THE WHITE HOUSE

WASHINGTON

February 9, 1971

MEMORANDUM FOR THE VICE PRESIDENT

FROM: JOHN R. PRICE

SUBJECT: Summary of Health Options

While the options break down most crudely into "supply" side and "demand" side proposals, they also are directed at five major things.

First, to provide improved financial access to health care which many can not now afford.

Second, to stem rising costs.

Third, to ameliorate the geographic maldistribution of availability of services.

Fourth, to improve the quality of care and increase or redirect the manpower to provide it.

Fifth, to place greater emphasis on prevention.

All of the five areas are woven together; merely to add more purchasing power without concurrently affecting the distribution of doctors, and perhaps their number would result in rising costs. Similarly, provision of care in some scarcity areas will be easier to stimulate if there is some additional purchasing power there.

In the broadest sense, the principal themes running through the options are:

-- recognize the good features in the current system, and try to retain them.

-- bring about change through incentives and the setting of standards, not through the direct assumption by the Federal government of the running of the health care system.

The message is now scheduled to go to the Congress on the 17th of February, next Wednesday. It will be accompanied by a lengthy "White Paper" or "Brandeis Brief" detailing the problems with the current system, and setting forth the rationale for the particular proposals we are making.

1. Financing

The details have not finally been resolved. In brief, the financing proposals have three parts. The first is we will mandate the provision by all employers of health benefits for their employees which will be comprehensive, including both in-patient and out-patient coverage. Private or mutual insurance carriers can provide the coverage. Tentatively, all employers with one or more employees will be required to cover their employees, although the extent of the employees' contribution to the cost is as yet unresolved, as is the effective date on which the mandated standards would come into play. The principle as you know is comparable to the fair labor standards principle. It would impose an additional cost on many employers, although a high percent of employers already are covering their employees with more or less comprehensive care. On the rationale that other alternatives being discussed on the Hill (like a payroll tax on employers to pay for Federally provided catastrophic insurance) would hit employers no less hard and probably harder than paying for our mandated coverage, we have decided not to subsidize the employers.

The proposal is starkly different from most of the schemes now being aired on the Hill. While it is bound to evoke charges that we are favoring the insurance industry, etc., in fact, if enacted, we think it could have a salutary effect on prices of coverage. This is because in the past, carriers have tended to blink at the high costs of care which providers charge to them, and to pass on these costs in the form of higher premiums. Now, since it is more a cost of doing business for an employer, the latter will tend to pressure the carrier to be more circumspect in allowing overcharging, or over-utilization.

Most importantly, it retains the current structure, and the insurance industry, providing a chance for "diversity, competition and experimentation" as the President said at a Leadership Conference this morning.

The second major part of the financing proposal is the Family Health Insurance Plan (FHIP). This is to help provide coverage for unemployed families, and for self-employed families. It is still undecided whether the cut-off level of income for a family would be the same as FAP ($3920 for a family of four) or $5,000. We have rejected a FHIP for

families with incomes running as high as $8,000. FHIP would replace Medicaid.

Self-employed persons above the income level would have available to them a State pooled insurance program with the same standards as mandated for the others.

Finally, Medicare would be amended so that the elderly and disabled who are on welfare (Old Age Assistance, Aid to the Blind and the Disabled) would have their health care provided by Medicare. Also, Parts A and B would be combined, and tentatively the part which had been paid for by contributions from the elderly, would be met now by financing under general revenues.

See decision paper from Secretary Richardson of February 8 for discussion of some of the last minute issues in financing.

2. Rising Costs

As mentioned, the insurance and mandated standards may have some impact on costs, although simply the provision of more insurance without structural change in the system could lead simply to a higher unit cost for care.

One of the principal proposals to combat cost increases is the health maintenance organization, with which you are familiar. As the proposal now stands, we would eschew the approach of requiring that any Federal reimbursement for service could be made only if the service were performed in an HMO (some bills go this far). Rather, we would put an option in both FHIP and in the standards for the mandated insurance coverage that HMOs could perform the service. This will mean that HMOs will be able to compete for service in areas where they have not ventured before. The combination of no option in most insurance policies, and of low local standards of coverage in many areas, meaning that pre-paid practice was costlier by far, have inhibited HMO growth in the past.

Also an obstacle to HMOs growing in the market of providers have been State laws restricting group practice. To remedy this, we will create a group in consultation with the States to develop a Model State Code for group practice. In the meantime, the Secretary of HEW would be given limited power to override or preempt State restrictions by contracting directly with HMO type organizations to provide care, reimbursed by FHIP funds. Resting on the supremacy clause

of the Constitution, this action could proceed while Model Codes are being developed.

The specific support devices for HMOs are discussed in the decision paper for the President of February 4th, and summarized in my memo for the President of February 8th.

Beyond the potential of HMOs to help control costs, the message will propose closer utilization review for all insurance payments. Tentatively, it is expected that the review will be provided through local medical societies, with outside persons or "consumers" also represented.

Another important factor in cost is the resource base of health personnel. Thus, the output of medical schools will be stimulated by capitation grants and by special grants for things such as shortening curriculum, etc. Similarly, the provision of more lower cost providers (allied health personnel) will be encouraged through two principle techniques: one is assistance to institutions to train them, and the other is the development of Model State Codes regulating their use, and easing entry to the market for them. As with States where law restricts group practice, so in States where allied health personnel are limited in what they can perform, the Federal government will preempt State law in a limited way by contracting directly for use of such personnel.

Doctors have often been anxious to use them, but reluctant to for fear of malpractice suits, in which awards have been skyrocketing. Therefore, the Secretary will establish a Commission to examine means to re-work the law of malpractice to protect customers while at the same time not precluding doctors from using physicians' assistants and other allied health personnel, and also avoiding their protective use of unneeded tests and consultations, all of which have helped to drive costs up.

3. Geographic Distribution

Area Health Education Centers will be located in poorly or underserved parts of the country, where it would not make economic sense to start the construction and staffing of a full medical school. Based on existing hospitals or centers, they would provide basic medical education for physicians' assistants, and refresher courses or continuing education. This is based on a recommendation of the Carnegie Commission and should jibe well with the President's interest in national growth policy and rural development.

Tentatively, too, there may be efforts to establish some 100 "Family Health Centers" over the next two years, using existing authority. These would be like the OEO "Neighborhood Health Centers" except they would not be subject necessarily to "community control" or contain activities like "health advocacy." They are discussed in detail in the February 4th and February 8th papers as are also HMOs for scarcity areas.

Tentatively, the President will implement the National Health Service Corps at a cost of $10 million, which will provide Public Health Service doctors and para-professionals to serve in scarcity areas after a local request for them is made to the Federal government. While our disposition at this point is to use them largely in the most sparsely settled parts of the country, it may be necessary for them to help staff any Family Health Centers or HMOs which start in urban areas which are poorly serviced.

Another attempt to influence better distribution of health personnel will be through partial or complete forgiveness by the Federal government of any loans owed by medical students for their education, if the student serves for a given period of time in a scarcity area. The definition of scarcity area has not yet been made, and it is undecided as yet whether the definition should be made by the States, or by the Federal government.

A very different approach to the maldistribution problem is to acknowledge that while a main difficulty is lack of facilities, another one is a surfeit of facilities, especially hospital beds, in other areas. Therefore, it will be proposed that we strengthen the hands of State planning bodies to permit them to exercise even greater control over the licensing of new hospital beds, and encourage them to define catchment areas for out-patient facilities which can then be tied to existing in-patient facilities.

4. Quality of Care

While the quality of care for some is extremely high, for other it is not good. This has to do not alone with geographic isolation of patients, but also with the ever higher percentage of doctors who move on into speciality areas, and are not available to help serve the primary needs of most people, but reserve their efforts for the more specialized and expensive care of which the few have need.

Therefore, one way of making more broadly available the high quality training of which our medical schools are capable is to encourage larger numbers of their graduates to engage in primary care. We will be seeking to do this by a loan forgiveness feature, similar to the one mentioned above for those who treat in scarcity areas, but for MDs who provide primary care. Also there will be higher graduate training stipends available for those entering primary care practice.

To strengthen the role of the medical schools themselves, and help some of them which are in precarious financial condition, it will be proposed that we make capitation grants for each student enrolled, to help defray his overhead for the school. Also, there will be project grants for enrollment increases, for shortening of the curriculum and reforms of the curriculum, and for the training of physician assistants.

Somewhat distinct from utilization review will be "peer" review of the quality of care provided. This review will seek to assure that widely accepted standards of practice are being employed, and may be accompanied by assistance for data development on treatment and hospital discharge, which should aid not only in peer review procedures, but the development of more efficient hospital mangement techniques.

The Area Health Education Centers are meant, as mentioned above, to expand continuing medical education, with consequent regional benefits in higher quality of care.

5. Prevention

The President will announce his desire to form a "National Health Education Foundation" which will be entirely privately financed and which will seek to draw together business, labor, and other user and provider groups. The Foundation will seek to develop and promote techniques of preventive health care, including advertising, using trade union organs, company health plans, etc.

The Foundation will hold its organizational meeting some week or two following the President's message.

The President has already announced his expanded biomedical research program for cancer and for sickle cell anemia, at a level of $100 million.

The remaining issue for resolution here is what level of visibility to give the effort. Benno Schmidt, a New York investment banker, will be coming in soon with a proposal, apt to be picked up by Ted Kennedy, that there should be a separate institute. There is some sympathy in the Administration for this but the prevailing view now is that such a move would lead to demands to do the same thing for heart and lung, and other types of biomedical research. These people would prefer to have a special reporting relationship from the responsible officials of the National Institute of Health to the Secretary of HEW.

A package is coming over late tonight containing proposed decisions on accident prevention, and on alcoholism and venereal disease. It will not be ready in time for your flight.