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INCREMENTAL NATIONAL HEALTH INSURANCE: A REVIEW OF CURRENT PROPOSALS

INTRODUCTION

In the 96th Congress a number of separate bills have been introduced that deal with specialized aspects of health care -- its costs, its quality, and its coverage. Although the sponsors of these bills claim that their legislation would improve the quality of health care services and lower the costs of health care to its consumers, it is evident that, on closer examination, the collective effect of this legislation would be the establishment of National Health Insurance (NHI). Senator Edward M. Kennedy (D.-Mass.) and Congressman Henry Waxman (D.-Cal.) have recently announced their own comprehensive and universal health insurance plan; the basis for the same comprehensive ("cradle to grave") and universal NHI system of governmentally provided health care would be effectively established if these other bills were enacted into law. A detailed examination is not necessary to prove this point, but a general acquaintance with their provisions should make their collective effect clear.

Hospital Cost Containment

The Carter Administration introduced its Hospital Cost Containment plan on March 7, 1979, but this bill (S.570, H.R. 2626) soon encountered criticism from Sen. Kennedy as well as from others in the Human Resources Committee and has to date not been reported out of the House Ways and Means Committee. Sen. Kennedy's objections were principally to the administrative details of the Presidents's proposal, and he introduced his own revised bill. However, the Kennedy bill is almost exactly the same as the Carter proposal in its general provisions, except that it establishes a higher lid on hospital costs than the Administration bill. The Kennedy bill provides for a "pass through" for the wages of non-supervisory labor, but controls will be placed on hospital spending so that these higher costs cannot be offset by increased

charges for goods and services. Hospitals will, therefore, have to cut back their goods and services, and the quality of their health care provisions will be impaired.

Another Hospital Cost Containment proposal is that of Senator Herman Talmadge (D.-Ga.) under the title of "Medicare-Medicaid Administrative Reimbursement Reform Act of 1979" (S. 505), now in the Senate Finance Committee. Senator Talmadge considers section 2 of the bill, dealing with hospital costs, to be the most important provision. This part would make government purchases of hospital care under Medicare and Medicaid dependent on governmentally established criteria of the efficiency or inefficiency of hospital operations. The bill's sponsors argue that hospitals would have an incentive to contain costs and that government regulation would not be involved. The government as a purchaser would seek to "patronize" efficient hospitals. However, the definition of efficiency would be established by the government itself and would be subject to redefinition by the government. In effect, therefore, the Talmadge bill would establish governmentally mandated standards to which hospitals are to conform and would thus constitute an extension of government intervention into hospital care.

Hospital Cost Containment is widely regarded as a prerequisite for NHI. The advocates of NHI admit that the demand for health care goods and services would increase enormously under a comprehensive and universal NHI proposal, and therefore admit that the costs of health care would increase unless held down by artificial constraints. The establishment of a Hospital Cost Containment program, whether that of the Administration, Sen. Kennedy, or Sen. Talmadge, should be seen as merely the prelude to a far more comprehensive NHI proposal.

Catastrophic Health Insurance

S. 760, introduced by Senator Russell B. Long on March 26, 1979, is a Catastrophic Health Insurance proposal designed to achieve three purposes: (1) requiring employers to provide insurance against catastrophic illnesses and providing tax credits for the purchase of such insurance; (2) replacing the current Medicaid program with a federalized medical assistance plan for low income groups; and (3) encouraging purchase of basic health insurance through private insurance. The Long bill, very similar to legislation introduced by Senators Long and Abraham Ribicoff (D.-Conn.) in previous Congresses, is considered by many to be an effective alternative to comprehensive NHI. As in the earlier bills, the current plan establishes a "deductible" paid by the insured parties, but all expenses above this deductible would be paid by the insurer. The bill establishes a wide coverage, including the insured parties' family, and provides for a wide range of illnesses, including mental health care. In regard to the second phase of the bill, the current variations in state Medicaid benefits would be abolished and uniform federal benefits would be established (thus encouraging consumption of health care resources and stimulating costs for the remaining supply).

The Long approach is often advocated as an alternative to NHI because it would deal with the most serious and expensive illnesses, require some payment by the beneficiaries, and rely on private insurers and employers rather than the government. However, the Long plan would be easily convertible into a comprehensive NHI plan simply by lowering the deductible and extending the range of coverage. These conversions could easily be affected by Congress, and the public must expect immense political pressure to be placed on Congress if the bill passes, just as such pressures have been successfully applied in expanding Social Security benefits, welfare payments, and food stamps benefits ever since the inception of the programs. Catastrophic health insurance, therefore, does not in principle differ from the more radical approach of comprehensive and universal NHI, and once the principle has been granted, one must expect a gradual expansion of the program into NHI.

Child Health Assurance Program (CHAP)

Bills for an expanded CHAP program were reported out of committee in the 95th Congress but did not reach the floor before adjourment. In the 96th Congress, three bills, each very similar to the other, but more extensive than that of the 95th Congress, have been introduced: the Carter bill (H.R. 2159) sponsored by Congressman Tim Lee Carter (R.-Ky.); the Maguire-Waxman bill (H.R. 2461) sponsored by Congressman Andrew Maguire (D.-N.J.) and Henry A. Waxman (D.-Cal.); and the Administration bill (H.R. 4053), also introduced by Mr. Waxman. Essentially each of these bills seeks to expand current programs for the early diagnosis and screening of the children of low income families. The bills propose to replace the current Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program under Medicaid by increasing federal grants to the states for the operation of the programs and by extending coverage in all states to children living in low-income, two-parent families. The CHAP proposal would be expanded from about 1.7 million to 2.5 million children. A similar program supported by the Carter Administration in 1977 was estimated to cost $180 million, but by October 1978, the supporters of the CHAP legislation stated that the cost for FY 1979 would be $229 million (Congressional Record, October 11, 1978, p. H12244).

Aside from the cost and the expansion of the welfare rolls, however, the most controversial aspect of CHAP is the innovation in the concept of welfare. Previously, welfare has been granted to the aged, blind, and disabled (Supplemental Security Income), to broken families (AFDC), or to other categories of needy persons who can establish a particular need (Medicaid and Food Stamps, for example). Under the CHAP proposal, for the first time, medical welfare benefits will be given to intact families of able bodied persons. The change in the title of the proposal is significant. Originally entitled the "Child Health Assessment Program," it is now called the "Child Health Assurance Program." The change in title

indicates the change in concept from one intended to test and examine children's health to one intended to assure and provide children's health. Whether the new concept and new intentions will be implemented any more effectively than other government aid programs is, of course, questionable.

Nevertheless, the concept and the principle established by CHAP moves the U.S. toward comprehensive and universal health care coverage by the government and can be seen as another step toward NHI, without actual identification as such. By including children in its provisions without regard to the special circumstances traditionally believed to justify government assistance, CHAP moves the population toward a comprehensive "welfare state" in which all citizens, regardless of need, depend on governmental assistance. Finally, it should be noted that, like Catastrophic and other health care programs, CHAP proposes to stimulate demand but not to increase supply, thus further inflating health care costs unless artificial lids are placed on them.

CONCLUSION

The bills outlined above are designed to achieve the basis for comprehensive coverage of Americans for health care -- in other words, the basic principles of NHI. As such, they would represent, if passed, an incremental realization of NHI, a goal long desired by many legislators and private interests but long resisted by others. Most of the criticisms of NHI that have informed those opposed to it continue to apply to these specific measures, and some review of the basic problems of NHI is in order.

There are many reasons why health care costs are escalating dramatically in the United States: intensive consumption by hospitals of labor, energy, food, and other goods and services particularly affected by inflation and the increased incidence of malpractice litigation and the insurance necessary to protect against it are only two of the most obvious causes. Perhaps less obvious but no less important is the reimbursement system currently in use. Under this system "third party" payors - i.e., government and insurance agencies - pay for about 50 percent of all health care costs. This system has evolved as government programs making health care more available have become more common under such plans as Medicare and Medicaid. The effect of these programs has been to stimulate a vast increase in demand for health care goods and services. As the demand increases, the remaining supply becomes more costly to the consumer -- and especially to those consumers less protected by third party payors (i.e., those not eligible for Medicare and Medicaid and those not fully covered by health insurance). Almost all health insurance proposals, whether catastrophic or comprehensive, are specifically designed to maximize demand - to make health care more available and accessible - and would have the effect of stimulating health care costs.

Advocates of government health insurance programs are generally aware of this effect, and for this reason they also propose "cost containment" programs. Such programs, which amount to price controls and rationing of health care goods and services, are logically necessary in any program which makes health care more available and thereby stimulates demand. The "plus" side of government-provided health care is therefore inseparable form the "minus" side: as government makes health care more affordable, it must also seek to restrict access to health care.

This has generally been the experience of the European health care systems in Great Britain and Sweden under their national health services. There, although many are now able to afford health care, consumers also find that the supply is limited: operations must be postponed; physicians' services are in short supply; new medical facilities are increasingly rare; and innovations in health care technology are more difficult to provide.

The bills outlined above will clearly achieve the basis of NHI in principle, and their expansion into NHI will be merely a matter of time. The Cost Containment proposals establish the basis for the price control and rationing provisions, and the Long bill establishes the basis for universal and comprehensive coverage once its limited coverage is extended by legislative amendment. The CHAP plan also lays the basis for comprehensive health and welfare benefits by extending coverage to intact, able-bodied families. Under these proposals, therefore, the foundations of National Health Insurance will have become a political reality, regardless of the intentions of the legislators.

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