The original documents are located in Box 16, folder "Health (1)" of the James M. Cannon Files at the Gerald R. Ford Presidential Library.

Some items in this folder were not digitized because it contains copyrighted materials. Please contact the Gerald R. Ford Presidential Library for access to these materials.

Questions of Life and Death

1975

By John Lachs

There is something abhorrent to many of us that the best surgeons, the best pro-

erything possible to nuture, protect and cure us.

This is good abstract thinking, but it is

I want to dissent. I want to say that the emphasis is wrong. Life by itself is not a value; it is only a necessary condition of

Health Costs—A One-Way Street

By I. D. ROBBINS

and the number of beds increased by or local leaders or fellow hospital adminis-

File

~~Call Naomi~~ to rev — 6/30/75

~~Dunbar~~ —

Copy to Veeneman?

Jim

THE WHITE HOUSE
WASHINGTON

File

DATE: June 25, 1975

TO: JIM CANNON

FROM: JIM CAVANAUGH

SUBJ: PLANNING FOR NATIONAL HEALTH INSURANCE

FYI X

Action ____

Copies have gone to

Dick Dunham and Art Quern.
and Neuman

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
WASHINGTON, D.C. 20503

JUN 20 1975

MEMORANDUM FOR JAMES CANNON

SUBJECT: Planning for National Health Insurance

The attached paper outlines major discussion topics we have identified as being of highest priority in development of an Administration national health insurance proposal. The list does not attempt to address the full range of significant policy issues that will need to be resolved, but it can serve as the basis for developing an agenda for the President's early guidance.

We would appreciate your reactions to these topics. At some point in the near future, we believe you will want to share these formally with HEW, Labor, Commerce, Defense, VA, HUD, and CEA for their reaction. HEW could then be directed to prepare options papers to focus debate on these key issues.

James T. Lynn
Director

Attachment

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
WASHINGTON, D.C. 20503

JUN 20 1975

MEMORANDUM FOR JAMES CANNON

SUBJECT: Planning for National Health Insurance

The attached paper outlines major discussion topics we have identified as being of highest priority in development of an Administration national health insurance proposal. The list does not attempt to address the full range of significant policy issues that will need to be resolved, but it can serve as the basis for developing an agenda for the President's early guidance.

We would appreciate your reactions to these topics. At some point in the near future, we believe you will want to share these formally with HEW, Labor, Commerce, Defense, VA, HUD, and CEA for their reaction. HEW could then be directed to prepare options papers to focus debate on these key issues.

(Signed) Jim

James T. Lynn
Director

Attachment

National Health Insurance (NHI)--Major Discussion Topics

I. Objectives

- Coverage: Should NHI provide universal health insurance coverage, assure universal availability of insurance at affordable rates, or cover specified and identifiable gaps in coverage?
- Benefits: Should NHI cover catastrophic expenses or provide more extensive protection?
- Financing/Administration: To what extent should government financing and administration of NHI be a Federal responsibility or a shared Federal-State function?
  Should NHI seek to control national health costs through stronger government regulation of the health industry, i.e., setting fees, hospital reimbursements, insurance premiums, etc.?

II. Major Data Requirements

- Need and Benefits: To what extent do individuals not receive needed medical services because of inadequate insurance coverage?

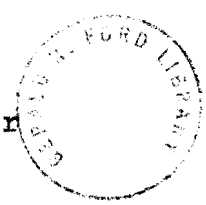
How many individuals incur health costs they are unable to pay or which impose serious hardship? How should hardship be measured? What impact would NHI have on such problems as low health status, financial security, and other measures of social welfare?

- Costs: What would be the cost impacts of national health insurance on employers, individuals, and Federal and State governments? How will these costs vary, e.g., by State? What specific estimating assumptions are used in these cost assessments and what is the degree of accuracy with which the cost impacts can be forecast?

III. Major Policy Issues

- Coverage: Should NHI coverage be voluntary or mandatory?

- Benefits: Should NHI plans cover a basic or a comprehensive range of health services? To what extent should NHI seek to restructure financial incentives for utilization of services?



Should there be a uniform health insurance plan or should individuals have a choice of benefits?

- Financing/Administration: To what extent should NHI require increased Federal or State regulation of the health industry?

  What are the appropriate Federal and State roles and responsibilities in NHI financing and administration?

  What share of premium costs should employers be required to pay?

  Should the special Federal tax code provisions for health expenditures be revised?

  What will be the impact of NHI on other existing major Federal health delivery programs, e.g., VA medical system, military medical care, categorical health grant, and direct health service delivery programs?

  What proposals, if any, should be made to relate national health insurance to these other programs?

IV. Structural Design Options

Assuming that there will be Federal or Federal-State financing programs for low income and aged persons and

private employer plans for most full-time employees, the following major structural design issues must still be addressed:

- Catastrophic Protection: Should catastrophic benefits be offered under private employer plans or be provided by a separate government program?
- High-Risk Persons and Firms: Which high-risk persons or firms unable to obtain private insurance at affordable rates, if any, should be through direct subsidized government insurance or through government-subsidized private insurance pools?
- Government Programs: How rapidly and at what income level should government subsidy of health insurance be phased out?

  Should low wage full-time workers be covered through employer plans or through the government program?

  How should eligibility, benefits, and cost-sharing under a government program be coordinated with welfare reform to assure equity, adequacy, and appropriate work incentives?

  Should some beneficiary cost-sharing be required at all income levels?

If NHI is State-administered, should States be permitted flexibility in determining eligibility and benefit standards for the Federal-State program?

THE WHITE HOUSE

WASHINGTON

July 17, 1975

MEMORANDUM FOR: JIM CANNON

THROUGH: DICK DUNHAM
JIM CAVANAUGH

FROM: ART QUERN
SARAH MASSENGALE

SUBJECT: Concern about the Maximum Allowable Cost Proposal

This memo is to apprise you of our concern about HEW's Maximum Allowable Cost (MAC) proposal and to request a meeting with you to discuss possible action before publication of any MAC regulations.

Issue

Briefly, the MAC program proposes to cut Medicaid costs by requiring substitution of generic drugs for brand name drugs and by reorganizing the system of reimbursement to pharmacists. Response to the proposal has been overwhelmingly critical.

Background

The publication of the proposed regulations elicited a very large response -- over 2600 comments to HEW, 95% of which were critical of MAC. The President, the Domestic Council, and Donald Rumsfeld are also receiving many letters against MAC. The basic criticisms and HEW responses are as follows:

1. Therapeutic Interchangeability of Drugs. Critics charge that FDA does not know enough to assure the therapeutic interchangeability of drugs (that is, that drug B will have the same medicinal effect as drug A). They point to the recent request of Dr. Crout, Director of the Bureau of Drugs, for Federal funds to investigate the therapeutic interchangeability of 150 drugs.

FDA admits that its knowledge is incomplete, but says that the regulations will apply initially to a limited number of tested drugs (10-15) and will finally include only 40-50 multi-source drugs. Also, the Department has proposed new regulations requiring evidence of bio-equivalence on some products to assure therapeutic effectiveness.

2. Drug Quality. Critics charge that FDA does not maintain good quality control over all manufacturers and therefore is not able to assure the quality of drugs manufactured by second or third-rate "drug mills". Opponents of MAC say that the Government is willing to let the poor have "second-rate medicine". It is charged that some drug makers have not been inspected since 1971. The large pharmaceutical companies say that part of the higher cost of brand name drugs is due to self-administered inspection programs necessary for quality control.

   FDA maintains that its quality control inspections are adequate, although Commissioner Schmidt has conceded that FDA is not adequately monitoring drug testing.

3. Costs and Benefits of MAC. It is charged that HEW has grossly miscalculated the economics of MAC. Evidence is cited of other unsuccessful programs which cost more and save less than estimated.

   FDA replies that "[in all the comments], the Department is not aware of any data showing that programs of this kind have resulted in a net loss to the reimbursing program". The Social Security Administration is preparing an economic impact statement which should examine this question.

4. Research. The question of research has not been as widely discussed as the above issues, but it is nonetheless important. The major drug manufacturers maintain that part of the higher price of their brand name drugs pays for in-house research which is a major source of drug advances. Dr. Jonas Salk, the developer of the polio vaccine, supports them and argues that the drug companies' "research capacity for the development of products for human use is necessary for the application of the results

of the fundamental research which is carried out in our universities and institutes...." Salk has telegraphed to Alan Greenspan his opposition to the proposed MAC regulations because of the effect they will have on "those companies that make so essential a contribution to our...research efforts".

5. Other criticims of MAC include charges of new government intrusions into private industry and of government meddling with a doctor's professional judgment and integrity, and concerns about fair reimbursement for pharmacists.

Status of the Issue

HEW will not issue the final MAC regulations until OMB has analyzed and cleared the SSA economic impact statement. OMB hopes to receive the statement this week.

Our approach has been to concentrate on the cost effectiveness of the program. The issues of quality and therapeutic interchangeability are ones best left to the experts. The economic arguments advanced by FDA and by critics are so widely at variance that no reasonable conclusions may be drawn. In this regard we will have to rely on OMB's analysis of the impact statement.

Possible Course of Action

A possible course of action would be to ask a third party to examine the issues of interchangeability, drug quality and research. Perhaps the National Science Foundation or the National Institutes of Health could review such matters as the state of the art in the sciences to determine interchangeability and the question of the impact on research.

As you know, the MAC program is an attempt to cut drug costs. The real effects of the program, however, are very important because the success or failure of MAC will have a bearing on the formulation and workings of the potential cost control elements of any National Health Insurance program.

Problems

Two possible problems arise with any White House action. We must be careful to avoid raising the issue of White House interference with the Secretary's rulemaking powers. And, we must avoid the appearance of "giving in" to the drug companies and "sacrificing the taxpayers interests" for the sake of industry profits.

Comments

We would like to discuss this with you at your earliest convenience to determine:

1. Whether we should continue to base our position solely on the judgment of the cost effectiveness of the program; or

2. Whether we should also engage some third party to review the issues of interchangeability, drug quality and research.

THE WHITE HOUSE

WASHINGTON

July 18, 1975

MEMORANDUM FOR: JACK MARSH
MAX FRIEDERSDORF
PHIL BUCHEN
BILL SEIDMAN
ALAN GREENSPAN

FROM: JIM CANNON

SUBJECT: HEW Proposed Amendments to Physician Bonus Regulation

Attached for your review and comment is a draft decision memorandum on HEW's proposed amendments to the Physician Bonus Regulation.

I would appreciate your comments and suggestions by 2:00 p.m., Monday, July 21.

Thank you.

Attachment

THE WHITE HOUSE

WASHINGTON

ACTION

July 18, 1975

MEMORANDUM FOR: THE PRESIDENT

FROM: JIM CANNON

SUBJECT: HEW AMENDMENTS TO PHYSICIAN BONUS REGULATION

This is to present for your decision amendments to the Physician Bonus Regulation from Secretary Weinberger. Memoranda from James Lynn and Casper Weinberger are attached at Tab A.

BACKGROUND

P.L. 93-274 authorized annual bonus payments of up to $13,500 in addition to any other pay or allowances for military and Public Health Service (PHS) physicians. You approved the implementing regulations last October, as required by the law.

ISSUE

HEW is now proposing three amendments to the regulations to correct three problem areas:

1. Bonus Repayments. Physicians who do not serve a full year are generally required by current regulations to repay the entire bonus. This amendment will allow officers leaving PHS for residency training in June, 1975, or retiring in September, 1975, to keep a pro-rata portion of the bonus.

2. Prohibition of Bonuses for Certain Physicians. Current regulations prohibit bonus payments to certain physicians with service commitments, usually those who had deferments to allow completion of residency training. The amendment would prohibit bonus payments to any of these physicians who resign from the PHS while still under an obligation and then reapply to PHS solely to be eligible for a bonus.

3. Bonuses for Physicians Who Received Federal Support for Residency Training. Current regulations permit the payment of a smaller bonus to physicians who received Federal salaries during residency training in return for service commitments. These physicians are normally commissioned in the PHS while in residency training. HEW proposes to enable this group of physicians to receive the full bonus while serving their period of obligation.

RECOMMENDATIONS

Weinberger - Approve 1, 2, and 3.

Lynn - Approve 1 and 2
- Disapprove 3 because it would:

-- be contrary to the purposes of Federal support of residency training, i.e., to obtain service commitments in return for salary support;

-- be inequitable to those physicians who freely accepted a Federal appointment in return for a full bonus, without having a prior service commitment. Under the HEW proposal, physicians would receive $13,500 regardless of whether or not they had prior service commitments;

-- result in the Federal Government paying both a salary and a full bonus for the same commitment period. DOD is not proposing a similar amendment.

DECISION

1. Amendment 1 - Bonus Repayments

_____Approve _____Disapprove

2. Amendment 2 - Prohibition of Bonus for Certain Physicians

_____Approve _____Disapprove

3. Amendment 3 - Bonuses for Physicians who received Federal Support for Residency Training

_____Approve _____Disapprove

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
WASHINGTON, D.C. 20503

DECISION

JUL 15 1975

MEMORANDUM FOR THE PRESIDENT

FROM: JAMES T. LYNN

SUBJECT: HEW Amendments to Physician Bonus Regulations

P.L. 93-274 authorized bonus payments of up to $13,500 annually for military and Public Health Service (PHS) physicians. P.L. 93-274 requires that you approve the implementing regulations. You did so last October, but HEW is proposing three amendments for your approval:

1. Bonus Repayments. Physicians who do not serve a full year are generally required by current regulations to repay the entire bonus. An exception was made for physicians leaving the PHS on June 30, 1975. Since the implementing regulations were not issued until October 1974 and departing PHS physicians normally begin residency programs on July 1, physicians leaving on June 30 were allowed to retain a pro rata amount of the bonus rather than repaying the entire amount. HEW is now proposing to change the June 30, 1975, date to any date from June 20, 1975, to the first anniversary of each physician's bonus contract. This change will provide time for physicians departing for residency training to travel to new locations before June 30. It will also allow those who plan to retire in September to retain a pro rata bonus, rather than repaying the entire amount.

2. Prohibition of Bonuses for Certain Physicians. Current regulations prohibit bonus payments to certain physicians with service commitments. Generally, these are physicians who received deferments to enable them to complete their residency training.

The proposed HEW regulations would prohibit bonus payments to any of these physicians who resign from the PHS while still under an obligation and then reapply to PHS solely to be eligible for a bonus.

3. Bonuses for Physicians Who Received Federal Support for Residency Training. Current regulations permit the payment of a limited bonus of $9,000, rather than the full $13,500, to physicians who received Federal salaries during residency training in return for service commitments. These physicians are normally commissioned in the PHS while in residency training.

HEW proposes to enable this group of physicians to receive the full bonus while serving their period of obligation. HEW believes that these physicians should receive the same bonus as other physicians who have completed residency training.

Recommendation. We recommend that you approve the first two amendments, but disapprove the third. We recommend against the third amendment because it would:

- be contrary to the purposes of Federal support of residency training, i.e., to obtain service commitments in return for salary support.
- be inequitable to those physicians who freely accepted a Federal appointment in return for a full bonus, without having a prior service commitment. Under the HEW proposal, physicians would receive $13,500 regardless of whether or not they had prior service commitments.
- result in the Federal Government paying both a salary and a full bonus for the same commitment period. DOD is not proposing a similar amendment.

Decision

☐ Approve the first two amendments, but disapprove the third amendment (OMB position).

☐ Approve all three amendments (HEW position).

☐ See me.

Attachment

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

RECEIVED
JUN 12 9 11 AM '75
OFFICE OF
MANAGEMENT & BUDGET

JUN 6 1975

Honorable James T. Lynn
Director, Office of Management and
Budget
Washington, D. C. 20503

Dear Mr. Lynn:

Reference is made to Public Law 93-274 which authorized the payment of Variable Incentive Pay for medical officers of the Public Health Service.

Since the implementation of the Variable Incentive Pay program in September 1974, some problem areas have been identified which require remedial changes to the Regulations.

Enclosed are three amendments to the Regulations which we propose to issue subject to the approval of the President.

Sincerely,

Secretary

3 Enclosures

ISSUE NO. 1

To authorize cancellation of certain Variable Incentive Pay service agreements after June 20, 1975.

DISCUSSION

The Regulations governing the payment of Variable Incentive Pay generally provide that if medical officers voluntarily leave the Service before completing one year of active duty under the requisite agreement to remain on active duty for one, two, three, or four years, they must refund the entire amount of the lump-sum payment they had received for that year.

Because of the four-month delay in the initial implementation of the Variable Incentive Pay statute, special one-time provisions were included in the Regulations allowing medical officers to cancel their initial agreement on June 30, 1975, and to repay the unearned portion of the lump-sum payment previously received. This was designed to do two things;

1. For those medical officers who will leave the Service on or about July 1, 1975, it permitted them to receive some Variable Incentive Pay for their last full year of active duty following enactment of the law; and

2. For those medical officers who entered the Service on or about July 1, 1974, it would permit them to receive some Variable Incentive Pay during their first year of service, and to sign a new agreement on July 1 to receive Variable Incentive Pay for each full year of service thereafter.

The General Counsel's office has advised that under the exacting terms of the Regulations, any medical officer who leaves the Service even one day before June 30, 1975, will be liable for repayment of the entire amount of their initial payment of Variable Incentive Pay. Moreover, any medical officer who leaves the Service after June 30, and before completing one full year of active duty under their agreement, they too must cancel their agreement on June 30. Failing to do so will make them liable for repayment of the entire amount of Variable Incentive Pay.

As in the past, there will be a number of medical officers leaving the Service in June to pursue residency training in non-Government hospitals. Since they are normally required to commence such training on July 1, they must commence travel to the training hospital during the last part of June. As a result, many of these officers must request release from

active duty a few days before June 30 and will be ineligible to retain the earned portion of their initial payment of Variable Incentive Pay.

The existing Regulations also adversely affect several career medical officers who may be compelled to retire on September 1, 1975, to avoid a substantial loss of retired pay. The Regulations also require these officers to cancel their active duty service agreement on June 30 in order that they will not forfeit the entire amount of the lump-sum payment previously received. Like those separating from the Service in June, these officers will be only eligible to retain the earned portion of their initial payment through June 30, and they must refund the prorata balance even though they will complete an additional two months of the initial service agreement. As an end result, some of these officers will complete all but about 10-20 days of their one-year service agreement but will be required to refund up to over $2,100.

RECOMMENDATION

That Section E of the Variable Incentive Pay Regulations be amended to read as follows:

2. As an exception to Section D, 11(a) and 12, a medical officer who enters into a one or two year active duty agreement under these regulations on or before December 31, 1974, may, with the approval of the Assistant Secretary for Health, or his designee, terminate that agreement at any time after June 20, 1975 and before the first anniversary of the agreement. In this situation, officers shall be entitled to be paid only for the proportionate part of the period of active duty that they served under the agreement and shall refund on a prorated basis any amount received in excess of that entitlement. (Revised text Underscored.)

APPROVED _____ DISAPPROVED _____

DATE JUN 6 1975

ISSUE NO. 2

To prohibit payment of Variable Incentive Pay to certain medical officers who resigned from the Commissioned Corps prior to the commencement, or completion, of a period of obligatory service, and applied for reentry in the Service at a later date.

DISCUSSION

The statute prohibits payment of Variable Incentive Pay while medical officers are serving an initial active duty obligation. This restriction is applicable to medical officers who were enrolled in the Commissioned Officer Residency Deferment (CORD) Program and the Senior Commissioned Officer Student Training (COSTEP) (early commissioning) Program to the extent that they are not eligible for Variable Incentive Pay during their first two years of active duty. This restriction also applies to medical officers who incurred a service obligation following their participation in the Public Health-National Health Service Corps Scholarship programs.

Before and after the passage of the Variable Incentive Pay statute, there were several medical officers who refused to honor their agreement to serve on active duty after completion of training under the CORD and Senior COSTEP programs and resigned their appointment. Subsequently, several of these physicians have applied for reappointment and call to active duty in the Commissioned Corps. In at least some instances, this course of action was deliberately taken in an effort to qualify for Variable Incentive Pay immediately after entry on active duty. Informally, the Office of the General Counsel has advised us that when we accepted the resignation and terminated the appointment of CORD and COSTEP officers, it (1) cancelled their obligation to serve on active duty, and (2) may have made them eligible for Variable Incentive Pay, under the present Regulations, if the Service later accepted their application for reappointment and entry on active duty.

While we realize that the statutory provisions in this connection are overly restrictive, particularly for CORD officers who received no Federal support while in residency training, the law should be equitably applied to the extent possible. Failing this, officers who resigned and reentered the Service may be eligible for Variable Incentive Pay during the same time period that this additional compensation is denied to others who are honoring their active duty commitment.

RECOMMENDATION

That Section D 4 of the Variable Incentive Pay Regulations be amended to add the following:

> "No medical officer shall receive Variable Incentive Pay earlier than the date they would have become eligible for such pay if they had entered on active duty immediately after an initial active duty obligation was incurred, and they had served on active duty continuously until completion of the obligatory service."

APPROVED cw DISAPPROVED _____

DATE JUN 6 1975

ISSUE NO. 3

To authorize full payment of Variable Incentive Pay to medical officers who remain on active duty following completion of residency or other training.

DISCUSSION

With the present restriction in the law prohibiting payment of Variable Incentive Pay during initial residency training, a medical officer in such training for four years, as an example, may receive up to $54,000 less in career earnings than a General Medical Officer who has only completed internship training. This disparity exists in spite of the fact that medical residents also render patient care in the training hospital during all or most of the period of their specialty training, and with a progressing level of professional responsibility as the training is completed. In addition to the payment restriction during initial residency training, the Regulations (1) prohibit the payment of Variable Incentive Pay while an officer is in other training outside the Service for more than 100 days, and (2) limit payment of Variable Incentive Pay to $9,000 per year during a period of obligatory service following training.

The $9,000 Variable Incentive Pay limitation applies in varying ways, depending upon the kind of training and the manner in which it may be provided by the Service. For example, in some medical specialties, residency training is conducted entirely in a Public Health Service Hospital, in which case residents incur no service obligation and are eligible for full payment of Variable Incentive Pay immediately after training. Whereas, in other specialties, affiliated training programs are involved with part of the training in a Public Health Service Hospital and the remainder on rotation through one or more non-PHS hospitals. In this situation, an officer may incur a service obligation up to two years and is subject to the $9,000 limitation during that period. This is also true of residencies in which some academic training is a requisite for specialty board eligibility.

Ideally, Variable Incentive Pay should be an inducement to retain medical specialists in the Public Health Service after they have completed residency or other training. Unfortunately, it does not accomplish this purpose when medical officers must incur an additional loss of career earnings while they are serving obligatory service following such training. Since the Public Health Service may not legally enforce any service obligation, the $9,000 Variable Incentive Pay rate during obligatory service is, in reality, a penalty imposed on those who voluntarily remain in the Service following training. In other words, it is viewed by some medical officers as an inducement to leave the Service to pursue their professional careers in the private sector.

There is an alternative solution of this problem, i.e., to revise the Commissioned Corps Personnel Manual to eliminate the requirement of any obligatory service following medical training. This is not a desirable course of action, however, for two reasons. First, there are some medical officers who remain in the Service following training merely because they consider that they are morally responsible to fulfill their service obligation. Secondly, any commissioned officer who leaves the Service prior to the completion of a training obligation is subject to two sanctions. Normally, they are not authorized travel and transportation benefits to their home and they forfeit their entitlement to payment for accrued annual leave. These benefits would thus be provided to all medical officers leaving the Service immediately after training if no obligatory service is required.

RECOMMENDATION

That the Variable Incentive Pay Regulations be amended to delete the text of Section D 6(a) which presently requires payment of such pay at the $9,000 rate.

APPROVED _____ DISAPPROVED _____

DATE JUN 6 1975

file

THE WHITE HOUSE

WASHINGTON

July 23, 1975

ADMINISTRATIVELY CONFIDENTIAL

MEMORANDUM FOR: JIM CANNON

FROM: JIM CONNOR

SUBJECT: HEW Amendments to Physician Bonus Regulations

The President has reviewed your memorandum of July 21st on the above subject and indicated the following decisions:

1. Amendment 1 - Bonus Repayments -- approved

2. Amendment 2 - Prohibition of Bonus for Certain Physicians -- approved

3. Amendment 3 - Bonuses for Physicians who received Federal Support for Residency Training -- disapproved

Please follow-up with appropriate action.

cc. Don Rumsfeld

THE WHITE HOUSE ACTION

WASHINGTON

July 21, 1975

MEMORANDUM FOR: THE PRESIDENT

FROM: JIM CANNON

SUBJECT: Hew Amendments to Physician Bonus Regulation

This is to present for your decision amendments to the Physician Bonus Regulation from Secretary Weinberger. Memoranda from Jim Lynn and Cap Weinberger are attached at Tab A.

BACKGROUND

P. L. 93-274 authorized annual bonus payments of up to $13,500 in addition to any other pay or allowances for military and Public Health Service (PHS) physicians. You approved the implementing regulations last October, as required by the law.

ISSUE

HEW is now proposing three amendments to the regulations to correct three problem areas:

1. Bonus Repayments. Physicians who do not serve a full year are generally required by current regulations to repay the entire bonus. This amendment will allow officers leaving PHS for residency training in June, 1975, or retiring in September, 1975, to keep a pro rata portion of the bonus.

2. Prohibition of Bonuses for Certain Physicians. Current regulations prohibit bonus payments to certain physicians with service commitments, usually those who had deferments to allow completion of residency training. The amendment would prohibit bonus payments to any of these physicians who resign from the PHS while still under an obligation and then reapply to PHS solely to be eligible for a bonus.

3. Bonuses for Physicians Who Received Federal Support for Residency Training. Current regulations permit the payment of a smaller bonus to physicians who received Federal salaries during residency training in return for service commitments. These physicians are normally commissioned in the PHS while in residency training. HEW proposes to enable this group of physicians to receive the full bonus while serving their period of obligation.

RECOMMENDATIONS

Weinberger - Approve 1, 2, and 3.

Lynn
- Approve 1 and 2
- Disapprove 3 because it would:

  -- be contrary to the purposes of Federal support of residency training, i.e., to obtain service commitments in return for salary support;

  -- be inequitable to those physicians who freely accepted a Federal appointment in return for a full bonus, without having a prior service commitment. Under the HEW proposal, physicians would receive $13,500 regardless of whether or not they had prior service commitments;

  -- result in the Federal Government paying both a salary and a full bonus for the same commitment period. DOD is not proposing a similar amendment.

Cannon
- Approve 1 and 2
- Disapprove 3

Greenspan
- Approve 1 and 2
- Disapprove 3 (additional comments at Tab B)

Marsh
- Approve 1 and 2
- Disapprove 3

Seidman - Approve 1 and 2
- Disapprove 3

Friedersdorf - No comment

Buchen - No comment

DECISION

1. Amendment 1 - Bonus Repayments

_____Approve
(Weinberger, Lynn, Cannon, Greenspan, Marsh, Seidman)

_____Disapprove

2. Amendment 2 - Prohibition of Bonus for Certain Physicians

_____Approve
(Weinberger, Lynn, Cannon, Greenspan, Marsh, Seidman)

_____Disapprove

3. Amendment 3 - Bonuses for Physicians who received Federal Support for Residency Training

_____Approve
(Weinberger)

_____Disapprove
(Lynn, Cannon, Greenspan, Marsh, Seidman)

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
WASHINGTON, D.C. 20503

DECISION

JUL 15 1975

MEMORANDUM FOR THE PRESIDENT

FROM: JAMES T. LYNN

SUBJECT: HEW Amendments to Physician Bonus Regulations

P.L. 93-274 authorized bonus payments of up to $13,500 annually for military and Public Health Service (PHS) physicians. P.L. 93-274 requires that you approve the implementing regulations. You did so last October, but HEW is proposing three amendments for your approval:

1. Bonus Repayments. Physicians who do not serve a full year are generally required by current regulations to repay the entire bonus. An exception was made for physicians leaving the PHS on June 30, 1975. Since the implementing regulations were not issued until October 1974 and departing PHS physicians normally begin residency programs on July 1, physicians leaving on June 30 were allowed to retain a pro rata amount of the bonus rather than repaying the entire amount. HEW is now proposing to change the June 30, 1975, date to any date from June 20, 1975, to the first anniversary of each physician's bonus contract. This change will provide time for physicians departing for residency training to travel to new locations before June 30. It will also allow those who plan to retire in September to retain a pro rata bonus, rather than repaying the entire amount.

2. Prohibition of Bonuses for Certain Physicians. Current regulations prohibit bonus payments to certain physicians with service commitments. Generally, these are physicians who received deferments to enable them to complete their residency training.

The proposed HEW regulations would prohibit bonus payments to any of these physicians who resign from the PHS while still under an obligation and then reapply to PHS solely to be eligible for a bonus.

3. Bonuses for Physicians Who Received Federal Support for Residency Training. Current regulations permit the payment of a limited bonus of $9,000, rather than the full $13,500, to physicians who received Federal salaries during residency training in return for service commitments. These physicians are normally commissioned in the PHS while in residency training.

HEW proposes to enable this group of physicians to receive the full bonus while serving their period of obligation. HEW believes that these physicians should receive the same bonus as other physicians who have completed residency training.

Recommendation. We recommend that you approve the first two amendments, but disapprove the third. We recommend against the third amendment because it would:

- be contrary to the purposes of Federal support of residency training, i.e., to obtain service commitments in return for salary support.
- be inequitable to those physicians who freely accepted a Federal appointment in return for a full bonus, without having a prior service commitment. Under the HEW proposal, physicians would receive $13,500 regardless of whether or not they had prior service commitments.
- result in the Federal Government paying both a salary and a full bonus for the same commitment period. DOD is not proposing a similar amendment.

Decision

☐ Approve the first two amendments, but disapprove the third amendment (OMB position).

☐ Approve all three amendments (HEW position).

☐ See me.

Attachment

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

JUN 6 1975

OFFICE OF MANAGEMENT & BUDGET

Honorable James T. Lynn
Director, Office of Management and
Budget
Washington, D. C. 20503

Dear Mr. Lynn:

Reference is made to Public Law 93-274 which authorized the payment of Variable Incentive Pay for medical officers of the Public Health Service.

Since the implementation of the Variable Incentive Pay program in September 1974, some problem areas have been identified which require remedial changes to the Regulations.

Enclosed are three amendments to the Regulations which we propose to issue subject to the approval of the President.

Sincerely,

Secretary

3 Enclosures

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

JUN 6 1975

Honorable James T. Lynn
Director, Office of Management and
Budget
Washington, D. C. 20503

Dear Mr. Lynn:

Reference is made to Public Law 93-274 which authorized the payment of Variable Incentive Pay for medical officers of the Public Health Service.

Since the implementation of the Variable Incentive Pay program in September 1974, some problem areas have been identified which require remedial changes to the Regulations.

Enclosed are three amendments to the Regulations which we propose to issue subject to the approval of the President.

Sincerely,

/s/Cap

Secretary

3 Enclosures

ISSUE NO. 1

To authorize cancellation of certain Variable Incentive Pay service agreements after June 20, 1975.

DISCUSSION

The Regulations governing the payment of Variable Incentive Pay generally provide that if medical officers voluntarily leave the Service before completing one year of active duty under the requisite agreement to remain on active duty for one, two, three, or four years, they must refund the entire amount of the lump-sum payment they had received for that year.

Because of the four-month delay in the initial implementation of the Variable Incentive Pay statute, special one-time provisions were included in the Regulations allowing medical officers to cancel their initial agreement on June 30, 1975, and to repay the unearned portion of the lump-sum payment previously received. This was designed to do two things:

1. For those medical officers who will leave the Service on or about July 1, 1975, it permitted them to receive some Variable Incentive Pay for their last full year of active duty following enactment of the law; and

2. For those medical officers who entered the Service on or about July 1, 1974, it would permit them to receive some Variable Incentive Pay during their first year of service, and to sign a new agreement on July 1 to receive Variable Incentive Pay for each full year of service thereafter.

The General Counsel's office has advised that under the exacting terms of the Regulations, any medical officer who leaves the Service even one day before June 30, 1975, will be liable for repayment of the entire amount of their initial payment of Variable Incentive Pay. Moreover, any medical officer who leaves the Service after June 30, and before completing one full year of active duty under their agreement, they too must cancel their agreement on June 30. Failing to do so will make them liable for repayment of the entire amount of Variable Incentive Pay.

As in the past, there will be a number of medical officers leaving the Service in June to pursue residency training in non-Government hospitals. Since they are normally required to commence such training on July 1, they must commence travel to the training hospital during the last part of June. As a result, many of these officers must request release from

active duty a few days before June 30 and will be ineligible to retain the earned portion of their initial payment of Variable Incentive Pay.

The existing Regulations also adversely affect several career medical officers who may be compelled to retire on September 1, 1975, to avoid a substantial loss of retired pay. The Regulations also require these officers to cancel their active duty service agreement on June 30 in order that they will not forfeit the entire amount of the lump-sum payment previously received. Like those separating from the Service in June, these officers will be only eligible to retain the earned portion of their initial payment through June 30, and they must refund the prorata balance even though they will complete an additional two months of the initial service agreement. As an end result, some of these officers will complete all but about 10-20 days of their one-year service agreement but will be required to refund up to over $2,100.

RECOMMENDATION

That Section E of the Variable Incentive Pay Regulations be amended to read as follows:

2. As an exception to Section D, 11(a) and 12, a medical officer who enters into a one or two year active duty agreement under these regulations on or before December 31, 1974, may, with the approval of the Assistant Secretary for Health, or his designee, terminate that agreement at any time after June 20, 1975 and before the first anniversary of the agreement. In this situation, officers shall be entitled to be paid only for the proportionate part of the period of active duty that they served under the agreement and shall refund on a prorated basis any amount received in excess of that entitlement. (Revised text Underscored.)

APPROVED _____ DISAPPROVED _____

DATE JUN 6 1975

ISSUE NO. 2

To prohibit payment of Variable Incentive Pay to certain medical officers who resigned from the Commissioned Corps prior to the commencement, or completion, of a period of obligatory service, and applied for reentry in the Service at a later date.

DISCUSSION

The statute prohibits payment of Variable Incentive Pay while medical officers are serving an initial active duty obligation. This restriction is applicable to medical officers who were enrolled in the Commissioned Officer Residency Deferment (CORD) Program and the Senior Commissioned Officer Student Training (COSTEP) (early commissioning) Program to the extent that they are not eligible for Variable Incentive Pay during their first two years of active duty. This restriction also applies to medical officers who incurred a service obligation following their participation in the Public Health-National Health Service Corps Scholarship programs.

Before and after the passage of the Variable Incentive Pay statute, there were several medical officers who refused to honor their agreement to serve on active duty after completion of training under the CORD and Senior COSTEP programs and resigned their appointment. Subsequently, several of these physicians have applied for reappointment and call to active duty in the Commissioned Corps. In at least some instances, this course of action was deliberately taken in an effort to qualify for Variable Incentive Pay immediately after entry on active duty. Informally, the Office of the General Counsel has advised us that when we accepted the resignation and terminated the appointment of CORD and COSTEP officers, it (1) cancelled their obligation to serve on active duty, and (2) may have made them eligible for Variable Incentive Pay, under the present Regulations, if the Service later accepted their application for reappointment and entry on active duty.

While we realize that the statutory provisions in this connection are overly restrictive, particularly for CORD officers who received no Federal support while in residency training, the law should be equitably applied to the extent possible. Failing this, officers who resigned and reentered the Service may be eligible for Variable Incentive Pay during the same time period that this additional compensation is denied to others who are honoring their active duty commitment.

RECOMMENDATION

That Section D 4 of the Variable Incentive Pay Regulations be amended to add the following:

> "No medical officer shall receive Variable Incentive Pay earlier than the date they would have become eligible for such pay if they had entered on active duty immediately after an initial active duty obligation was incurred, and they had served on active duty continuously until completion of the obligatory service."

APPROVED _____ DISAPPROVED _____

DATE JUN 6 1975

ISSUE NO. 3

To authorize full payment of Variable Incentive Pay to medical officers who remain on active duty following completion of residency or other training.

DISCUSSION

With the present restriction in the law prohibiting payment of Variable Incentive Pay during initial residency training, a medical officer in such training for four years, as an example, may receive up to $54,000 less in career earnings than a General Medical Officer who has only completed internship training. This disparity exists in spite of the fact that medical residents also render patient care in the training hospital during all or most of the period of their specialty training, and with a progressing level of professional responsibility as the training is completed. In addition to the payment restriction during initial residency training, the Regulations (1) prohibit the payment of Variable Incentive Pay while an officer is in other training outside the Service for more than 100 days, and (2) limit payment of Variable Incentive Pay to $9,000 per year during a period of obligatory service following training.

The $9,000 Variable Incentive Pay limitation applies in varying ways, depending upon the kind of training and the manner in which it may be provided by the Service. For example, in some medical specialties, residency training is conducted entirely in a Public Health Service Hospital, in which case residents incur no service obligation and are eligible for full payment of Variable Incentive Pay immediately after training. Whereas, in other specialties, affiliated training programs are involved with part of the training in a Public Health Service Hospital and the remainder on rotation through one or more non-PHS hospitals. In this situation, an officer may incur a service obligation up to two years and is subject to the $9,000 limitation during that period. This is also true of residencies in which some academic training is a requisite for specialty board eligibility.

Ideally, Variable Incentive Pay should be an inducement to retain medical specialists in the Public Health Service after they have completed residency or other training. Unfortunately, it does not accomplish this purpose when medical officers must incur an additional loss of career earnings while they are serving obligatory service following such training. Since the Public Health Service may not legally enforce any service obligation, the $9,000 Variable Incentive Pay rate during obligatory service is, in reality, a penalty imposed on those who voluntarily remain in the Service following training. In other words, it is viewed by some medical officers as an inducement to leave the Service to pursue their professional careers in the private sector.

There is an alternative solution of this problem, i.e., to revise the Commissioned Corps Personnel Manual to eliminate the requirement of any obligatory service following medical training. This is not a desirable course of action, however, for two reasons. First, there are some medical officers who remain in the Service following training merely because they consider that they are morally responsible to fulfill their service obligation. Secondly, any commissioned officer who leaves the Service prior to the completion of a training obligation is subject to two sanctions. Normally, they are not authorized travel and transportation benefits to their home and they forfeit their entitlement to payment for accrued annual leave. These benefits would thus be provided to all medical officers leaving the Service immediately after training if no obligatory service is required.

RECOMMENDATION

That the Variable Incentive Pay Regulations be amended to delete the text of Section D 6(a) which presently requires payment of such pay at the $9,000 rate.

APPROVED _____ DISAPPROVED _____

DATE JUN 6 1975

THE CHAIRMAN OF THE
COUNCIL OF ECONOMIC ADVISERS
WASHINGTON

July 21, 1975

MEMORANDUM FOR JIM CANNON

This is in response to your request for my comments and suggestions on the draft decision memo for the President on HEW's proposed amendments to the Physician Bonus Regulations.

I support the HEW proposal number (1) that a physician leaving the PHS before the end of his contract year be required to return only the pro-rata amount of the bonus, rather than the entire bonus for the year. Rather than focusing exclusively on those leaving the PHS for residency programs or retirement, the discussion of the issue should be broadened. The bonus is a means of paying a higher salary than allowed under the current civilian and military Government pay schedules so that the military and PHS can compete effectively for the services of experienced physicians. The denial of the annual bonus for a person who leaves before the end of his contract year will induce some to leave earlier and will unnecessrily penalize persons who unexpectedly decide to leave the PHS within the year. There appears to be no particular loss to the PHS from those who leave before the expiration of the year.

I also endorse HEW proposal (2) that physicians with service obligations to the PHS and who are therefore not entitled to the bonus, should be denied a bonus if they resign and then reapply. The proposed regulation means that those with a service commitment, presumably because of Government subsidies for their education, receive a lower salary in the PHS until they fulfil this obligation. It should be made clearer for the President, however, under what circumstances a physician with a service obligation is allowed to resign.

Proposal (3) would raise the current limited bonus of $9,000 to the full bonus of $13,500 to those who received Federal salaries during their residency training in return for the subsequent service commitment. I share the OMB objection to this proposal. Those who voluntarily receive federally subsidized training should be obligated to compensate the Government in some form, such as through a smaller bonus.

These proposals touch on the relation between the Federal Government and the subsidization of medical education. It is ironic that we provide large subsidies to the training of persons who are very wealthy -- the present value of the future earnings of physicians is very high! Many youths may have difficulty financing their own medical schooling without assistance, but this problem could be solved by cash loans to medical students that they are required to repay in cash. This policy would avoid the gross inequities that now exist and the numerous problems that arise from attempts to require specific performance, in terms of job or location, on the part of physicians, or persons in any occupation.

Alan Greenspan

Health

THE WHITE HOUSE

WASHINGTON

July 24, 1975

MEMORANDUM FOR: JIM LYNN

FROM: JIM CANNON

SUBJECT: HEW Amendments to Physician Bonus Regulations

The President has reviewed Secretary Weinberger's memo of June 6 which you recently sent to him on HEW proposed amendments to physician bonus regulations.

The President has approved Amendment 1, Bonus Repayments, and Amendment 2, Prohibition of Bonus for Certain Physicians, and disapproved Amendment 3, Bonuses for Physicians Who Received Federal Support for Residency Training.

THE WHITE HOUSE

WASHINGTON

August 4, 1975

MEMORANDUM FOR: JIM CANNON

FROM: PHILIP BUCHEN P.W.B.

SUBJECT: Interpretation of Health Maintenance Organization Statute

After reviewing your memorandum of July 31, 1975, and the attachments, we support the DOL position.

In my opinion, it is consistent with the applicable provisions of the HMO Act of 1973 (P.L. 93-222) and represents the better policy.

cc: Art Quern

THE WHITE HOUSE

WASHINGTON

August 26, 1975

MEMORANDUM FOR: JACK MARSH
MAX FRIEDERSDORF
PHIL BUCHEN
BILL SEIDMAN
ALAN GREENSPAN

FROM: JIM CANNON

SUBJECT: Proposed HEW and DOD Amendments to the Physician Bonus Regulations

Attached for your review and comment is a draft decision memorandum on the proposed HEW and DOD amendments to the Physician Bonus Regulation.

Please send your comments and suggestions to Sarah Massengale by 2:00 p.m., Wednesday, August 27.

Thank you.

Attachment

THE WHITE HOUSE

WASHINGTON

ACTION

MEMORANDUM FOR: THE PRESIDENT

FROM: JIM CANNON

SUBJECT: Proposed HEW and DOD Amendments to the Physician Bonus Regulations

This is to present for your decision amendments to the Physician Bonus Regulations proposed by HEW and DOD. A memorandum from Jim Lynn is attached at Tab A.

BACKGROUND

As you know, Members of the Military and Public Health Service (PHS) have a financial incentive to retire before October 1, 1975 because of the retired pay inversion problem. Under current law, they receive a year's worth of cost of living annuity adjustments -- up to $2,500 per year -- which they would not receive if they retire after October. HEW requested an amendment to the PHS physician bonus regulations to remove the bonus repayment penalty if a physician retires before completing the full year of service required by the bonus contract.

The decision you made in early August on our recommendation to approve the HEW amendments has not yet been communicated to HEW. Two developments have occurred since your decision:

-- Defense has proposed a similar amendment;

-- Congress has agreed to legislation -- in an amendment to the Defense Procurement Authorization Bill -- to remove the pre-October 1 retirement incentive.

The Defense Procurement Authorization Bill is almost certain to be enacted soon after the Congressional recess.

ISSUE

The issue is whether to approve or disapprove the HEW and DOD amendments. The pending legislation will remove the need for the proposed HEW and DOD amendments since retiring military and PHS physicians will no longer have to choose between a lower retirement annuity and repaying their full annual bonuses.

RECOMMENDATIONS

Lynn — Disapprove the HEW and DOD amendments "the legislation will encourage. . . officers to remain. . . approval of the amendments now would be undesirable since it would. . .[encourage] early retirements. . . ."

Cannon — Disapprove the HEW and DOD amendments

DECISION

1. Approve HEW and DOD amendments

_____APPROVE _____DISAPPROVE

2. Disapprove HEW and DOD amendments

_____APPROVE _____DISAPPROVE

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
WASHINGTON, D.C. 20503

AUG 15 1975

ACTION

MEMORANDUM FOR: THE PRESIDENT

FROM: JAMES T. LYNN

SUBJECT: Proposed DOD and HEW Amendments to the Physician Bonus Regulations

Members of the military and Public Health Service (PHS) have a financial incentive to retire before October 1, 1975 because of the retired pay inversion problem. Under current law, they receive a year's worth of cost of living annuity adjustments -- up to $2,500 per year -- which they would not receive if they retire after October 1.

As you know, HEW requested an amendment to the PHS physician bonus regulations to remove the bonus repayment penalty if a physician retires before completing the full year of service required by the bonus contract. Normally, military and PHS physicians must repay their entire annual bonus if they serve less than one year. Since the bonus plan began last October, no physician would have completed a full year of service before a pre-October 1, 1975 retirement. Initial implementation of the bonus was delayed several months before last October by administrative problems.

On our recommendation, you approved the HEW amendment last week. We have not yet communicated your decision to HEW, however, and two developments have occurred since we submitted the amendment for your consideration:

- Defense has proposed a similar amendment, and
- Congress has agreed to legislation -- in an amendment to the Defense Procurement Authorization Bill -- to remove the pre-October 1 retirement incentive.

The Defense Procurement Authorization Bill is almost certain to be enacted soon after the Congressional recess.

The pending legislation will remove the need for the proposed HEW and DOD amendments since retiring military and PHS physicians will no longer have to choose between a lower retirement annuity and repaying their full annual bonuses. In effect, the legislation will encourage military and PHS officers to remain on board. Moreover, approval of the amendment now would be undesirable since it would have the effect of encouraging early retirements, i.e., the physicians could break their bonus contracts without penalty. In view of the need for physicians in DOD and HEW, it would not seem sensible to encourage any of the physicians now on board to retire.

Accordingly, we recommend that you disapprove the proposed DOD amendment and reconsider and disapprove the proposed HEW amendment, on the grounds of the expected Congressional action.

Decision

/ / Approve the DOD and HEW amendments

/ / Disapprove the DOD and HEW amendments (OMB recommendation)

THE WHITE HOUSE

WASHINGTON

September 3, 1975

MEMORANDUM FOR: JIM CAVANAUGH

FROM: ART QUERN

SUBJECT: Secretary Mathews' Position on Reducing Medicaid Funds to States

This is in reply to your inquiry about the UPI story which reports that Secretary Mathews is refusing to enforce regulations requiring a reduction of medicaid matching funds to states if certain utilization control requirements are not met.

The Secretary's position as given in testimony this morning is as follows:

1. Section 1903(g) of the Social Security Act provides for a reduction in Federal medicaid matching to states if certain utilization control requirements are not met; it does not mandate a date when the reduction must be imposed.

2. The Secretary is concerned that extensive confusion over a court case brought by the AMA leading to a preliminary injunction of portions of the utilization control sections -- but not the portion in question -- has had a serious effect on the states' ability to proceed with utilization review surveys.

3. He, therefore, has directed an intensive study of this issue and possible alternatives which would better accomplish the purposes of the reduction provisions.

4. While this study is proceeding, imposition of the reductions has been suspended.

5. If it is ultimately decided to make reductions they will be made back to the effective date provided for in the statute.

UP-029

(MEDICAID)

WASHINGTON (UPI) -- HEW SECRETARY DAVID MATHEWS HAS TOLD CONGRESS HE WILL REFUSE AT LEAST TEMPORARILY TO ENFORCE A LAW REQURING HIM TO REDUCE FEDERAL MEDICAID FUNDS TO CERTAIN STATES, UPI HAS LEARNED.

IT WAS THE FIRST TIME MATHEWS HAS PUBLICLY ANNOUNCED HIS REFUSAL TO ENFORCE A LAW SINCE HE TESTIFIED AT CONGRESSIONAL HEARINGS THIS SUMMER, BEFORE HIS CONFIRMATION, THAT HE WOULD ENFORCE COURT RULINGS AND LAWS EVEN WHERE HE PERSONALLY DISAGREED WITH THEM.

MATHEWS SAID IN A LETTER TO REP. JOHN MOSS, D-CALIF., THAT AMENDMENTS TO THE SOCIAL SECURITY ACT REQUIRE HIM TO REDUCE FEDERAL MEDICAID PAYMENTS TO STATES THAT FAIL TO PROVIDE SPECIFIC CONTROLS OVER THE USE OF HOSPITAL AND NURSING HOME SERVICES.

THE LETTER WAS TO BE RELEASED TODAY AT A HEARING BY MOSS' HOUSE OVERSIGHT AND INVESTIGATIONS SUBCOMMITTEE. A COPY WAS MADE AVAILABLE TO UPI BY AN HEW SOURCE.

IN THE AUG. 29 LETTER MATHEWS SAID HE IS CONCERNED THAT REDUCING MEDICAID PAYMENTS "WILL BE COUNTERPRODUCTIVE TO THE END RESULTS THAT YOU AND I SEEK."

THE REQUIRED REDUCTION OF FEDERAL AID "IS SO SEVERE THAT IT HAS THE POTENTIAL FOR CRIPPLING A STATE'S MEDICAID PROGRAM," HE WROTE. THE FEDERAL-STATE MEDICAID PROGRAM PROVIDES MEDICAL SERVICES TO THE NEEDY. MATHEWS TOLD MOSS THAT THE ULTIMATE LOSER IF FEDERAL PAYMENTS TO STATES WERE CUT COULD BE MEDICAID RECEIPIENTS.

"SUCH LARGE REDUCTIONS, AS A RESULT, DEFEAT THE OBJECTIVES OF THE LAW AND CAUSE UNDUE HARDSHIP TO THE VERY PEOPLE THE ACT WAS ESTABLISHED TO HELP," HE WROTE.

UPI 09-03 09:58 AED

UP-0

THE NEW YORK TIMES, Tuesday, September 16, 1975

Rationing Medical Care

By Harry Schwartz

Vice President Rockefeller has created a ministorm by asserting that government cannot afford to give everyone first class medical care. Mr. Rockefeller's critics feel particularly betrayed because as governor of New York he was an outspoken advocate of national health insurance and a decade ago sponsored the most generous state Medicaid law in the nation.

The Vice President's critics seem unaware that his present position almost echoes the official stand of the British Labor Government toward the demands on the National Health Service, Britain's generation-old "free" — that is, tax-supported—medical system.

The Wilson Government's position

ciency through r
ical system.

Unfortunately
permissive United
evidence that h
done very much
of disease as s
alcoholism and d
don't have any B
they find demar
care outstrips th
over, Washingtor
two years to pus
organizations as
medical care ha
pointing results
pushed this solut

There can, of
and improvemen
icine but there i

HEALTH LEGISLATION MEETING
w/Cavanaugh, Quern, O'Neill,
Loffler, Meagher
Friday, September 19, 1975
12:15 p.m.

Mr. Cannon's Office