later date if the patient's needs become more costly.

The State Department of Social Services, in an administrative letter to the counties, has indicated flexibility so that if a patient's costs exceed his allocation for a temporary period, the patient may remain in the program. The county department of social services will review the budget monthly.

Currently, Medicaid reimbursement for home health care is available only for nursing and home health aide services, occupational, speech and physical therapy, and medical supplies and equipment. The "nursing home without walls" program will include reimbursement for a wider range of services needed to keep patients at home, including respiratory therapy; psychological counseling; nutrition services; structural improvements; respite care; and home maintenance services. Often the availability of these additional services is key in preventing premature institutionalization of the elderly.

SELECTION AND MANAGEMENT OF PATIENTS

Medicaid eligible persons who have been assessed as needing care normally provided in either a skilled nursing facility or a health related facility are eligible to receive "nursing home without walls" care. This care may be provided in the person's own home or in the home of a responsible relative or other responsible adult.

To be accepted into the "nursing home without walls" program the following steps will be taken:

(1) The client, or someone on his behalf, indicates that he believes SNF or HRF care is needed.

(2) A medical assessment in either the person's home or in a facility in which the person is a patient must be completed.

(3) If the client is assessed as needing either skilled nursing or health related care, and a long term home health care program exists in the county in which he resides, the local social services department must inform him of its availability.

(4) The patient, or his representative, must indicate whether he is interested in receiving care at home.

(5) If the patient desires "nursing home without walls" care, and if his physician has indicated that home care can appropriately meet his needs, a comprehensive home assessment will be performed. The appropriateness of the home environment in relation to care the patient requires would be determined as well as the feasibility of delivering that care at home. This assessment forms the basis for a plan of care tailor-made to the individual patient's needs. The assessment team includes the patient's physician, the provider of "nursing home without walls" care, and the county social services department. If the patient is referred from a hospital or nursing home, the facility's discharge planner also participates. If the physician determines that the patient's health and safety needs cannot be met at home, the patient would be deemed inappropriate for "nursing home without walls" care.

(6) A coordinated plan of care is developed through the cooperation of the assessment team.

(7) The physician must give final approval to the plan of care, specifying kinds and amount of services required. The plan is then submitted to the county social services department for a budget review to determine whether the total cost of the program is less than 75% of the monthly average SNF or HRF rate, as appropriate.

(8) The provision of care begins.

Both the long term home health care provider and the local department of social services will play important roles in managing each case. The local social services department will provide case management services, including Medicaid eligibility determinations; participating in the comprehensive assessment; preparing the monthly budget, including maintenance of the "paper credit"; arranging for the delivery of supportive services required in the plan of care; and arranging for the continuation of services, provision of additional services, or provision of alternative services if necessary.

The long term home health care provider will have responsibility for cooperating with the assessment, particularly from a medical, nursing and rehabilitative focus; development of the plan of care; implementation and evaluation of the plan of health care; assuring that medical orders are followed; and supervision of health services.

The comprehensive assessment will be repeated at 4-month intervals, or more often if the patient's needs require. The reassessment is to include a total reevaluation of the current medical, social, environmental and rehabilitative needs of the patient.

The same Law also establishes a State Council on Home Care Services to advise the Governor and the Commissioners of those departments involved with the welfare of the elderly as well as the social and physical needs of our citizens. This Council, which will meet at least quarterly, will concern itself with the review and coordination of efforts regarding the development of home care services and is to make appropriate recommendations to the Governor and the Legislature. The Governor may also prescribe other functions for the 25-member Council which serves on a voluntary basis. Members shall include Commissioners of relevant state departments, the Chairman of the State Hospital Review and Planning Council, plus 17 members who are deliverers of home care service and representatives of the public, to be appointed by the Governor with the consent of the Senate. Each Health Systems Agency is to be represented. Appointments to the Council are now being made and it is expected that during the summer of 1978 the Council will be in full operation.

The Commissioner of Health is authorized to inspect certified home health agencies and providers of long term home health care programs with respect to equipment, personnel, standards of service and care, accounts and financial resources. In addition, any organization which provides or makes available home care services must annually submit a description of its operation to the Commissioner. This will be public information so that all citizens may be aware of available services.

Prior to April 1, 1978, the effective date of this Law, the New York State Department of Health had received over 120 letters from agencies and facilities interested in becoming "nursing home without walls" providers. By early June, 14 formal applications were received, and on June 15, 1978 the first application was acted upon favorably by the State Hospital Review and Planning Council.

The Department of Social Services has applied to the U. S. Department of Health, Education and Welfare for waivers necessary to fully implement this program. The Department of Social Services has estimated that in its first year of operation, the "nursing home without walls" program would result in savings of $11.8M over what would have to be spent to care for the same patients in residential health care facilities. These estimates are based on a projection of 2,000 "nursing home without walls" patients by March 31, 1979.

The Departments of Health and Social Services, as well as the appropriate legislative committees will carefully monitor the implementation of this law to assure that appropriate quality care is delivered through this new program which is the first of its kind in the nation.
6/19/78

HEALTH BULLETIN

Senator Tarky Lombardi, Jr., Chairman
New York State Senate Health Committee

CATASTROPHIC HEALTH CARE
EXPENSE PROGRAM - S.9428 and S.10288

Room 612, Legislative Office Building
Albany, New York 12224

The New York State Senate has recently passed my major legislation designed to aid State residents burdened by catastrophic health care expenses. I fully expect the State Assembly to act favorably on these bills when it reconvenes later this summer. Since the Governor has given his full support to this legislation, I feel confident he will sign it into law. Under this proposal a family would not have to impoverish itself in order to obtain assistance in meeting medical expenses beyond the family's ability to pay.

Currently those families above the poverty level are generally not eligible for assistance in meeting the costs of needed health care services, regardless of the severity of their medical needs. In order to become eligible for financial assistance families are forced to meet rigid income and resource requirements which often alter family life to such an extent that the wage earner leaves employment in order to receive a public assistance grant and medical assistance. Under our new program, family members could receive assistance and continue as productive working members of society.

This program would be limited to selected social services districts to assure its effectiveness before going state-wide.

This legislation would not replace Medicaid but would provide coverage to eligible citizens after available insurance benefits were exhausted. Eligible health care services would be the same as those currently covered under Medicaid, with the exception of care in residential health care facilities, which would continue to be covered under the existing program.

All families that incure costs for medical services in excess of an amount that a family could reasonably be expected to pay would be included. There would be no limitation on age, income, or assets. Assistance would be available to anyone having catastrophic health care expenses. In order that a family is not required to use all its available assets prior to becoming eligible for assistance, the program contains no asset limitations so that savings would not have to be depleted, life insurance policies could remain in effect, and property would not have to be sold in order to be eligible for assistance. Because of the requirement for patient participation, the family is encouraged to be a "prudent buyer" of services.

Eligibility for assistance in meeting the costs of medical care would be related solely to family income and health care expenses. A family would be determined to have incurred catastrophic health care expenses when, in a calendar year, these expenses exceeded 50 percent of the difference between the available family income during that year and the basic public assistance grant. At this point, "cost sharing" would begin and the family would be eligible for full or partial reimbursement on health care expenses it incurs after reaching that threshold. Eligible families would be able to apply to local social services districts for interim authorization to be billed for services provided at the rate established for Medicaid services.

As medical expenses increase, a family will be unable to share in the costs of its needed medical services. Therefore, a family would be eligible for full medical benefits when its health care expenditures during a calendar year exceed 75 percent of the difference between available family income and the basic public assistance grant level. When health care expenditures have reached this level, the family would receive authorization for full medical benefits for the balance of the calendar year, without cost sharing, on a vendor payment basis.

(over)

To insure the prudent use of limited medical and fiscal resources, family fiscal participation in health care costs is important. Under "cost sharing" health care expenses would be shared between the family and the program on a percentage basis, as determined by the Commissioner of Health. When receiving full medical benefits, any payments made on a vendor payment basis during the balance of the calendar year would reduce the amount of reimbursement the family would receive under cost sharing.

Reimbursement to a family would be made on a retrospective basis, after the health care expenses have been incurred and paid by the family. Applications for reimbursement would be made between January 1 and June 30 of the year following the year in which the catastrophic health care expenses were incurred. Payment would be made directly to the family.

This program recognizes that some provision must be made for those who, because of other obligations, are unable to pay in the first instance the costs of medical services received. A "hardship" provision, under which direct vendor payments can be made to a provider of service, is included. This provision does not alter eligibility requirements, but only permits the portion the family would receive under cost sharing to be paid directly to the vendor of services.

Since health insurance premiums, whether paid by or on behalf of the family, would be considered a health care expense in determining whether the family has incurred catastrophic health care expenses, families would be encouraged to purchase and maintain health insurance policies.

The following are approximate examples of how the program could work for two families of four, one with a total annual income of $20,000; the other with a total annual income of $6,500:

Total family income	$20,000.
Less Court ordered payments	5,000.
Balance	$15,000.
Less imputed Federal income tax on $15,000.	1,385.
Available balance	$13,615.
P A grant level	5,000.
Available income in excess of grant level	$ 8,615.

To be eligible for cost sharing, this family must first meet a deductible of $4,307.50 ($8,615 x 50%). The family may be reimbursed under cost sharing on the basis of health care expenditures that exceed $4,307.50. To be eligible for full medical benefits, health care expenditures must exceed $6,469. ($8,615 x 75%).

Total family income	$ 6,500.
Less imputed Federal income tax	0.
Balance	$ 6,500.
P A grant level	5,000.
Available income in excess of grant level	$ 1,500.

To be eligible for cost sharing, this family must first meet a deductible of $750. ($1,500 x 50%). The family may be reimbursed under cost sharing on the basis of health care expenditures that exceed $750. To be eligible for full medical benefits, health care expenditures must exceed $1,125. ($1,500 x 75%).

(more)

The Department of Social Services has estimated the cost of the program as follows:

After full programmatic development, the fiscal implications of enactment of the proposed legislation, on an annual basis, for those classifications of persons eligible under current Federal Medicaid law, are estimated to be:

	Million $			
	Gross Expenditures	Federal Share	State Share	Local Share
Annual Basis	+$74.0	+$37.0	+$18.5	+$18.5

This estimate is exclusive of the potential increase in cost which would occur in the event that some persons reduced or eliminated their existing health insurance coverage as a result of enactment of the proposed legislation.

That Department also stated should a national catastrophic illness program be enacted or demonstration grant authority be obtained to receive Federal financial participation, this "enabling legislation" would permit New York State to more rapidly implement such program. Consequently, the fiscal estimate provided above assumes waivers of Federal resources and retrospectivity tests.

My proposal, which would require 50% participation by the Federal government before it would become effective, could become the foundation for such a national health program. I have met with HEW officials who have expressed serious interest in the program and expect to continue these meetings.

Recent published reports have indicated that high level Federal officials, including the Chairman of the President's Council of Economic Advisers, the Secretary of the Treasury and the Director of the Office of Management and Budget, are seeking to dissuade the President from proposing a comprehensive national health insurance program on the grounds that it would be inflationary and fail to reach desired goals. Instead, these top advisers are arguing for a national health program that for the time being would include coverage only for catastrophic illness and injury and extended protection for the poor. The New York State program is totally in line with this thinking.

6/30/78

National Conference of State Legislatures

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NCSL POLICY RESOLUTIONS ON OLDER AMERICANS

THE HUMAN RESOURCES COMMITTEE TAKES THE FOLLOWING POSITIONS ON ISSUES OF CONCERN TO OLDER PERSONS. THESE POSITIONS ARE BASED ON THE DELIBERATIONS AND RECOMMENDATIONS OF THE SUBCOMMITTEE ON AGING, WHICH HAS BEEN CREATED PURSUANT TO AN EARLIER RESOLUTION ADOPTED BY THE NCSL.

1. REAUTHORIZATION OF THE OLDER AMERICANS ACT

BY PASSING THE OLDER AMERICANS ACT IN 1965, THE FEDERAL GOVERNMENT SET FORTH OBJECTIVES FOR ASSISTING OLDER PERSONS AND ESTABLISHED THE ADMINISTRATION ON AGING AS THE FOCAL POINT FOR ITS EFFORTS TO MEET THE OBJECTIVES.

THREE GRANT PROGRAMS WERE CREATED: THE TITLE III PROGRAM OF GRANTS TO STATES FOR COMMUNITY SOCIAL SERVICE PROJECTS, THE TITLE IV PROGRAM FOR RESEARCH AND DEMONSTRATION PROJECTS, AND THE TITLE V PROGRAM FOR TRAINING IN THE FIELD OF AGING.

SINCE ITS INCEPTION, THE OLDER AMERICANS ACT HAS BEEN AMENDED SEVERAL TIMES. THE MORE IMPORTANT AMENDMENTS HAVE STRENGTHENED THE TITLE III COMMUNITY SERVICES PORGRAM; PROVIDED FOR MORE EFFECTIVE, COMPREHENSIVE AND COORDINATED SOCIAL SERVICE SYSTEMS AT THE LOCAL LEVEL; AUTHORIZED GRANTS FOR MULTI-PURPOSE SENIOR CENTERS AND THE COMMUNITY EMPLOYMENT PROGRAM; ENACTED A NATIONAL NUTRITION PROGRAM; AND AUTHORIZED THE FOSTER GRANDPARENT AND RETIRED SENIOR VOLUNTEER PROGRAMS.

IN 1966 THE TOTAL APPROPRIATION UNDER THE OLDER AMERICANS ACT WAS $7.5 MILLION. THE APPROPRIATION FOR THE PRESENT FISCAL YEAR IS AROUND $500 MILLION. PRESIDENT CARTER HAS REQUESTED A "HOLD THE LINE BUDGET" FOR OLDER AMERICANS ACT PROGRAMS FOR FISCAL YEAR 1979.

THE OLDER AMERICANS ACT MUST BE REAUTHORIZED BY CONGRESS BY SEPTEMBER 30, 1978. THE HUMAN RESOURCES COMMITTEE BELIEVES THAT THE PROGRAM AND SERVICES UNDER THE ACT HAVE SIGNIFICANTLY IMPROVED THE HEALTH AND WELL-BEING OF MANY OLDER PERSONS. THE OLDER WORKERS EMPLOYMENT PROGRAM PROVIDES PART-TIME JOBS FOR SOME 47,500 PERSONS. AN ESTIMATED 11 MILLION SERVICES ARE PROVIDED ANNUALLY THROUGH THE COMMUNITY SERVICES PROGRAM.

BECAUSE OF THE REAL GAINS MADE TO ASSIST OLDER PERSONS WHICH HAVE RESULTED FROM THE PROGRAMS AND SERVICES UNDER THE OLDER AMERICANS ACT, THE HUMAN RESOURCES COMMITTEE RECOMMENDS THAT THE ACT SHOULD BE REAUTHORIZED AND FUNDED FOR AT LEAST 3 YEARS.

HOWEVER, THE COMMITTEE BELIEVES THAT THE COORDINATION OF PROGRAMS AND SERVICES FOR THE ELDERLY CAN BE IMPROVED AND THAT STATE AND LOCAL PRIORITY-SETTING AND DECISION-MAKING CAN BE STRENGTHENED. ACCORDINGLY, THE HUMAN RESOURCES COMMITTEE RECOMMENDS THAT THE CONGRESS SHOULD INCLUDE IN THE REAUTHORIZING LEGISLATION FOR THE OLDER AMERICANS ACT PROVISIONS WHICH:

- GIVE STATES THE AUTHORITY AND FUNDING REQUIRED TO EFFECTIVELY IMPLEMENT THE PROGRAMS AND SERVICES UNDER THE ACT:

- REQUIRE THE COORDINATION OF THE MULTIPLICITY OF FEDERAL PROGRAMS AND SERVICES AUTHORIZED BY BOTH THE ACT AND OTHER FEDERAL LAWS:

- ENCOURAGE AND SUPPORT STATES' EFFORTS TO PROVIDE INNOVATIVE SERVICES TO THE ELDERLY;

- ENABLE STATES TO BE RESPONSIVE TO THE NEEDS OF THE ELDERLY PERSONS WITHIN THEIR JURISDICTIONS, BY PROVIDING FOR INCREASED DECISION-MAKING AND PRIORITY-SETTING AT THE STATE AND LOCAL LEVELS; AND

- ENSURE THAT THERE IS JOINT PLANNING AT THE FEDERAL, STATE AND LOCAL LEVELS IN ORDER TO MORE EFFICIENTLY USE THE RESOURCES AVAILABLE FOR OLDER PERSONS AT EACH OF THESE LEVELS.

IN ADDITION TO THE PRECEDING RECOMMENDATIONS ABOUT COORDINATION AND STATE AND LOCAL PRIORITY-SETTING, THE HUMAN RESOURCES COMMITTEE URGES CONGRESS TO INCLUDE THE FOLLOWING PROVISIONS IN THE LEGISLATION REAUTHORIZING THE OLDER AMERICANS ACT:

- FUNDING FOR THE RETIRED SENIOR VOLUNTEER PROGRAM (RSVP) SHOULD BE CONTINUED AT AT LEAST ITS CURRENT LEVEL.

- THERE SHOULD BE A CONTINUING FOCUS ON THE PROBLEMS OF COORDINATION AND DUPLICATION OF TRANSPORTATION SERVICES.

- A GREATLY INCREASED CONCENTRATION ON DEVELOPING QUALITY ALTERNATIVES TO NURSING HOME CARE SHOULD BE INCLUDED IN THE ACT.

- STATE AND AREA AGENCIES ON AGING SHOULD BE REQUIRED TO ACT AS ADVOCATES ON BEHALF OF THE OLDER RESIDENTS OF THEIR COMMUNITIES. IN ADDITION, THE INTENT OF H.R. 11411, A BILL TO ESTABLISH A LONG-TERM CARE ADVOCACY PROGRAM SHOULD BE INCLUDED IN THE ACT.

- STATES SHOULD BE GIVEN A GREATER ROLE IN DECIDING WHO WILL BE THE NATIONAL CONTRACTORS UNDER THE TITLE IX OLDER AMERICANS EMPLOYMENT PROGRAM. THE ELIGIBILITY REQUIREMENTS THAT ARE USED FOR TITLE XX OF THE SOCIAL SECURITY ACT SHOULD ALSO BE USED FOR TITLE IX.

- THE U.S. DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT AND THE U.S. DEPARTMENT OF HEALTH, EDUCATION AND WELFARE SHOULD BE MANDATED TO COORDINATE CONGREGATE HOUSING PROGRAMS WITH SOCIAL SERVICES.

- THE EXISTING 1-YEAR PLANNING CYCLE SHOULD BE DISCONTINUED AND REPLACED WITH A 3-YEAR PLANNING CYCLE.

- THE PRESENT ARRAY OF DIFFERENT FUNDING RATIOS UNDER THE ACT SHOULD BE REPLACED WITH A UNIFORM RATIO OF 90% FEDERAL/10% STATE FUNDING FOR ALL PROGRAMS.

- States should have increased flexibility and authority to direct the flow of funds under the act. This should be accomplished by allowing each state to have discretion over the use of 10% of the total amount of federal dollars alloted to it under the Act.

2. Negative Effects of Increased Social Security Payments

Many lower income, older persons receive increases in their Social Security payments, only to find that they are no longer eligible for Medicaid benefits. In many instances, the value of the lost Medicaid eligibility is far greater than the increase in the Social Security payment. Often the loss of Medicaid elibibility results in a financial hardship for these persons, because they become ill and because the cost of health care is so high.

The Human Resources Committee recognizes this problem, and recommends that the Congress and the appropriate federal agencies should work toward a solution of it. The committee believes that a reasonable approach to the problem would be for the Congress to enact legislation which would prevent new or increased benefits of any type received by an individual from resulting in a net loss of benefits for that individual.

Home health care — M.4 Tarky Lombardy

"Nursing home without walls"

① screening of patients -
② certification of agencies -
③ payment mechanisms

A SUMMARY OF PENDING FEDERAL LEGISLATION RELATED TO THE AREA OF HUMAN RESOURCES

PREPARED FOR
The Human Resources Committee
of the
National Conference of State Legislatures

Staff Contact: Dick Merritt

BILL AND BACKGROUND	LEGISLATIVE STATUS AND OUTLOOK	NCSL POSITION
ABORTION The issue of federal funding for abortions has been debated as part of the FY 79 Labor-HEW Appropriations bill. The House position has been that federal money for abortions should be permitted only in instances where the mother's life is endangered. The Senate's position, however, has been to extend federal funds for abortions deemed "medically necessary" and in cases of rape, incest or which endanger the mother's life	House action taken on HEW-Labor Appropriations bill. Senate Appropriations Labor-HEW subcommittee is currently marking up its version of the FY 79 appropriations bill.	No position
AGING H.R. 12255 S. 2850 Both bills reauthorize the funding and provisions of the Older Americans Act. The following is a summary of key provisions of the two bills: Consolidation. Both bills consolidate the administration of Title III (state and community programs on aging), Title V (multipurpose senior citizens centers) and Title VII (nutrition programs) into a new Title III. Authorizations. H.R. 12255 provides for separate authorizations under the new Title III for social services, senior centers, nutrition services, legal services and ombudsman services. S. 2850 maintains separate authorization for the nutrition programs, and requires that 50% of all other funds under Title III be used for "access" services (transportation, outreach, and information and referral), in-home services, and legal services. Funding ratio. NCSL supports a uniform ratio of 90% federal/10% state funding for all services provided under the Act. The House bill includes a step toward the NCSL position. It provides that	Legislation to reauthorize the Older Americans Act has been ordered reported by both the House Education and Labor Committee and by the Senate Human Resources Committee. The House passed H.R. 12255 on May 15th. No significant amendments were adopted. The Senate will soon take action on S. 2850. A conference committee will have to meet to work out the differences between the two bills.	Funding for the Retired Senior Volunteer Program (RSVP) should be continued at least at its current level. There should be a continuing focus on the problems of coordination and duplication of transportation services. A greatly increased concentration on developing quality alternatives to nursing home care should be included in the act. State and area agencies on aging should be required to Act as Advocates on behalf of the older residents of their communities. In addition the intent of H.R. 11411, a bill to establish a Long Term Care Advocacy Program should be included in the Act.

BILL AND BACKGROUND	LEGISLATIVE STATUS AND OUTLOOK	NCSL POSITION
funding for senior centers (Title V) will change from a 75%/25% ratio to a 90%/10% ratio. The Senate Committee accepted an amendment proposed by Senator Jacob Javits (R-NY) to maintain the match for all service programs at the 90%/10% ratio for FY 1979 and to change the match to 85%/15% for FY 1980. Without this amendment the match under S. 2850 would have been 75%/25%. Advocacy. NCSL supports the concept that the Administration on Aging should have an advocacy function. Both the Senate and the House bills include provisions for the AOA to carry out this function. AOA Commissioner. Under the House bill, the Commissioner on Aging would be directly responsible to the Secretary of Health, Education and Welfare. Presently, the Commissioner reports to an Assistant Secretary. The Senate bill includes no change with respect to the role of the Commissioner on Aging. FCOA. H.R. 12255 strengthens the role of the Federal Council on Aging. S. 2850 originally called for the elimination of the FCOA. The Senate Committee altered this provision, such that the FCOA is now required to conduct specific studies related to the operation of the AOA network, including an analysis of the need for a separate program of legal services. Planning Cycle. NCSL supports a 3-year planning cycle under the Act. The House bill provides that both state plans and area agency plans should cover a 3-year period. The Senate bill includes a 2-year cycle. Long Term Care. Both the House and Senate bills establish a program of community-based assessment of long-term care needs. Both bills also require each state to establish an ombudsman program for residents in long-term care facilities. However, the Senate bill does not designate any funds for the ombudsman program. NCSL supports both the ombudsman program and the assessment of long-term care needs.		States should be given a greater role in deciding who will be the national contractors under the Title IX Older Americans Employment Program. The eligibility requirements that are used for Title XX of the Social Security Act should also be used for Title IX. The U.S. Department of Housing and Urban Development and the U.S. Department of Health, Education and Welfare should be mandated to coordinate congregate housing programs with social services. The existing 1-year planning cycle should be discontinued and replaced with a 3-year planning cycle. The present array of different funding ratios under the Act should be replaced with a uniform ratio of 90% federal /10% state funds for all programs. The states should have increased flexibility and authority to direct the flow of funds under the Act.

BILL AND BACKGROUND	LEGISLATIVE STATUS AND OUTLOOK	NCSL POSITION
Home Delivered Meals. H.R. 12255 includes separate funding for home-delivered meals. An amendment to add separate funding to S. 2850, proposed by Senator Edward Kennedy (D-Mass); was rejected by the Senate Committee by a vote of 10 to 5. Title X. NCSL believes that states should be given a greater role in deciding who will be the national contractors under the Title IX Older Americans Employment Program. NCSL also believes that the eligibility requirements used for Title XX under the Social Security Act (up 125% of the poverty level) should also be used for Title IX. The House bill expands the eligibility criteria to 125% of the poverty level. The Senate bill increases the coordination between the states and the national contractors and requires the Secretary of Labor to review comments by the states before approving the plans of the national contractors. Action. The House bill reauthorizes the ACTION programs (RSVP, Foster Grandparents, and Retired Senior Companion Program) for only one more year. Because ACTION programs do not fall within the jurisdiction of the Senate Committee S. 2850 does not include any reference to these programs. Age Discrimination. One of the more significant features of the House bill was added by Congressman Mario Biaggi (D-NY). His amendment gives people the right to sue federally funded programs for age discrimination. The Senate bill contains no similar provision.		

BILL AND BACKGROUND	LEGISLATIVE STATUS AND OUTLOOK	NCSL POSITION
CHILD HEALTH CARE HR 6706. S. 1392 (Child Assessment Act of 1977) Would require States to provide Medicaid coverage for all children under 6 years old whose families meet the state's income test for AFDC but who are uneligible for Medicaid due to categorical restrictions. Would raise the federal matching rate on the average to 75 percent of cover assessments and all ambulatory treatment provided to assessed children. Children assessed under the program would continue to be eligible for medical care for six months after eligibility for medical assistance would otherwise end. Performance criteria would be established to provide a standard against which a State's achievements could be measured. States demonstrating excellent performance could have their administrative match increased to 75%; states falling below the performance standards could face a reduction in their administrative match. S. 1071 (The Comprehensive Maternal and Child Health Protection Act) All pregnant women and children from birth to age six initially would be eligible; by 1983 children up to age 14 would be eligible. Covered services include all health care services related to the diagnosis and treatment of any disease, injury or disability as well as any other services necessary for adequate protection, maintenance or restoration of	Hearings were held before the House Commerce Subcommittee on Health. Mark-up sessions were begun but not completed before the same sub-committee Pending before Senate Finance Committee Pending before the Senate Human Resources Committee	No position specifically on this bill. However, NCSL has endorsed coverage of comprehensive health benefits, particularly preventive services, for children as a chief priority in phasing in benefits under a national health insurance program.

BILL AND BACKGROUND	LEGISLATIVE STATUS AND OUTLOOK	NCSL POSITION
mental and physical health. Eligible providers would be paid on a prospective capitation basis. Would authorize a tax credit for individuals based on their catastrophic medical expenses.		
COMPREHENSIVE EMPLOYMENT AND TRAINING AMENDMENTS OF 1978 HR 12452, S. 2570 Would limit participant eligibility to persons who are economically disadvantaged and either unemployed or underemployed. Would create specific programs for training of displaced homemakers under Title III. Would set a 78-week maximum limit in three years for Title II public service jobs, and a 2½ year maximum limit in five years for a combination of training and jobs. Would create a $400 million private sector trianing initiative program in new Title VII. Would no longer permit substitution in PSE jobs, limited wage supplementation, and contains stiffer anti-abuse language. Requires local prime sponsors to submit copies of comprehensive employment and training plans to state legislature for review.	House Committee on Education and Labor reported bill in early May. Floor vote is expected at any time. Senate Committee on Human Resources reported bill in mid-May. No floor action has been scheduled, but anticipated in July.	NCSL supports reauthorization of CETA with expanded state legislative role.

BILL AND BACKGROUND	LEGISLATIVE STATUS AND OUTLOOK	NCSL POSITION
CLINCIAL LABORATORIES H.R. 10901 Would set national standards for laboratories and authorize penalties for kickbacks and fraudulent billing.	Passed the Senate. Currently undergoing mark-up before the House Commerce Health Subcommittee. Hearings concluded before Ways and Means Committee.	No position
DISPLACED HOMEMAKERS H.R. 10270, S. 418 Would provide for at least 50 multipurpose service centers for displaced homemakers on a 90-10 matching basis. Services to be offered include: job counseling, training, placement and assistance with health care, legal and financial problems.	Hearings were held before the Senate Subcommittee on Employment, Poverty and Migratory Labor and before the House Education and Labor Subcommittee on Employment Opportunities. No action is planned as displaced homemakers is expected to be included in CETA reauthorization	NCSL supports the legislation.
HEALTH PLANNING H.R. 11488 The SHCC "establishes" the state health plan following which the Governor has 60 days to disapprove the plan. If it is not disapproved, it goes into effect. Governor must make public the basis for the disapproval and specify the needed changes. The Governor may select the Chairman of the SHCC from among the members of the SHCC. The bill calls for "an appropriate number" of public elected officials on HSA governing boards.	Bill has been reported out of full Commerce Committee and is awaiting floor action.	The Governor should approve or disapprove the state health plan. Appropriate legislative committees should be able to "review and comment" on the plan. The Governor, with the advice and consent of the State Senate, should appoint the Chairman of the SHCC.

BILL AND BACKGROUND	LEGISLATIVE STATUS AND OUTLOOK	NCSL POSITION
Acquisition of expensive equipment by physicians would be covered only when the state agency determines that the equipment was obtained to circumvent the planning process. An HMO need not obtain a CON if it can demonstrate its enrolled membership is large enough to deserve its own hospital. The HMO, however, must make an effort to share or contract with an existing facility before the exemption is triggered.		Legislation should provide that one-third of the members of HSA governing bodies be public elected officials and that public officials should be exempt from the requirement that they be categorized as consumers or providers.
In order to prevent state legislatures from overturning CON decisions, the bill would require each CON issued to be "based solely on the record established in administrative and judicial proceedings." Failure to do so would place the state CON program out of compliance and in jeopardy of losing federal funds. (Similar provision in Senate bill)		Objects to provisions which would pre-empt State decisions to cover HMOs under CON.
Would permit all States -- not just the six in present law -- to receive grants to perform rate review and regulation. Provides for a voluntary grant program to encourage State decertification activities. State planning agencies would be eligible for grants to assist them in identifying excess hospital beds and in establishing programs to reduce the number of unnecessary hospital beds. S. 2410		Believes that federal financial assistance should be made available to any State wishing to experiment with hospital rate review or rate setting.
The SHCC, with the concurrence of the Governor, would develop the state health plan. Grants cannot be made to the SHPDA until the state health plan is in effect.	Bill has been reported out of full Human Resources Committee and is awaiting floor action.	

BILL AND BACKGROUND	LEGISLATIVE STATUS AND OUTLOOK	NCSL POSITION
Requires coverage of diagnostic and therapeutic equipment that exceeds $150,000 regardless of setting. Would permit states to cover HMO start-ups and construction of HMO outaptient facilities under CON only if they cover other types of ambulatory care services.		
HOME HEALTH CARE H.R. 453 Would eliminate present restriction under Medicare for coverage up to 100 home health visits a year, leaving no limit on the number of covered visits. Would mandate coverage of home health services under Medicaid.	Referred jointly to Ways and Means and Interstate and Foreign Commerce Committees.	No position.
Would authorize as a Medicaid benefit payment of rent for an elderly or handicapped person when such payment is necessary to avoid institutional care of the individual. S. 2009 Would eliminate most restrictions under Medicard for qualifying for home health benefits.	Referred to Finance Committee	No position.

BILL AND BACKGROUND	LEGISLATIVE STATUS AND OUTLOOK	NCSL POSITION
HOSPITAL COST CONTAINMENT		
H.R. 6575 (Commerce Committee Version) Would permit a two year voluntary hospital cost containment program during which time the rate of increase in inpatient hospital costs must be reduced by 2 percent for each of the two years. The success or failure of the voluntary effort will be judged on a state-by-state rather than a national basis. Would exempt most hospital workers' wages from revenue controls under the voluntary program, leaving only capital spending and supply costs subject to the voluntary controls. For states wherein the voluntary approach was unsuccessful, a mandatory, transitional hospital cost containment program would operate. Under the mandatory program, rate of increase in each hospital's inpatient revenues (from charges or costs) would be limited to a fixed percentage increase over revenues allowed in the previous accounting year. The basic limit on increases in revenues would reflect general price trends in the economy and would be equal to 11/2 times the percentage increase in the GNP deflator. The basic limit would be adjusted to take into account major changes in a hospital's patient load. Special provisions for increases in revenue would exist for hospitals in rapid growth areas. Exceptions to the limit would be provided in certain cases, e.g., where a hospital had undertaken major changes in faculties or services approved by the State health planning agency. A 15 member Hospital Costs Commission would be created to make recommendations on the establishment of a new system for hospital reimbursement and on the development of an economic index of hospital costs to be used in place of the revenue cap.	Presently undergoing markup before the Interstate and Foreign Commerce Committee	NCSL supports a federal initiative of interim restraints on increases in hospitals' revenues, applicable to each State until the State enacts and implements an effective hospital cost containment program. State programs should implement minimum federal guidelines, but states should enjoy considerable flexibility in the method ology for constraining costs. NCSL believes that the federal government should provide financial assistance for start-up costs for State hospital cost containment programs.

BILL AND BACKGROUND	LEGISLATIVE STATUS AND OUTLOOK	NCSL POSITION
Would impose a $3 billion national limit on new capital expenditures. States that are operating effecitve cost containment programs would be exempt from the federal financial assistance which would be available to encourage other states to develop cost containment systems. S. 1391 Limits on hospital inpatient revenues would begin January 1, 1979. All non-federal acute care hospitals would be subject to the cap, except those with fewer than 2,000 admissions. Requires HEW to develop an index that more accurately reflects hospital costs to be used to calculate allowable revenue increases. The revenue increase formula is to be adjusted by a volume load formula. State programs would be exempt from the federal controls if (1) the state is already operating rate review commission covering all payors and can control revenue increased to 110 percent of the federal cap; (2) the state has a rate review commission which covers 90 percent of all hospitals, applies the cap to all revenues and controls revenue increases within 110 percent of the federal limit; or (3) the state qualifies for a demonstration experiment under Section 222 of the Social Security Act. Would place an immediate moratorium on all capital expenditures in excess of $150,000. The moratorium is lifted once a state's certificate-of-need program is approved. Then a $2.5 billion ceiling on new capital expenditures would go into effect nationally. Provides for an exemption of wages of non-supervising personnel from the calculations of the revenue cap except in those states operating rate review commissions.	Bill was reported out of Human Resources Committee	

BILL AND BACKGROUND	LEGISLATIVE STATUS AND OUTLOOK	NCSL POSITION
HR 6575 (Ways and Means Health Subcommittee version) Would permit a two year voluntary cost containment program to reduce the rate of increase in total hospital revenues by two percent each year. If the volumtary program fails to achieve the targeted objectives, a mandatory program would be triggered. The mandatory program would impose a limit on the percentage increase that is allowed for each hospital's in-patient revenues, and the calculation would be on a per admission basis. The percentage limit would be equal to 1½ times the GNP deflator. Adjustments would be made for changes in a hospital's patient load only if admissions increased by more than 2 percent or decreased by more than 6 percent. Hospitals would have the option to pass through wage increases for non-supervisory workers and energy payments. States with effective cost containment programs would be exempt from the federal program. Also, federal assistance (80-20 match) would be available to cover developmental and administrative costs in states that create hospital cost containment programs.	Bill was reported out of Ways and Means Health Subcommittee by a vote of 7 to 6. Full Ways and Means Committee action is deferred until the Commerce Committee acts.	

BILL AND BACKGROUND	LEGISLATIVE STATUS AND OUTLOOK	NCSL POSITION
MEDICAID REFORM H.R. 3, S. 143 (Anti-Fraud and Abuse Amendments) Strengthens fraud and abuse provisions such as requiring disclosure of ownership information and upgrading penalties for fraudulent activities to a felony. Provides funds to States to establish medicaid fraud units Defines relationship of state government to PSROs. Specifically, would require PSROs to consult with the state during preparation of review plan and would provide federal matching for state monitoring of PSRO review. If state monitoring demonstrates poor PSRO performance resulting in detrimental impact on state Medicaid expenditures or quality of care, States can seek the temporary suspension of PSRO binding authority pending an evaluation by the secretary.	Enacted into law Oct 25, 1977. PL 95-142	NCSL supports most of the legislation, especially the provision defining the relationship between the State and the PSROs. NCSL also supports amending the law to permit states to exclude Medicaid providers with consistent patterns of program abuse from participating in the program.
H.R. 1701 (Medical Assistance Accountability Act) Would create a position of Special Auditor General for Medicaid fraud and abuse to direct or conduct inspections and audits of state Medicaid programs. Would require states to operate a system of prevention and detection of Medicaid fraud and abuse, with 90% federal matching for such a program	Referred to Interstate and Foreign Commerce Committee	NCSL supports the legislation.

BILL AND BACKGROUND	LEGISLATIVE STATUS AND OUTLOOK	NCSL POSITION
S. 1470, H.R. 7079 (Medicare and Medicaid Administrative and Reimbursement Reform Act) Would establish specific performance criteria with respect to state administration of Medicaid. States which exceed the standards would receive a higher administrative match. State that are deficient would receive technical assistance, but may face eventual reductions in administrative match if deficiencies go uncorrected. Would establish a new method of reimbursement of routine operating costs for hospitals under Medicare and Medicaid. The new mechanism would provide for incentive reimbursement -- rewarding hospitals whose comparable routine operating costs are less than the average and penalizing those hospitals with above average costs.	Mark-up began in June before full Senate Finance Committee	NCSL has testified twice on this legislation. NCSL supports: -- reasonable performance criteria for state Medicaid administration -- Additional federal support for the development of Medicaid Management Information systems. -- States that have a successfully demonstrated hospital reimbursement program should be allowed to continue their system in place of the incentive system proposed in the bill. -- Federal assistance to states to encourage the development of alternative hospital reimbursement programs. -- Greater State flexibility in developing methods for reimbursing institutional providers.

BILL AND BACKGROUND	LEGISLATIVE STATUS AND OUTLOOK	NCSL POSITION
MEDICARE S. 2144 Would extend coverage for outpatient prescription drugs for the 24 million elderly in the country not just those eligible for Medicare and Social Security.	Referred to Senate Human Resources Committee	NCSL believes that the health care of the elderly should be the primary responsibility of the federal government.
NATIONAL HEALTH INSURANCE (See attached supplement comparing major NHI proposals)	The President is expected to announce NHI "principles" in July and deliver a proposal to Congress before the end of the second session.	NCSL believes that a NHI plan should contain the following elements: -- Comprehensive coverage phasing in benefits with an initial emphasis on preventive and child health services. - State and local governments should be directly involved in the administration and regulation of the plan in accordance with minimum federal guidelines. - State and local governments with federal assistance should experiment with different comprehensive health care systems before implementation of NHI program. - States should have the primary authority for cost control.

BILL AND BACKGROUND	LEGISLATIVE STATUS AND OUTLOOK	NCSL POSITION
PREVENTIVE HEALTH S 1191 (National Preventive Medicine Health Maintenance and Health Promotion Act) Would create a National Bureau of Human Development charged with conducting and supporting basic and applied research and training relating to health maintenance and the prevention and cure of disease. Would create a Bureau of Health Education to identify priorities among preventive health programs of the Public Health Service.		No position on bill. However, NCSL in its position on a National Health Policy declared that a national health policy is the only effective mechanism which can adequately grapple with the difficult public policy issues being forced on society by the proliferation of expensive, sophisticated, yet frequently cost-ineffective technologies. It is needed to reflect a consensus on the kind of future health care system we desire and on the means by which we should allocate limited health resources.
RECOMBINANT DNA HR 11192 Would provide federal regulation of DNA research including industrial research. Would essentially preempt state and local governments from adopting regulatory requirements more stringent than the federal standards. S 1217 Would provide interim regulation of DNA activities and establish a Commission for the Study of Research and Technology Involving Genetic Manipulation. Provides no preemption of state and local governments.	Reported out of House Interstate and Foreign Commerce Committee	NCSL supports the need for federal regulation of DNA research but strongly opposes language designed to preempt the states from enacting stronger requirements than those imposed at the federal level.

BILL AND BACKGROUND	LEGISLATIVE STATUS AND OUTLOOK	NCSL POSITION
RURAL HEALTH Mandates coverage of rural health clinic services for "categorically needy" under Medicaid in those states which permit primary health care services to be furnished by a nurse practitioner or physician assistant. Coverage for the medically needy remains optional.	Enacted into law December 13, 1977 (P.L. 95-210)	
SOCIAL SERVICES HR 10833 Would raise the funding ceiling for Title XX social services programs from the current level of $2.5 billion a year to $2.9 billion in FY 79, $3.15 billion in FY 80 and $3.45 billion in FY 81. Would permit states to adopt a comprehensive services plan for a two year period, rather than one year. Would require state officials to consult with local officials in the development of the state's comprehensive social services plan.	Reported out of House Ways and Means Subcommittee on Public Assistance as HR 12973. Reported out of full House Ways and Means Committee. Floor action under suspension of rules expected in July. Will be offered as an amendment to HR 7200 (Public Assistance Amendments) in the Senate.	NCSL supports increasing the funding ceiling and retaining state flexibility in determining their own social services needs and priorities.
VOCATIONAL REHABILITATION HR 12467 Would extend the program for five years, making basic program an entitlement, and provide adjustments in authorizations reflecting increases in the CPI.	Passed the House - 5/16/78 Senate action is expected the week of July 10.	

BILL AND BACKGROUND	LEGISLATIVE STATUS AND OUTLOOK	NCSL POSITION
VOCATIONAL REHABILITATION (continued) Would establish comprehensive rehabilitation services and independent living programs for the handicapped, to be administered through state Voc Rehab agencies. Would reaffirm congressional intent that any organizational scheme relative to the basic state program must conform to the intent and purposes of the Act, i.e., the Commissioner of the Rehabilitation Services Administration should not approve any plan which does not provide for a single, identifiable, administrative unit for rehabilitation. Would mandate the Commissioner to withhold federal funds if state plan is out of compliance, regardless of the filing of an appeal, and would give the Commissioner authority to disburse funds withheld from the state to any public or nonprofit private organization within the state. Would transfer all authority for approving states' rehabilitation services plans (and determining their non-compliance) from the Secretary of HEW to the Commissioner of RSA.		

BILL AND BACKGROUND	LEGISLATIVE STATUS AND OUTLOOK	NCSL POSITION
WELFARE REFORM H.R. 9030 (S.2084), H.R. 10950, H.R. 10711, S S. 2777 Four major welfare reform bills are pending in Congress: -- President Carter's original proposal HR 9030, S. 2084 -- The Corman Subcommittee bill, HR 10950, which is the administration proposal as amended by the special House Ways and Means subcommittee chaired by James C. Corman, D-Calif. -- The Ullman bill (HR 10711) sponsored by Al Ullman, D-Ore, chairman of the Ways and Means Committee. -- The Baker-Bellmon bill, S. 2777, whose principal sponsors are Sens. Howard Baker, Jr., R-Tenn., Senate minority leader; Henry Bellmon, R-Okla; Abraham Ribicoff, D-Conn, and John C. Danforth, R-Mo. All 4 proposals: -- Extend cash assistance coverage to two parent families. -- Establish a national minimum benefit -- Move in the direction of greater uniformity of rules and eligibility standards -- Simplify administration -- Provide public service jobs for poor families -- Expand the earned income tax credit -- Recognize the "importance of cashing out food stamps for at least some recipients "as a step toward a consolidated cash system." The major issues involved include the following: Programs. The Carter and Corman bills would combine existing Aid to Families with Dependent Children (AFDC), Supplemental Security Income	From mid-May thru most of June, the New Coalition -- a group of state and local officials that represents NCSL, The National Governor's Association, the National Association of Counties, the U.S. Conference of Mayors and the National League of Cities -- worked closely with key Congressional and Administration officials to fashion a compromise reform bill. As the result of the New Coalition's efforts, basic components of a reform bill were agreed upon during a June 7 meeting of key federal officials. These components included the following: -- the cost should be between $9-$11 billion. -- there should be around $2 billion in fiscal relief for welfare costs for states and localities. -- there should be a national minimum benefit of $4200 for a family of 4. -- 650,000 - 700,000 public service employment slots should be provided However, on June 20, House Speaker Thomas P. O'Neill told the House whips that because Senate leaders had decided that the Senate could not act this year, there was no point in bringing a compromise before a reluctant House. Everyone assumed that welfare reform is dead for this Session of Congress.	NCSL supports comprehensive welfare reform. HR 10950 most closely embodies NCSL policy positions.

BILL AND BACKGROUND	LEGISLATIVE STATUS AND OUTLOOK	NCSL POSITION
(SSI), food stamp and general assistance programs into one single cash payment. Ullman and Baker Bellmon would retain the existing separate programs. Coverage. Carter and Corman would extend welfare benefits to all needy persons, including single individuals and childless couples. Baker-Bellmon and Ullman would retain the prohibition against AFDC payments to single individuals and childless couples. All four bills make mandatory AFDC benefits to families with unemployed fathers but Ullman limits the aid to 17 weeks in a year. Benefits. All four proposals would establish national minimum benefits, with the Carter, Corman, and Ullman proposals all setting a minimum through a combination of cash ($2,550) and food stamps ($1650). Baker-Bellmon would allow states to continue to set benefit levels, but establishes targets at the following levels: 55 percent of the poverty level in fiscal 1981, 60 percent in 1982 and 65 percent in 1985. In 1978, 55 percent of the poverty level ($6200 for a non-farm family of four) was about $3,400. Tax Incentives. All four bills would expand the earned income tax credit, a tax break designed to increase the financial incentive for heads of low-income households to work. All four would prohibit tax credits on income earned from public jobs. Job Credits, Vouchers. The Baker-Bellmon bill also contains two financial incentives for employers who hire welfare recipients and unemployed poor persons not on welfare. A job voucher program would allow employers to receive a subsidy of $1 an hour per employee for a year. Or, employers could receive tax credits of $1 an hour for one year for each eligible employee they hired.	On June 28, Senators Moynihan, Cranston and Long introduced the State and Local Welfare Reform and Fiscal Relief Act of 1978. This $5 billion proposal provides around $3 billion in fiscal relief to states and localities, incentives for employers to hire welfare recipients, and additional funds for low-income workers with families via increases in the earned income tax credit.	

BILL AND BACKGROUND	LEGISLATIVE STATUS AND OUTLOOK	NCSL POSITION
The Ullman plan contains an expansion of the employer tax credit approved in the 1977 stimulus tax bill to provide an additional 10 percent credit to employers who hire WIN (Work Incentive Program) participants. Public Service Jobs. All four bills would establish public service jobs for low-income persons. Carter would establish the most -- 1.4 million, including 300,000 part-time jobs, in a new section under the Comprehensive Employment and Training Act (CETA), with workers to be paid at the minimum wage. Corman has the same number of jobs but would require workers to be paid prevailing wages. Carter and Corman would both abolish the WIN program. Ullman would establish 500,000 public service jobs under the WIN program, at minimum wages. Baker-Bellmon would establish 375,000 public service jobs under CETA, at average CETA wages (about $7800 a year, adjusted for regional and area differences) Baker-Bellmon and Ullman would give states control of the WIN program. Work Requirements. All four measures include work requirements for able-bodied welfare recipients, with some exceptions, most notably mothers with young children. Fiscal Relief to States. Under existing law, the federal government pays 100 percent of the cost of food stamps and SSI. The federal share of AFDC ranges from 50 to 78 percent. Carter and Corman would establish a 90 percent federal contribution for single cash payments. Baker Bellmon and Ullman would retain a 100 percent federal payment for food stamps and SSI. Ullman sets the state share of AFDC at 85 percent of the 1977 cost of benefits; the federal government would then pay 100 percent of all benefit costs beyond the fixed state share. Baker-Bellmon would increase the AFDC match to the 80-90 percent range by fiscal 1982. The following estimates have been made for actual dollar amounts of fiscal aid to states under each of the plans;		

BILL AND BACKGROUND	LEGISLATIVE STATUS AND OUTLOOK	NCSL POSITION
Carter, $3.4 billion, Corman, $2.2 billion, Ullman, $1.2 billion; Baker-Bellmon, $3 billion. Costs. All four measures would increase the amount of money the federal government spends on welfare. As of late April 1978, administration officials said the Carter bill would cost an additional $8.77 billion in 1982. The Congressional Budget Office (CBO) placed the price tag at $17.36 billion. The Corman bill would cost about $20.22 billion more than existing programs, according to the CBO. Baker-Bellmon according to preliminary CBO estimates, would cost about $9.33 billion more. Ullman's staff has estimated the added cost of his proposal at between $4.75 billion and $9 billion.		

PRINCIPLES AND RECOMMENDATIONS ON A NATIONAL HEALTH CARE POLICY

The Human Resources Committee of the
National Conference of State Legislatures

June 26, 1978

PREAMBLE

Serious deficiencies and inequities exist within the U.S. health care system. The overall health status of Americans compares rather poorly with many other industrialized nations. Adequate health services are not always available or appropriately utilized. Financial barriers still prevent many from obtaining needed medical services. Six percent of our Nation's population are totally without any form of health care protection, while another twenty-five percent are considered to have inadequate or only marginal protection.

Today's medical care system focuses predominately on illness and technological remedies to the exclusion of maintaining and promoting good health. Health services tend to be shaped as much by the growth of technology as by patients' needs.

The distribution of physicians, both geographically and by specialty, remains grossly uneven. Substantial evidence points to considerable excess hospital use and capacity, representing an unnecessary and frequently wasteful diversion of limited national resources from other pressing health and human service needs.

Annual increase in health care costs consistently outpace the consumer price index. Total health expenditures are rapidly approaching ten percent of our Nation's Gross National Product.

Such unsettling facts lead to one basic conclusion: a thorough reassessment of past public policies with respect to health care is badly needed. A national health care policy is required in order to modify the many perverse incentives that presently exist within the health care system while protecting the public commitment to the attainment of positive health goals.

The need for a national health care policy grows out of the recognition that a goal of "highest quality care for everyone at any price" is unrealistic given limited national resources. Deliberate choices among alternative uses of health resources cannot be avoided. A coherent national health policy can most effectively help to shape and guide those choices consistent with overall goals.

A national health insurance system is an essential, but secondary component of a national health policy. NHI can help resolve certain inadequacies in terms of improving access and equity; yet, a mechanism for financing health care cannot, by itself, encourage the reforms in the organization and delivery of health services that are needed. Only a national health policy can hope to develop the correct strategy for ensuring the effective governance and operation of the health system. The overriding goal of a national health policy ought to be the discovery of the appropriate mix of strategies that can effectively balance and accommodate three fundamental interests: patient need, physician discretion and clinical judgment, and the public purse.

A national health policy is predicated on the proposition that traditional medicine has reached a pinnacle in terms of its ability to enhance overall health status. Hence, the policy must aim at leveling out those resources directed toward expanding the availability of sophisticated, yet costly medical technologies and practices and focusing our attention more on those biological, environmental, and behavioral factors which demonstrate a marked effect on health.

NATIONAL HEALTH POLICY GOALS

1. Should Assure that Adequate Health Care is Accessible to all Individuals.

DISCUSSION

Barriers to universal access to adequate health care include: financing inequities, inadequate health care planning and uneven distribution of health manpower and resources.

While private health insurance and public programs such as Medicare and Medicaid provide some protection against the burden of medical bills to a large segment of the population, there are still significant gaps in coverage.

The Department of HEW estimates that perhaps as many as 30 million people under 65 have neither private nor public coverage of any kind.

Most basic insurance policies exclude preventive care services and ambulatory care; and many policies still exclude pre-existing conditions and congenital defects.

Comprehensive health planning has yet to bring about the necessary changes in the development and allocation of the nation's health resources. Experts suggest, for example, that between 70,000 to 80,000 excess acute care hospital beds may exist nationwide.

Clearly, health manpower policy has not resolved the geographical and specialty maldistribution problem of physicians. Physicians remain overly concentrated in the metropolitan areas. In 1973, the ratio of active, non-federal physicians engaged in patient care to the population in the most populous metropolitan counties was 6 times the ratio in the least populous rural counties. In the same year, there were 2.2 internists per 10,000 persons within SMSA's but only 0.6 per 10,000 outside SMSA's. Moreover, the decline of the general practitioner relative to the specialist has markedly affected the health care system.

2. Should Ensure that no one Suffers Financial Ruin from Catastrophic Illness

DISCUSSION

Major medical insurance is designed to protect families against very large medical bills; however, at present only about 60 percent of the population have major medical coverage. Moreover, many of those that do have major medical policies face limits on the amount of coverage, as well as substantial co-insurance provisions, so that in cases of prolonged illness or when intensive care is required, they may be confronted with a crushing financial burden.

About one half of all private policies limit total benefits payable in a lifetime to $10,000 or less, and almost two thirds of current policies limit hospitalization to 60 days or less.

3. Should Promote a Reduction in the Rate of Increase of Health Care Costs

DISCUSSION:

During the fiscal year ending June 30, 1977, the U.S. spent $167 billion for health care -- 12 percent more than what it spent the previous year. Per capita health care expenditures reached $737.00, up 13 percent from the previous year.

In 1950, health care outlays were only 4.5 percent of GNP; by 1972 the percentage increased to 7.2 percent; and in 1977, it reached 8.7 percent. Assuming no change in the delivery of financing of the health care system, total health expenditures will reach 9.1 percent of GNP in 1980, with total expenditures approximating $230 billion.

Historically, the medical care price increases have exceeded the increases in the total consumer price index. Between 1950 and 1976, medical care prices increased 3.4 times while the CPI increased 2.4 times.

During 1976, charges for semi-private hospital rooms were the most rapidly growing prices in the medical care sector, increasing 13 percent over the previous year. The cost of an average hospital stay increased from $311 in 1965 to $1,017 in 1975.

4. Should Encourage Desirable Changes in the Organization and Delivery of Health Care Services and Promote More Individual Responsibility for Health.

DISCUSSION:

Hospital expenditures account for just over 40 percent of all national health dollars, while nearly 60 percent of public program expenditures are devoted to hospital care. Every year institutional services, i.e., those provided by hospitals and nursing homes, claim an increasing share of the health care dollar.

The traditional use of the hospital as the locus for a high percentage of acute illness has been a major contributor to health care cost escalations. Such escalations are as much a function of the absence of more appropriate and less costly alternatives to institutional care as other contributing factors, such as, wage increase, technological advances and overall economic inflation. Inappropriate utilization of costly hospital services is further influenced by the general practice of health insurers to provide higher benefits for hospital care than for home health care or ambulatory services. Ninety one percent of the U.S. population have some form of third party coverage for hospital care.

Moreover, it is a widely held assumption that if the health care delivery system is improved the overall health care delivery system is improved the overall health of those its serves will be enhanced. However, over the past decade improvements in the delivery of medical care have demonstrated very little impact on health status even though expenditures on health care today are four and a half times as much as that spent in 1960. The greatest potential for improving the health of the American people may lie in investments outside the traditional medical care system, for example, in creating incentives for individuals to improve their own lifestyles and for promoting collective decisions to reduce environmental hazards.

In Addition, National Health Policy Should be Consistent with the Following Objectives:

A. Promote maximum increase in health status given limited resources;

B. Promote an acceptable quality of services;

C. Assure continuing competency of health care professionals;

D. Promote the availability of cost effective services on an equitable basis;

E. Promote administrative and organizational efficiency;

F. Assist consumers in using health care services appropriately;

G. Encourage innovation and flexibility;

H. Redirect the health care system away from its current acute care orientation;

I. Encourage a coordinated and continuous system of delivery;

J. Promote improved geographical distribution of services;

K. Encourage more rational distribution of personnel according to specialty and geography;

L. Stimulate and reinforce cost containment activities;

M. Be responsive to local needs and conditions

BASIC PRINCIPLES AND RECOMMENDATIONS

I. Cost Containment

A strong cost containment program is an essential precursor to a national health insurance system. A comprehensive cost control strategy must be implemented immediately in order to prevent further inflationary problems resulting from new financing and increased demands on the delivery system.

A cost containment strategy should include, but not be limited to, the following elements:

1. Hospital cost containment through prospective reimbursement or incentive reimbursement reforms. The federal program should be waived in any state that has a hospital cost containment system which meets minimum federal requirements. Federal funding should be available to encourage states to develop alternative hospital cost containment programs.

2. Federal incentive payments to states to contain costs generated by underutilization or inappropriate utilization of existing resources, e.g., appropriateness review, decertification of facilities and services, hospital mergers and closures.

3. Establishment of a nationwide, regional, and/or state limitation on capital expenditures.

4. Promotion of more economically rational health plans with built-in incentives for cost effectiveness, e.g., health maintenance organizations, individual practice associations, health care alliances, and prepaid group practices.

II. Population Eligibility

Enrollment in the national health insurance program should be universal and mandatory.

III. Benefit Structure

- A national health insurance program should provide coverage for a broad, comprehensive package of services.
- Preventive health services of known medical value and demonstrated to be cost effective should also be covered.
- Coverage should be equitable and uniform for the entire population.
- The benefit package should encourage the utilization of lower-cost, quality controlled substitutes and services which maintain health.
- Assuming that the benefit structure will be introduced on an incremental basis, priority should be given to the following benefits:
  - -- Protection to assure that no one's standard of living is seriously impaired because of the consumption of medically necessary, covered services.

-- Preventive health services, including diagnostic, screening, immunization and health maintenance.

. Limitations on coverage of long-term care services would be appropriate. Long term care services which are strictly social services in nature should not be covered under the benefit structure.

IV. Finance

. Financing the public cost of delivering health care services under NHI should be shared by the Federal government and States, with the States being responsible for a substantial share of any increased costs which result from factors under state control.

. All costs resulting from factors beyond the control of States should be 100 percent federally financed.

. States should initially maintain current effort in financing health services with subsequent equalization of burdens among States based upon an appropriate formula.

. State contributions must be predictable -- State contributions must be adjusted downward if a state encounters an uncontrollable reduction in state revenues.

. Annual ceilings on costs should be set nationally and applied State by State, allowing for differential needs in different States.

. Federal financial participation with the States should be prospective.

V. Administration

. Administrative authority under the national health insurance program should be shared by Federal, State and local governments. The various administrative tasks of each level of government must be clearly specified in the legislation.

. The Federal government should establish uniform national standards where uniformity is required to assure equity or to achieve other objectives and should set minimum standards in all other instances. Federal authority should include monitoring powers and the authority to provide positive and negative incentives:

-- To the extent practical, the Federal standards should be specified in terms of performance objectives.

-- In case of continuing unsatisfactory performance by a State, the Federal government should have the authority to assume the administrative functions for which the State was found deficient.

. States should be allowed to use insurance carriers as profit or non-profit fiscal intermediaries.

VI. Reimbursement

. Any NHI program should incorporate mechanisms to allow States and local governments to develop innovative reimbursement programs within federally established performance standards.

. There should be Federal incentives for the establishment or maintenance of rate-setting programs which meet Federal performance standards.

. Reimbursement policies should encourage the development of needed primary care services and the reduction of excess acute and institutional care capacity. Incentives for the closing of excess hospital capacity and ceilings on capital expenditures should be included.

VII. Cost Sharing

If cost sharing (i.e., co-payments and deductibles) is mandated in order to either help control utilization of services or finance the program, the mandate should be consistent with the following conditions:

. Cost sharing should not apply to low-income families and individuals.

. Cost sharing should be used only when the consumer has a major part in making the decisions about utilization.

. Preventive services which are known to be effective should not be subject to cost sharing.

VIII. Planning

. The focal point for health planning and regulation should be at the state level.

. The Federal government should, with the input of state and local governments, establish broad national planning goals and provide financial and technical assistance to the states and localities toward meeting those goals.

. Greater participation among state and local public elected officials in the health planning process is necessary to ensure accountability of decision-making.

IX. Manpower

Reimbursement mechanisms must be modified to encourage a more balanced geographic and specialty distribution of physicians and health professionals.

. Special attention must be given to the adverse impact an excess supply of physicians may have on utilization and costs.

. Greater flexibility in the utilization of allied health professionals should be encouraged.

X. Other Principles

. The national health insurance program should encourage individuals to take responsibility for maintaining their own health and for controlling cost. Specific measures should include providing incentives for appropriate use of health services by consumers and support of research to develop more effective tools for health education.

. A concern for community-wide public health programs must not be overshadowed by the need for a nationwide program for medical care financing. Federal, state and local governments must continue to enhance their commitment to public health efforts. The benefits that accrue from preventive programs, such as immunization or restoration of environmental quality, will far exceed those benefits in improved health which reasonably can be expected from the medical care system.

. As a prelude to the enactment and implementation of a national health insurance plan, the proper role of the federal government ought to be one of immediate encouragement of state governments to make adequate health care coverage more widely available, and at the same time experiment with alternative approaches to such policy areas as financing, levels of coverage, administration, cost containment, cost sharing and reimbursement. Over time and after systematic evaluation, the federal government could narrow the range of acceptable approaches and variations to those that have proven most workable and cost efficient when implemented by states.