Mr Louis Blair
P6/b(6)

October 24, 1996

12/4
In response to his call, I spoke w/ Mr. Blair again - he wanted two things (1) to know if we had problems / ?s about the validity of his proposal + (2) if we don't agree with his plan, then what do we propose?

Ms. Sandy Bublick-Max, Policy Analyst
Office of Domestic Policy
Old Executive Office Building, Room 213
1700 Pennsylvania Avenue
Washington, D. C. 20502

Dear Ms. Max,

In our telephone conversation earlier this week you asked for information supporting the financial efficacy of my health reform proposal.

Enclosed is another copy of the one page overview of my proposal, the bottom lines of which report that my proposal will save $292 billion over the first six years of its operation and $175 billion per year thereafter. In support of these statements I am enclosing a copy of the December 16,1993 CBO letter to Congressman Jim McDermott scoring H. R. 1200, the American Health Security Act of 1993. The entire letter deserves rereading but pages 8 and 9 plus Table 2 (including my insert) which follows page 9 is my preliminary response to your request for financial information supporting my proposal. Additionally, I am enclosing a sheet which is extrapolated from Table 2. It emphasizes that if there is no reform:

a) private health care costs will increase from $614 billion to $1,022 billion by 2003 - but with H. R. 1200 private health care costs would increase only $310 billion - $712 billion less.

b) It points out that even with the universal coverage provided by H. R. 1200, public health care costs would increase only $537 billion - a saving of $175 billion in total national health care costs in the year 2003.

My proposal - like H. R. 1200 - is based on providing universal coverage and replacing other health care programs. But it contains several important and different strategies, for example:

a) Insurance companies, HMOs, and providers will compete on the basis of excellence of the care provided - as judged be those receiving the care in their own healthcare market area.

b) The "Oregon Benefit Plan" assures better cost-benefits.

I will promptly respond to your additional requests for details about my proposal. I respect your ability and responsibility to inquire about features of my proposal which could not be included in a one page overview and I look forward to receiving your requests.

Sincerely,

Louis B. Blair HandsNet HN7442

Mr Louis Blair
P6/b(6)

THE HEALTH CARE CRISIS - A PLAN FOR REFORM 4/22/96

THE PROBLEMS: During 1996, of the 260 million people in the U. S. almost half will be uninsured, seriously underinsured or covered by Medicare or Medicaid. GAO reports state "20% of the dollars spent on patient care is wasted, that up to 10% is spent on avoidable administrative costs" There are no incentives assuring quality or cost control!

THE PLAN: expand present managed care system to cover Medicare, Medicaid, Veterans, Workman's Compensation and the 40 million uninsured by strategies assuring quality care, cost control and patient, provider and insurer satisfaction.

THE RECOMMENDATIONS: a universal coverage plan providing for:

A) Federal Health Policy Board responsible for:
- 1) Issuing Health Care Insurance Cards (HCICs)
- 2) Setting health care benefits (Oregon Plan Benefits)
- 3) Designing form for annual reports of clinical and financial outcomes.
- 4) Recommending to Congress:
  - a) the amount of the flat percentage increase of personal and corporation income taxes needed to finance the health care benefits
  - b) indexing of these funds to the states in accordance with the states' population and economic levels
- 5) Recommending to Congress that states establish state health policy boards to receive and administer the capitated health care funds.

B) State Health Policy Boards responsible for:
- 1) Identifying their Health Care Market Areas (HCMAs)
- 2) Establishing eligibility standards for HMOs to bid for franchises to provide health benefits in their HCMAs requiring HMOs' applications for franchise to include:
  - (a) identification of contracting providers (physicians groups, hospitals, pharmacies, various health care agencies and other suppliers).
  - (b) provision for prompt completion and submission of the federally required outcome report. (The State Health Policy Board to monitor but not interfere with the HMO's provision of care.) The report is to be made public.
  - (c) HMO's bid for a franchise covers only its operating cost and profit. Thus, its bid and its operation of the franchise is focused on competition with other franchises by the provision of quality care.
- 3) Receiving applications and awarding franchises.
- 4) Receiving federal funds and distributing them to franchised HMOs after additional indexing needed because of different costs among their HCMAs.

C) Graduate Medical Education should be separately financed.

Extrapolations of CBO reports indicate this plan will save $292 billion its first six years, $175 billion annually thereafter. Specific plan details will be supplied on receipt of requests.

CONGRESSIONAL BUDGET OFFICE
U.S. Congress
Washington, DC 20515

Robert D. Reischauer
Director

December 16, 1993

Honorable Jim McDermott
U.S. House of Representatives
Washington, D.C. 20515

Dear Congressman:

At your request, the Congressional Budget Office has prepared a preliminary estimate of effects of the spending provisions of H.R. 1200, the American Health Security Act of 1993. If we can be of further assistance, please call me. The CBO staff contact is Paul Van de Water (226-2800).

Sincerely,

Robert D. Reischauer

cc: Honorable Dan Rostenkowski
Chairman
Committee on Ways and Means

Honorable Bill Archer
Ranking Minority Member
Committee on Ways and Means

Honorable John Dingell
Chairman
Committee on Energy and Commerce

Honorable Carlos J. Moorhead
Ranking Minority Member
Committee on Energy and Commerce

Honorable Ronald V. Dellums
Chairman
Committee on Armed Services

Honorable Floyd Spence
Ranking Minority Member
Committee on Armed Services

Honorable William Clay
Chairman
Committee on Post Office and Civil Service

Honorable John T. Myers
Ranking Minority Member
Committee on Post Office and Civil Service

Honorable G.V. Montgomery
Chairman
Committee on Veterans' Affairs

Honorable Bob Stump
Ranking Minority Member
Committee on Veterans' Affairs

Honorable Pete Stark
Chairman
Subcommittee on Health
Committee on Ways and Means

Honorable Bill Thomas
Ranking Minority Member
Subcommitte on Health
Committee on Ways and Means

December 16, 1993

H.R. 1200, AMERICAN HEALTH SECURITY ACT OF 1993

H.R. 1200 would create a single-payer program of national health insurance modeled after the Canadian system. The bill, coauthored by Congressmen Jim McDermott and John Conyers, was introduced in March 1993 and has 91 current cosponsors. This memorandum provides a preliminary estimate of the effects of H.R. 1200 on government outlays and national health expenditures. It does not include an estimate of revenues, because many of the revenue-raising provisions of H.R. 1200 were included in the Omnibus Budget Reconciliation Act of 1993. The estimate assumes that the bill would be enacted in 1994 and that the program would begin in 1997. A recent CBO paper, *Estimates of Health Care Proposals from the 102nd Congress* (July 1993), summarizes CBO's methodology for estimating the effects of health reform proposals and emphasizes the uncertainty of such estimates.

SUMMARY OF THE BILL

H.R. 1200 would make all legal residents eligible for comprehensive health benefits with no out-of-pocket payments for acute care or preventive services. People would pick their own health care providers, and providers accepting payments from state programs would be prohibited from billing patients for covered services.

The national health insurance program (called the American Health Security Plan) would be financed largely by the federal government and would be administered by the states under the direction of a federal Health Security Standards Board. The board would develop most of the policies and regulations required to carry out the program. It would also establish a national health budget, which would grow no more rapidly than the economy plus the rate of growth of the population.[1] States that established a health security program would

[1]As noted below, H.R. 1200 defines the limit on the growth of health expenditures in two different ways. The alternative definition would limit the growth of health spending to the rate of increase of GDP.

receive federal grants that would average 86 percent of their per capita share of the budget but could vary from 81 percent to 91 percent depending on their income and other factors.

Benefits

The benefits provided by the program would include payment for hospital care, physician and other professional services, nursing home care, home health services, hospice care, prescription drugs, preventive health services, home and community-based long-term care services for people unable to perform two or more activities of daily living, durable medical items such as eyeglasses and hearing aids, dental care for children, and other services. The bill requires care-management procedures for drug abuse treatment, home and community-based services, and mental health benefits over specified limits.

The new program would replace most existing public and private health insurance programs. Medicare, Medicaid, Federal Employees Health Benefits, and benefits for military personnel under the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) would be terminated. Federal health programs for veterans and Native Americans would continue, however, as would the direct provision of health care by the Department of Defense to active members of the armed forces.

Administration and Cost Control

The national health insurance program would be administered by the states under the guidance of an American Health Security Standards Board, comprising the Secretary of Health and Human Services and six other members appointed by the President. The states could contract with private entities to process claims for payments, but each state could generally have no more than one processor.

The national board would set eligibility, enrollment, and benefit rules, determine provider participation standards and qualifications, review and approve state plans, and establish annual state and national budgets for health spending. The budgets would include separate amounts for health professional education, quality assessment activities, and administration.

Hospitals and nursing homes would receive payments based on state-approved annual operating budgets, not on the volume or type of services provided. States could choose to base payment for home health services, hospice care, and facility-based outpatient services on a budget, a fee schedule, or another prospective payment method. Physicians and other professionals would be reimbursed using a fee schedule similar to Medicare's resource-based relative value scale. Payments to health maintenance organizations would be based either on budgets or set amounts per enrollee. States would be responsible for adjusting payments or budgets when HMOs contract with hospitals operating under global budgets. Payments for other items and services, including prescription drugs, would also be made on the basis of fee schedules established by the health board.

ESTIMATED FEDERAL COSTS[2]

H.R. 1200 would, at the start, more than double federal government spending for health. Federal costs will comprise grants to the states for the universal health insurance plan, additional direct spending for primary care training and public health efforts, and additional authorizations of appropriations for the Public Health Service.

Part of the federal costs of H.R. 1200 would be offset by repealing Medicare, Medicaid, and other existing federal health programs. To avoid increasing the deficit, the remaining costs would have to be covered by additional taxes and payments by states or beneficiaries. Table 1 summarizes the effects of the bill on federal outlays.

Payments to the States

The bill provides that federal payments to the states would total 86 percent of spending for health services covered by the national health insurance program. The estimate assumes that this percentage would apply in the first year of the program. In later years, federal grants are assumed to increase by the combined

[2]The estimates in this section do not include the states' share of spending under the American Health Security Plan. CBO is currently reviewing the appropriate budgetary treatment of such spending.

TABLE 1. ESTIMATED FEDERAL OUTLAY EFFECTS OF H.R. 1200
(By fiscal year, in billions of dollars)

	1996	1997	1998	1999	2000	2001	2002	2003
Payments to the States	0	630	939	995	1,052	1,110	1,171	1,235
Health Care Training and Delivery	0	2	3	3	3	4	4	4
Repeal Medicare[a]	0	-147	-217	-239	-265	-292	-323	-358
Repeal Medicaid	0	-95	-141	-157	-174	-192	-212	-233
Repeal Federal Retiree Health Benefits	0	-4	-6	-7	-8	-9	-10	-11
Authorizations of Appropriations[b]	c	-15	-22	-24	-26	-28	-30	-32
Total	c	371	556	571	583	592	600	605

SOURCE: Congressional Budget Office.

NOTE: This table does not include the states' share of spending under the American Health Security Plan. CBO is currently reviewing the appropriate budgetary treatment of such spending.

a. Includes Medicare premiums and administrative costs.

b. Includes repeal of federal employee health benefits and benefits under the Civilian Health and Medical Program of the Uniformed Services. These changes in discretionary programs would not be counted for pay-as-you-go scoring under the Budget Enforcement Act.

c. Less than $500 million.

TABLE 1B. ESTIMATED BUDGETARY EFFECTS OF H.R. 1200 (AS INTENDED: LOW CAP)
(By fiscal year, in billions of dollars)

	1996	1997	1998	1999	2000	2001	2002	2003
Outlays								
Contributions to the States	0	625	925	973	1,020	1,068	1,118	1,171
Additional Direct Spending	0	2	3	3	3	3	4	4
Repeal Medicare[a]	0	-147	-217	-239	-265	-292	-323	-358
Repeal Medicaid	0	-95	-141	-157	-174	-192	-212	-233
Repeal Retiree Health Benefits	0	-4	-6	-7	-8	-9	-10	-11
Authorizations of Appropriations[b]	*	-15	-22	-24	-26	-28	-30	-32
Total, Outlays	*	365	542	549	551	550	547	541
Revenues								
Income and Payroll Taxes on Additional Income[c]	—							
Long-Term Care Premium	—							
Other:								
Total, Revenues	—							
Total Effect of H.R. 1200	—							

SOURCES: Congressional Budget Office; Joint Committee on Taxation.

a. Includes Medicare premiums and administrative costs.
b. Includes repeal of federal employee health benefits and benefits under the Civilian Health and Medical Program of the Uniformed Services. These changes would not be counted for pay-as-you-go scoring under the Budget Enforcement Act.

rates of growth of GDP and population, as the bill specifies. To the extent that the national health budget is not fully effective in limiting the growth of health spending (as discussed below), the federal share of the total would fall below 86 percent.

Health Care Training and Delivery

H.R. 1200 provides that a total of up to 0.32 percent of the federal revenues dedicated to the national health insurance program shall be devoted to specified public health activities. These activities include health professional education (up to 0.06 percent), public health grants (up to 0.14 percent), grants to community health centers (up to 0.10 percent), and health outcomes research (up to 0.02 percent). The estimate assumes that spending for these activities would equal 0.32 percent of the federal payments to states.

Repeal of Existing Federal Programs

The new program would replace Medicare, Medicaid, Federal Employees Health Benefits, and CHAMPUS benefits for military service members. Of these programs, Medicare benefits, Medicaid, and health benefits for federal retirees are considered mandatory, and the rest are discretionary. The savings from eliminating these programs would equal CBO's baseline projections of spending, extrapolated through 2003. The bill also authorizes appropriations for a new Office of Primary Care and Prevention Research in the National Institutes of Health; CBO estimates that this office would cost about $200 million a year. The net reductions in discretionary programs would not be counted for pay-as-you-go scoring under the Balanced Budget Act.

EFFECT ON NATIONAL HEALTH EXPENDITURES

CBO estimates that enactment of H.R. 1200 would raise national health expenditures at first but would reduce spending about 6 percent in 2003. The administrative savings from switching to a single-payer system would offset some of the cost of the additional services demanded by consumers. Over the longer run, the cap on the growth of the national health budget--assumed to be 75 percent

effective, as explained below--would hold the rate of growth of spending on covered services below the baseline.

In addition to reducing national health expenditures in the long run, H.R. 1200 would shift a large amount of health spending from the private to the public sector. The new program would assume virtually all spending now covered by private health insurance. The only health spending remaining in the private sector would be coinsurance for covered services and out-of-pocket spending for services not covered by the federal program, such as over-the-counter drugs, some dental care and eyeglasses, and cosmetic surgery.

CBO estimated the total cost of the national health insurance program in the following three steps:

- Estimate the amount of covered health services in 1996, the year before the new program would take effect.
- Add the estimated amount of additional health services that would be demanded under the new program in the absence of a limit on total health spending, and subtract the estimated administrative savings.
- Estimate total spending for 1997 through 2003 based on the expenditure limit set in the bill and its likely effectiveness.

Covered Services

The program would cover virtually all spending for hospital care, physician and other professional services, nursing home care, and home health services. For these items, the estimate excludes only other private funding (largely philanthropic contributions), 20 percent of current out-of-pocket spending (representing an estimate of services that the new program would not cover), and spending by the Veterans Administration and Indian Health Service. All spending on prescription drugs is assumed to be covered.

States would have to cover dental care for children under age 18, except for orthodontic care. CBO estimates that this represents approximately 25 percent of baseline dental spending from all sources of payment in 1996. The bill authorizes

the board to place limits on the cost and frequency of benefits for eyeglasses and durable medical equipment. The estimate assumes that all baseline third-party payments and half of baseline out-of-pocket expenditures for durable medical equipment would be covered.

Additional Demand for Services

Under H.R. 1200, spending on health care would no longer be limited by a person's income, wealth, or insurance coverage. Providing health insurance to people who currently lack insurance and eliminating most copayments for those who have insurance would increase the demand for health services. Expanding the coverage of health care to include home and community-based services for the disabled would also greatly increase their use. The bill prohibits cost-sharing only for acute care services. CBO assumes that states would impose copayments or coinsurance for drugs, nursing homes, durables, and home and community-based services. The copayments moderate the additional demand for these services.

The estimated additional demand for health services under the bill is based on the methodology detailed in the CBO memorandum, *Behavioral Assumptions for Estimating the Effects of Health Care Proposals* (November 1993). Under those assumptions, hospital utilization would grow by 12 percent if not constrained by the national health budget; the estimate assumes that this increase would occur gradually over the first three years of the plan. The unconstrained demand for physician and other professional services, dental care, and prescription drugs is assumed to increase by 30 percent, also building up over three years. CBO assumes that spending for vision care and durable medical equipment would increase by 22 percent over three years. The demand for home health care is assumed to grow by 50 percent and nursing home use by 38 percent; these latter increases are assumed to be experienced over five years because of their size and the need to expand the capacity of the industries. All of the figures in this paragraph represent weighted averages of the estimated increases in demand on the part of the currently uninsured, Medicare beneficiaries, Medicaid recipients, and people with private health insurance coverage. The estimates of unconstrained demand assume that spending would increase in proportion to the growth in the use of health care services.

In the absence of cost-control, CBO assumes that spending for drug abuse treatment would triple over baseline expenditures, adding $16 billion a year to the cost of these benefits by the third year of the plan. The benefit for home and community-based services and the unlimited mental health benefit would add almost $50 billion a year to uncapped health spending after three years.

Administrative Savings. Replacing a variety of private insurers, government programs, and individual out-of-pocket payments with a single payer in each state would reduce the costs of administering the health care system. The national health expenditure accounts, developed by the Health Care Financing Administration, record administrative expenses in several places. The category labeled "administration" includes only the direct costs of administering government programs as well as profits, overhead costs, and additions to the reserves of private health insurers. The costs of billing for services, filing claims forms, complying with utilization review, and other administrative requirements are included in hospital and physician expenditures and other specific categories of personal health spending.

The estimate assumes that the national health insurance program would operate with direct administrative costs equal to 5.5 percent of spending for covered services in 1997, 4.5 percent in 1998, 4 percent in 1999, and 3.5 percent thereafter. In comparison, administrative costs of all insurers (public and private) are currently about 7 percent of spending for covered services, Medicare's administrative cost rate is about 2 percent, and the administrative cost of Canada's single-payer system is less than 2 percent of spending. Although the administrative costs of the national health insurance program might eventually fall closer to the Canadian level, the estimate assumes that this level would not be reached within the first seven years.

The estimate also assumes that hospitals, physicians, home health agencies, and other health care professionals could save 6 percent of revenues by dealing with only one payer and eliminating copayments and other billing. These savings would be phased in over two years. No administrative savings are assumed for nursing homes, prescription drugs, dental and vision care, and other categories of personal health expenditures.

Collection of Coinsurance. The estimate assumes that, as allowed in the bill, states would impose charges for nursing home care, home and community-based services, prescription drugs, and durable medical items. CBO assumes that the states would follow Medicaid's approach for coinsurance in nursing homes and would recover a portion of patients' Social Security and pension income. The ratio of coinsurance payments to total nursing home spending under H.R. 1200 is assumed to equal the projected baseline ratio of out-of-pocket spending to total nursing home spending, or about $40 billion in the early years of the plan. The estimate also assumes that states would charge recipients of home and community-based services a copayment amounting to $2.50 a visit and would collect coinsurance equivalent to 20 percent of spending for prescription drugs and durable medical equipment.

The assumption that states would collect coinsurance for these services has three effects on the cost estimate. First, coinsurance reduces the demand for services and total spending. Second, the coinsurance payments reduce state spending and increase private spending. Finally, states incur higher costs to administer the coinsurance.

Efficacy of Expenditure Limit

H.R. 1200 would limit the rate of growth of spending for the national health insurance program to the rate of increase of GDP for the previous year plus population growth. The present estimate assumes that this limit, after allowing for the increase in demand for health care services and the reduction in administrative costs, would be 75 percent effective. The estimated savings from the limit equals the difference between the unconstrained demand created by the bill and the bill's expenditure limit, multiplied by its effectiveness rating of 75 percent.

H.R. 1200 contains many of the elements that, CBO has concluded, would make its expenditure limit reasonably likely to succeed. The bill establishes a single payment mechanism and a uniform system of reporting by all providers of health care. It sets up global prospective budgets for hospitals and nursing homes. And, by prohibiting participating providers from billing for covered services, it makes it unlikely that people would purchase health care outside the regulated system.

These are the billions which HR 1200 will cost (more-or less) - than if no reform occurs — a total of $292 billion saving over the seven years.

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TABLE 2. PROJECTIONS OF NATIONAL HEALTH EXPENDITURES, BY SOURCE OF FUNDS (By calendar year, in billions of dollars)

Source of Funds	1996	1997	1998	1999	2000	2001	2002	2003
Baseline								
Private	614	661	712	766	824	886	952	1,022
Public								
Federal	379	418	460	505	555	610	670	735
State and local	169	184	200	216	234	253	273	295
Total	1,163	1,263	1,372	1,488	1,613	1,748	1,894	2,052
Changes from Baseline								
Base Estimate: H.R. 1200 (Higher Expenditure Cap, 75 Percent Effective)								
Private	0	-441	-477	-574	-559	-606	-655	-709
Public								
Federal	a	530	545	558	566	572	576	578
State and local	0	-29	-11	-9	-7	1	9	17
Total	a	59	57	32	0	-33	-71	-114
Alternative Estimate: H.R. 1200 (Lower Expenditure Cap, 75 Percent Effective)								
Private	0	-442	-478	-518	-561	-607	-658	-712
Public								
Federal	a	522	529	533	531	527	520	510
State and local	0	-28	-8	-5	-1	-8	-17	-27
Total	a	53	43	11	-30	-73	-121	-175

SOURCE: Congressional Budget Office.

a. Less than $500 million.

Under H.R. 1200 the states, not the federal government, are at risk if the expenditure caps are not completely effective. If a state exceeds its budget in a given year, it must fund from its own revenues any health spending above the limit. If a state provides all covered health services for less than the budgeted amount, it may retain the full federal payment. Because states generally cannot run deficits to finance current services, and because resistance to tax increases is strong, states would have a strong incentive to stay within their share of the national health budget. No penalties would apply, however, if a state failed to live within the budget, and some states may therefore opt to spend more on health care services than the budget provides. As a result, the expenditure limit is unlikely to be fully effective in controlling the growth of national health expenditures.

H.R. 1200 defines the limit on national health expenditures in two different ways. Section 601(a)(1) states that the national health budget "shall not exceed the budget for the preceding year increased by the percentage increase in gross domestic product." Section 602(a)(2), however, would allow per capita spending to rise by the rate of increase in GDP; under this specification, the health budget would increase by the rate of growth of population plus GDP.

Because of this ambiguity, Table 2 shows two different estimates of the effect of H.R. 1200 on national health expenditures. The base estimate assumes the less stringent expenditure cap (rate of growth of GDP plus population) and 75 percent effectiveness at achieving the cap. The alternative estimate assumes the tighter cap (rate of growth of GDP alone) and 75 percent effectiveness.

In the base estimate, the additional demand for health services raises national health expenditures in the early years, but the expenditure limit eventually causes spending to fall below the baseline level. National health expenditures fall more rapidly in the alternative, which features a more stringent cap. In both cases, federal grants to the states would grow at the budgeted rate, and any spending above the budgeted amounts would be funded by the states. In 2003, health spending by state and local governments would be 5 percent above baseline levels in the base case and 10 percent higher in the alternative.

Alternative Scenarios

The assumption about how effectively the states restrain the growth of health spending has a significant effect on the estimate of national health expenditures. Because the United States has no experience with a program like the one envisioned in H.R. 1200, the assumption about the effectiveness of the spending limit in the bill is highly uncertain. Table 3 illustrates the sensitivity of the estimate to this assumption. The table provides five alternative estimates, in which the effectiveness of the spending limit ranges from zero to 100 percent.

If the spending limit were fully effective, national health expenditures in 2003 would be some $250 billion below the baseline. If the spending limit were 50 percent effective or less, however, national health expenditures would exceed the baseline in each year. Under these latter scenarios, state government spending on health would be substantially above the baseline, and the federal government would probably be pressed to increase its share of payments under the national health insurance program.

COMPARISON WITH PREVIOUS ESTIMATE

CBO has previously analyzed another single-payer health insurance plan, the Universal Health Care Act of 1991, sponsored by former Congressman Martin Russo. (See *Estimates of Health Care Proposals from the 102nd Congress* [July 1993]). Compared to the Russo bill, H.R. 1200 contains additional benefits for many health services and would be administered primarily by the states instead of the federal government. H.R. 1200 prohibits cost-sharing only for acute care and preventive services, whereas the Russo bill prohibited all cost sharing. The additional demand for prescription drugs and nursing home services is estimated to be somewhat less than for the Russo bill because of this cost-sharing by patients, but administrative expenses would be somewhat greater.

OTHER CONSIDERATIONS

This memorandum deals only with the costs of this bill. Any major reform of the health care system, however, would have many other significant effects. Providing universal health insurance coverage would increase the demand for

TABLE 3. PROJECTIONS OF NATIONAL HEALTH EXPENDITURES UNDER ALTERNATIVE ASSUMPTIONS ABOUT THE EFFECTIVENESS OF THE SPENDING LIMIT IN H.R. 1200 (By calendar year, in billions of dollars)

	1996	1997	1998	1999	2000	2001	2002	2003
Baseline								
National Health Expenditures	1,163	1,263	1,372	1,488	1,613	1,748	1,894	2,052
Changes from Baseline								
H.R. 1200 100 Percent Effectiveness	a	36	0	-40	-90	-139	-195	-257
H.R. 1200 75 Percent Effectiveness	a	59	57	32	0	-33	-71	-114
H.R. 1200 50 Percent Effectiveness	a	83	115	108	96	81	63	42
H.R. 1200 25 Percent Effectiveness	a	107	175	186	198	203	208	212
H.R. 1200 0 Percent Effectiveness	a	130	237	269	305	333	364	397

SOURCE: Congressional Budget Office.

a. Less than $500 million.

health care services. At the same time, the imposition of a limit on health expenditures would reduce the resources available. These changes could affect the incomes of providers, access to certain types of care, accessibility of some providers, the pace of technological change, and other important aspects of the health care system.

TABLE 1B. ESTIMATED BUDGETARY EFFECTS OF H.R. 1200 (AS INTENDED: LOW CAP)
(By fiscal year, in billions of dollars)

	1996	1997	1998	1999	2000	2001	2002	2003
Outlays								
Contributions to the States	0	625	925	973	1,020	1,068	1,118	1,171
Additional Direct Spending	0	2	3	3	3	3	4	4
Repeal Medicare[a]	0	-147	-217	-239	-265	-292	-323	-358
Repeal Medicaid	0	-95	-141	-157	-174	-192	-212	-233
Repeal Retiree Health Benefits	0	-4	-6	-7	-8	-9	-10	-11
Authorizations of Appropriations[b]	*	-15	-22	-24	-26	-28	-30	-32
Total, Outlays	*	365	542	549	551	550	547	541
Revenues								
Income and Payroll Taxes on Additional Income[c]	—							
Long-Term Care Premium	—							
Other:								
Total, Revenues	—							
Total Effect of H.R. 1200	—							

SOURCES: Congressional Budget Office; Joint Committee on Taxation.

a. Includes Medicare premiums and administrative costs.
b. Includes repeal of federal employee health benefits and benefits under the Civilian Health and Medical Program of the Uniformed Services. These changes would not be counted for pay-as-you-go scoring under the Budget Enforcement Act.

Source of Funds (billions)	Base-line 1996	If there is no reform 2003	Change from baseline with HR1200 by 2003		Projected costs with HR 1200 in 2003		Difference in 2003
			With higher expenditure cap	With lower expenditure cap	With higher expenditure cap	With lower expenditure cap	
Private	614	1,022	-709	-712	213	310	-712
Public - Federal	379	735	578	510	1,313	1,245	+510
Public - State & Local	169	295	17	27	312	322	+27
Total Public	548	1,030	595	537	1,625	1,567	+537
TOTALS	1,163	2,052	-114	-175	1,838	1,877	-175

The above dat weve extrapolated from the December 16, 1993 letter from CBO Director Robert Reischauer to Congressman Jim McDermott.

Mr. Louis Blair
1300 13th St NW
Cedar Rapids IA 52405-2441

Friday, September 20, 1996

Ms. Jill Pizzuto, Administrative Assistant
Office of Domestic Policy
West Wing, Second Floor
The White House
Washington, D. C. 20502

Dear Ms. Pizzuto,

Thank you for your telephone call this afternoon.

Enclosed herewith is a copy of the material which we had discussed.

Please be certain of my eagerness to respond to requests for details of the proposals in my one page plan for reform of health care delivery.

Sincerely,

Louis B. Blair

P6/b(6)

Sandy -
You may already have All of This? In any case, I'm just forwarding to you since you ~~have~~ are the lucky one !
Jill

THE WHITE HOUSE

WASHINGTON

July 23, 1996

Mr. Louis B. Blair

P6/b(6)

Dear Mr. Blair:

Thank you for your letter. I appreciate your sharing your expertise regarding health care reform with the Administration.

In order to give your proposal the appropriate attention, I have forwarded your letter and the materials you enclosed to Carol Rasco, Assistant to the President for Domestic Policy, for review. You can be sure that she will give your proposal careful consideration.

Again, thank you for writing.

Sincerely,

Leon E. Panetta
Chief of Staff

cc: The Honorable Carol Rasco

LEP/tab

May 23, 1996

Mr. Leon E. Panetta
Chief of Staff
The White House
Washington, D. C.

Dear Mr. Panetta,

I appreciate very much your response (copy enclosed) to my plea (copy enclosed) for consideration of health care reform.

A year has passed and Congress has not legislated any substantive health care reform. I do not know what the Executive branch has done - or is doing, but I do know that health care delivery is very complex and that reform will take at least five years from conception to delivery. It may take a year to develop a plan to the point at which it can be reliably scored, two years to be debated in Congress and two more years for the federal, state and local infrastructure to be prepared.

Please look again at the attached one page overview of my proposal for reform (and the bottom line offer to supply the details). Despite every thing else you do, the importance and urgency of health care reform demands that planning start **now.**

Please arrange for some one in your office or in the OBM to evaluate me and my plan. I'll come to Washington at my own expense. I'm not looking for a job, I just want to use some of my sixty years of experience in the health field to get sound planning of health care off the proverbial dime.

Sincerely,

Louis B. Blair

P6/b(6)

THE WHITE HOUSE

WASHINGTON

May 17, 1995

Mr. Louis B. Blair

[redacted] P6/b(6)

Dear Mr. Blair:

Thank you for your letter and enclosed proposal regarding health care reform. While my very busy schedule precludes me from calling you to discuss your ideas, I certainly appreciate hearing your thoughts on this crucial issue.

This Administration remains determined to fulfill the fundamental principle of reform -- guaranteed private health care coverage for all Americans.

As we continue to make progress, it is important to have your input. It is clear that you have given this much thought, and you can be certain that your ideas will receive appropriate consideration.

Thank you again for taking the time to write. I will keep your views in mind.

Sincerely,

Leon E. Panetta
Chief of Staff

LEP/tab

THE HEALTH CARE CRISIS - A PLAN FOR REFORM 4/22/96

THE PROBLEMS: During 1996, of the 260 million people in the U. S. almost half will be uninsured, seriously underinsured or covered by Medicare or Medicaid. GAO reports state "20% of the dollars spent on patient care is wasted, that up to 10% is spent on avoidable administrative costs" There are no incentives assuring quality or cost control!

THE PLAN: expand present managed care system to cover Medicare, Medicaid, Veterans, Workman's Compensation and the 40 million uninsured by strategies assuring quality care, cost control and patient, provider and insurer satisfaction.

THE RECOMMENDATIONS: a universal coverage plan providing for:

A) Federal Health Policy Board responsible for:
1) Issuing Health Care Insurance Cards (HCICs)
2) Setting health care benefits (Oregon Plan Benefits)
3) Designing form for annual reports of clinical and financial outcomes.
4) Recommending to Congress:
   a) the amount of the flat percentage increase of personal and corporation income taxes needed to finance the health care benefits
   b) indexing of these funds to the states in accordance with the states' population and economic levels
5) Recommending to Congress that states establish state health policy boards to receive and administer the capitated health care funds.

B) State Health Policy Boards responsible for:
1) Identifying their Health Care Market Areas (HCMAs)
2) Establishing eligibility standards for HMOs to bid for franchises to provide health benefits in their HCMAs requiring HMOs' applications for franchise to include:
   (a) identification of contracting providers (physicians groups, hospitals, pharmacies, various health care agencies and other suppliers).
   (b) provision for prompt completion and submission of the federally required outcome report. (The State Health Policy Board to monitor but not interfere with the HMO's provision of care.) The report is to be made public.
   (c) HMO's bid for a franchise covers only its operating cost and profit. Thus, its bid and its operation of the franchise is focused on competition with other franchises by the provision of quality care.
3) Receiving applications and awarding franchises.
4) Receiving federal funds and distributing them to franchised HMOs after additional indexing needed because of different costs among their HCMAs.

C) Graduate Medical Education should be separately financed.

Extrapolations of CBO reports indicate this plan will save $292 billion its first six years, $175 billion annually thereafter. Specific plan details will be supplied on receipt of requests.

LOUIS B. BLAIR

CONGRESSIONAL BUDGET OFFICE
U.S. Congress
Washington, DC 20515

Robert D. Reischauer
Director

December 28, 1994

Honorable Charles E. Grassley
United States Senate
Washington, D.C. 20510

Dear Senator:

Thank you for your recent letter to the Congressional Budget Office concerning the health system reform proposal prepared by your constituent, Mr. Lou Blair.

As you know, the Congressional Budget Office has a significant role to play as part of the legislative process in analyzing and providing cost estimates of program and policy options under consideration by the Congress. Regarding the health system reform alone, CBO provided the Congress with dozens of estimates of policy changes, comprising thousands of computations over the last year. Such intense efforts, combined with the ongoing flow of CBO's regular work, absorb our available resources. As a result, we are not able to do analyses of initiatives not under active consideration by Congressional committees, or of initiatives which committees are not planning to take up in the near future.

The Congressional Budget Office has done a substantial amount of research and analysis in the area of health system reform and we would be most pleased to share any and all of this work with your constituent. He can contact our publications office directly at (202) 226-2809. If your staff has any additional questions, please have them contact our Office of Intergovernmental Relations at (202) 226-2600. Please call me directly at (202) 226-2700 if you wish to discuss this further.

Sincerely,

Robert D. Reischauer

CONGRESSIONAL BUDGET OFFICE
U.S. Congress
Washington, DC 20515

Robert D. Reischauer
Director

February 3, 1995

The Honorable Charles E. Grassley
United States Senate
Washington, D.C. 20510

Dear Senator:

This letter is in response to your request for CBO to score a proposal submitted by your constituent, Mr. Lou Blair. We regret that we are unable to develop a cost estimate of his proposal since CBO's analysts can only develop cost estimates if they have received detailed legislative language. We appreciate Mr. Blair's interest, however, and offer some comments on his proposal.

We agree with Mr. Blair's assessment that the estimated costs of H.R. 1200 would have been lower if cost-sharing requirements for acute care services had been higher. Although a less generous benefit package would also have resulted in lower costs, eliminating all benefits except those in the Oregon "essential" and "very important" categories would probably not have been feasible without other significant changes to H.R. 1200. That proposal would, for example, have repealed the Medicare and Medicaid programs. But Medicaid is currently the primary payer for long term care services, which would not be covered under Mr. Blair's proposal. An alternative source of funding for long term care would, therefore, be needed.

Mr. Blair's proposal for the establishment of comprehensive health services organizations is interesting, but we are not sure how these would function or interact with the states. Certainly, the proposed responsibilities for states could be quite complex and require extensive information systems that do not currently exist.

Please let me know if we can be of further assistance to you in this matter.

Sincerely,

Robert D. Reischauer

BIOGRAPHIC; LOUIS BLISS BLAIR

PERSONAL: P6/b(6)

Wife: Ernestine M. Smith Blair
Children: three daughters and a son

EDUCATION: Elementary and High School, Cincinnati, OH
Maryville College, Maryville, TN, BA 1932
University of Cincinnati,
Graduate School, part time, 1933-35

EMPLOYMENT: Cincinnati General Hospital, Admin. Ass't 1935-40

Lawrence Co General Hospital, Ironton, OH
Bus. Mgr., then Sup't, 1940-42

Ohio State University Hospital, Columbus, OH
Superintendent 1942-48

St. Luke's Methodist Hospital, Cedar Rapids IA
Superintendent 1948-1975

United Methodist Church, Board of Health and Welfare Ministries, New York, N. Y.
Special Consultant (among 75 U. M. C. related hospitals in the U. S. and India).

Meth-Wick Retirement Community
Interim Administrator 1986

MISCELLANEOUS PROFESSIONAL ACTIVITIES:

Preceptor for Master's Degree in Hospital Administration for the State University of Iowa, University of Michigan and Washington University

Author of articles in professional and news media

AFFILIATIONS AND RESPONSIBILITIES:

American College of Hospital Administrators, retired member

American Hospital Association, Life Member;
Council on Professional Practice, 1957-60;
Council on Government Relations, 1960-63;
Governing Board Type VIII Membership (Hospital Schools of Nursing) 1971-73, Chm., 1973

American Protestant Hospital Association,
Board of Directors 1964-71
Executive Committee 1965-71;
Council on Gov't Relations 1964-66, Chm. 1965;
Council on Education 1966-69, Chm. 1968-70;
Committee on Hospital Schools of Nursing 1969-71

National League For Nursing

National Association of Methodist Hospitals and Homes,
President 1966-67

Central Ohio Blue Cross, Board of Directors 1945-48

Upper Mid-west Hospital Conference, President 1953-54

Iowa-South Dakota Blue Cross-Hospital Advisory Board,
1960-75, Chairman 1964

Iowa Hospital Association, Life Member
President 1951-52 and 1954-55

Iowa Interprofessional Society,
President 1957

Iowa Hospital and Related Facilities Advisory Council 1952-67

Iowa Hospital Licensing Board 1961-67

Iowa League For Nursing

Public Health Nursing Board 1965-73

Linn County Mental Health Association Board 1971-74

Linn County Mental Health Clinic Board 1969-77

Linn County Medical Society, Honorary Member 1974-

Cedar Rapids United Way Board , Executive Committee 1976

Cedar Rapids Rotary Club 1948- President 1972-73

St. Paul's United Methodist Church 1948-

MEMORANDUM OF CALL

Previous editions usable

TO: JMP

☒ YOU WERE CALLED BY– ☐ YOU WERE VISITED BY–

Lou Blair , Cedar Rapids, IA

OF (Organization)

☐ PLEASE PHONE ☐ FTS ☐ AUTOVON

(P6/b(6)

☐ WILL CALL AGAIN ☐ IS WAITING TO SEE YOU

☐ RETURNED YOUR CALL ☐ WISHES AN APPOINTMENT

MESSAGE

please call back

RECEIVED BY	DATE	TIME

50383-111 NSN 7540-00-634-4018 OPTIONAL FORM 363 (Rev. 1-94)
*U.S. G.P.O.:1994-300-891/00003 Prescribed by GSA

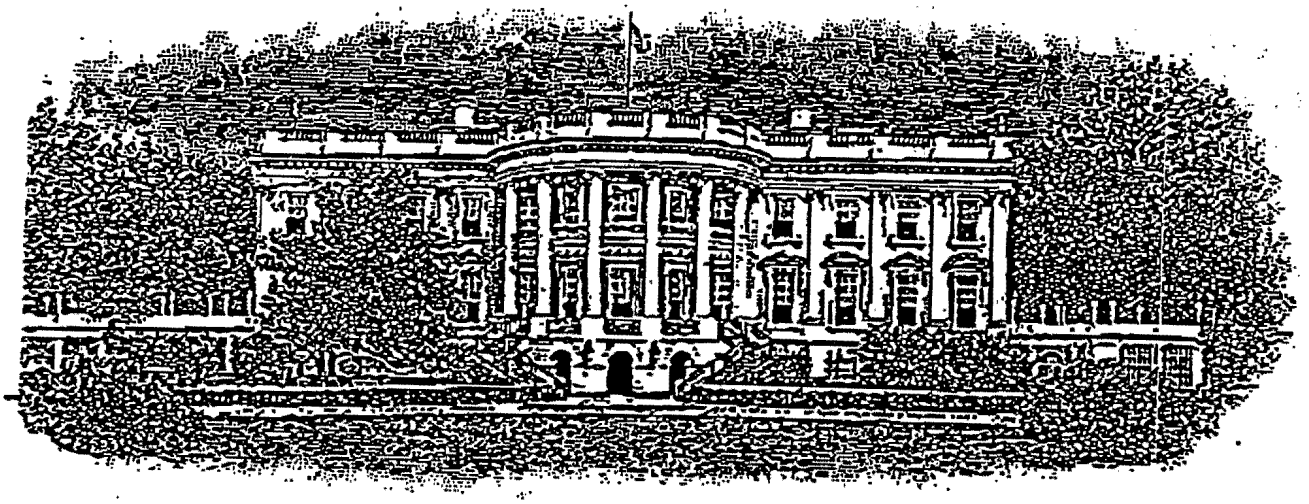
faxed 1
Received
info from
Blair 9/25
- gave to Eliz
9/24

OEfice of Domestic Policy Correspondence Log

Received Date: AUG 14 1996

Received From	Subject	Forwarded Name	Forwarded Action	Date Sent	Due Date	Recd Date
Dr. Larry Berman — Am. Assoc. of Suicidology	invite to Conference on Youth Suicide by Firearms					
WH Office of News Analysts	WH News Report					
Harold Ickes	Memo: FYI, Erskine Bowles will head up POTUS debate					
Leon Panetta	CC: CLO's got letter from L. Blair re: health care reform; forwarded to DPC for consideration					
Alicia Munnell	Econ Report Prelim 2nd Quarter Release					

The White House



DOMESTIC POLICY

FACSIMILE TRANSMISSION COVER SHEET

TO: J. Pizzuto

FAX NUMBER: 6-7828

TELEPHONE NUMBER: 6-2249

FROM: B

TELEPHONE NUMBER: 6-2216

PAGES (INCLUDING COVER): 2

COMMENTS: Per your request!

E X E C U T I V E O F F I C E O F T H E P R E S I D E N T

20-Sep-1996 12:24pm

TO: Elizabeth E. Drye

FROM: Jill Pizzuto
Domestic Policy Council

SUBJECT: tracking down letter

Eliz:

... I haven't addressed this to CHR yet, asking you first.

Mr. Louis Blair, the nicest 86year old man, called Wed re: a letter that he originally sent to Panetta and Panetta replied that CHR or someone from DPC would be happy to help him out and cc'd us the reply. According to Log sheet, we did receive on 8/14. I had Bernice fax me the log sheet, but there is no direction on what happened to letter.

I could ask staff and/or Carol if she may recall. Letter had to do w/ Healthcare Reform suggestions -- I didn't see anything in Jennings folder.

I could also call back Mr. Blair who said that he'd be happy to send the letter directly to us. He is looking to set up a meeting w/ someone.

suggestions?

Budget Copies
311 3rd Avenue S.E.
Cedar Rapids, Iowa 52401
(319) 362 - 4400
FAX: (319) 362 - 0816

FAX TRANSMISSION SHEET

Date: Wednesday, September 25, 1996

To: Jill Pizzuto, Administrative Assistant

City or Location: The White House, Office of Domestic Policy, West Wing, Second Floor

Fax Number: 202-456-2878

From: Louis B. BLAIR

Sender's Home or Work Phone #: P6/b(6)

Number of pages including this page 8

Comments:

Distribute to: Jill Pizzuto

If you do not receive all of the pages indicated, please call (319) 362 - 4400 as soon as possible. Thank you.

FILE COPY

b/ PRIORITY MAIL

Friday, September 20, 1996

9-26

Eltz.

All we need is someone to call this week & talk about his letter / ideas. He has extensive experience in Healthyield

- He's 86 yrs. old. - !

- NOTE Panetta letter too!

Blair has been wanting to talk to someone since July.

Ms. Jill Pizzuto, Administrative Assistant
Office of Domestic Policy
West Wing, Second Floor
The White House
Washington, D. C. 20502

Dear Ms. Pizzuto,

Thank you for your telephone call this afternoon.

Enclosed herewith is a copy of the material which we had discussed.

Please be certain of my eagerness to respond to requests for details of the proposals in my one page plan for reform of health care delivery.

Sincerely,

Louis B. Blair

P6/b(6)

I spoke with Mr. Blair on 10/3/96. He will follow-up by sending cost estimates for his plan (although I did not solicit this information)
Sandy

THE WHITE HOUSE
WASHINGTON

July 23, 1996

Mr. Louis B. Blair
P6/b(6)

Dear Mr. Blair:

Thank you for your letter. I appreciate your sharing your expertise regarding health care reform with the Administration.

In order to give your proposal the appropriate attention, I have forwarded your letter and the materials you enclosed to Carol Rasco, Assistant to the President for Domestic Policy, for review. You can be sure that she will give your proposal careful consideration.

Again, thank you for writing.

Sincerely,

Leon E. Panetta
Chief of Staff

cc: The Honorable Carol Rasco

LEP/tab

May 23, 1996

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Chief of Staff
The White House
Washington, D. C.

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Sincerely,

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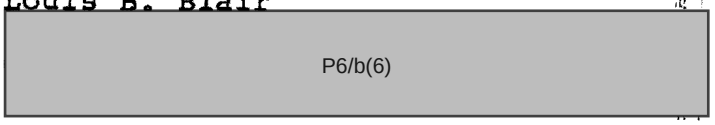

file copy
by priority mail 3/6

March 5,1995

Mr. Leon Panetta,
Chief of White House Staff
The White House
1600 Pennsylvania Avenue
Washington, D. C.

Dear Mr. Panetta,

This morning I was delighted by your David Brinkley Show comment that the federal budget cannot be balanced without health care reform.

HR 1200 is the only proposal which will provide universal coverage (the President's first priority) and which will make it possible to eliminate the deficit.

The amendments to HR 1200 which I propose should make the plan more"politically correct" to everyone but the sponsors of the "Harry and Louise" scenarios.

My health care reform proposal will solve our nation's two most critical problems.

Please note the enclosed 12/28/94 and 2/3/95 letters from CBO Director Reischauer to Senator Grassley and my C. V.

Please risk a few minutes to read the synopsis of my plan - and to call me so I can respond to your questions

Sincerely,

Louis B. Blair

P6/b(6)

CONGRESSIONAL BUDGET OFFICE
U.S. Congress
Washington, DC 20515

Robert D. Reischauer
Director

December 28, 1994

Honorable Charles E. Grassley
United States Senate
Washington, D.C. 20510

Dear Senator:

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U.S. Congress
Washington, DC 20515

Robert D. Reischauer
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February 3, 1995

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Robert D. Reischauer

Mr Louis Blair
P6/b(6)

THE HEALTH CARE CRISIS - A PLAN FOR REFORM 4/22/96

THE PROBLEMS: During 1996, of the 260 million people in the U. S. almost half will be uninsured, seriously underinsured or covered by Medicare or Medicaid. GAO reports state "20% of the dollars spent on patient care is wasted, that up to 10% is spent on avoidable administrative costs" There are no incentives assuring quality or cost control!

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      b) indexing of these funds to the states in accordance with the states' population and economic levels
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