Brief Summary of
Statement of
The American Society of Internal Medicine
on the
Catastrophic Health Insurance and Medical Assistance Reform Act, S. 350
before the
Senate Finance Committee
March 1979

The American Society of Internal Medicine supports the enactment of legislation that would protect all Americans against the sometimes catastrophic costs of illness; would provide better health insurance coverage for the poor; and would encourage basic health insurance coverage through the private sector. Such legislation would assure all Americans access to needed medical care services by building on the strengths of our current health care delivery system. S. 350 accomplishes this, but we believe certain modifications would improve the bill. In the full statement we comment on specific issues and concerns in each of the major three titles in S. 350.

Title XXI--Catastrophic Health Insurance Program

- Recommend that the $2,000 medical expense deductible be increased to $5,000 as proposed in S. 748.
- Support the benefits offered under the catastrophic plan, including the limitations placed on mental health services and extended care services.
- Support the use of health planning and the PSRO program to help prevent any undesirable shift in resources toward secondary and tertiary care and away from preventive and primary care.
- Recommend that careful consideration be given to the mandated employer/employee premium financing contained in S. 748 in order to maximize the provision of catastrophic coverage through the private sector.

New Title XIX--Medical Assistance Plan for Low-Income People

- Support standardizing the benefits and eligibility requirements for the poor.
- Support using the administrative and reimbursement methodology of the Medicare program under the new Title XIX.
- Strongly support the "spend-down" provision in Section 1932 that protects lower income people who are not immediately eligible for the new medical assistance plan.
- Support the copayment requirements, but we recommend that provision be made to allow adjustment of the copayment level based on program experience.

Title XV--Private Basic Health Insurance Certification

- Support governmental certification to ensure certain minimum standards in basic private health insurance policies.
- Recommend including a requirement to make available basic health insurance policies that include 20-percent copayment and reasonable inpatient deductible levels.
- Recommend deletion of Section 1504(c)(7) that sets Medicare reimbursement levels as the standards for determining reasonable charges under private health insurance policies.

If, due to economic considerations, programs would have to be phased in, we recommend that the catastrophic plan be implemented first.

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Mr. Chairman and members of the Committee, I am Dr. Tom Connally, Chairman of the American Society of Internal Medicine (ASIM) Task Force on National Health Insurance, and a member of the Board of Trustees. I am in private practice here in Washington, D.C. With me today is Mr. Mark Leasure, ASIM's Director of Government Relations. We appreciate the opportunity to testify today. Most of our comments will be directed toward the Catastrophic Health Insurance and Medical Assistance Reform Act, S. 350, with some references to the recently introduced Catastrophic Health Insurance and Medicare Amendments of 1979, S. 748.

ASIM is a federation of state component societies of internal medicine with approximately 16,000 members who, by training and practice standards, are recognized as specialists in internal medicine and its subspecialties. The vast majority are in direct patient care. Due to the nature of the specialty, internists have a broader perspective on our health care delivery system than other groups of physicians. Most deliver all levels of care--primary, secondary and tertiary--and do so in a variety of settings--the office, hospital and extended care facilities. We think it's important to share this broad perspective as it relates to the proposals before this Committee.

S. 350 would establish a national program to protect every American from financial ruin due to large medical expenses; would replace the current Medicaid program with a new one that improves and standardizes coverage for the poor; and would facilitate the availability of basic health insurance through the private sector.

ASIM has been studying the national health insurance question for several years and has come to the same general conclusion as have the sponsors of S. 350. Namely, to provide all Americans access to needed services, we need not dismantle our current medical- care delivery system; we need only to identify and correct existing gaps in insurance coverage by building on the strengths of our present system. The lack of protection against large medical expenses and inadequate and inequitable health insurance coverage for the poor--unemployed and working--are the significant gaps in our current system. ASIM believes that S. 350 is the best proposal yet devised to eliminate these gaps.

I would now like to address more specifically the three major titles of S. 350.

Title XXI--Catastrophic Health Insurance Program

In 1975, the ASIM House of Delegates, composed of internist leaders from every state in the country, went on record in support of a national program to protect all Americans against the catastrophic costs of illness. Millions of Americans have no insurance coverage against very large medical bills. In our opinion, this is the first gap that must be addressed. The provisions in Title XXI offer a sensible, targeted approach to protect all Americans from financial ruin due to serious illness.

Payment under Title XXI would begin after 60 days of hospitalization and/or after $2,000 in medical expenses. We believe a 60-day deductible for inpatient coverage is reasonable under a program designed to cover the costs of catastrophic illness. However, we would favor the $5,000 medical expense deductible set in S. 748 instead of the $2,000 deductible in S. 350. We believe it is more realistic and would lower the cost of the catastrophic program. We strongly support the provision included in both S. 350 and S. 748 that calls for increasing the medical expense deductible based on increases in the medical care

component of the Consumer Price Index. It is a must. It will help slow the rate of increase in program costs and, at the same time, assure that basic health insurance will continue to be provided through the private sector.

The scope of benefits provided in Section 2103 are broad, covering essential physician and institutional services. There are, however, some limitations placed on mental health services and extended care services. Unfortunately, providing either of these on an open-ended basis could be inordinately expensive and strain the resources available to the program. We believe the benefit limitations for these services in S. 350 are reasonable.

A serious concern with any catastrophic program is the potential to shift further the allocation of resources toward secondary and tertiary care and away from preventive and primary care. The high cost of the End Stage Renal Disease program illustrates our concern. Section 2104(f)(l) and (2) acknowledges this problem by giving the Secretary of the Department of Health, Education, and Welfare authority to set standards and criteria for "unusually expensive or complex" procedures or courses of treatment. While there probably will be a need for standards and criteria in certain instances, we object to authorizing the Secretary alone to decide when there is a need and to determine what the standards and criteria will be. First, we believe the Secretary should consult not only with the relevant government groups, such as the new National Center for Health Care Technology, but with appropriate medical organizations in the private sector as well.

Secondly, the actual development of any standards and criteria should be made the responsibility of the PSRO program. We urge that this role for PSRO be explicitly stated in the law.

In addition, the potential reallocation problem should be partially solved by two existing programs--health planning and PSRO. Since the inception of these programs, ASIM has been encouraging its members to become involved in both. They are designed to help assure that our health care resources are allocated and utilized appropriately. We urge Congress to look toward these programs to help prevent any undesirable shift in resources.

Our major concern with Title XXI is the payroll tax/tax credit financing mechanisms. ASIM believes that catastrophic coverage should be, to the greatest extent possible, financed and administered through the private sector. We are not convinced that the tax credits offered in S. 350 will provide sufficient incentive for small employers and employers with predominantly lower income employees to purchase approved plans in the private sector. Instead, we fear many will find it easier to allow their employees to obtain coverage through the federal plan. We urge that careful consideration be given to the mandated employer/employee premium financing contained in S. 748. It places responsibility for the program in the private sector and limits bureaucratic intrusion. This is a goal for which there is growing public consensus.

New Title XIX--Medical Assistance Plan for Low-Income People

The Medicaid program has provided many of our less fortunate citizens access to needed medical care services. But the program, as it exists today, falls short of helping all who need and deserve help. Because the benefits provided and the eligibility requirements vary from state to state, some who are ineligible in one state are eligible in another. We strongly support the provisions in the new Title XIX which standardize benefits and eligibility requirements for the poor.

The administrative requirements and reimbursement levels of many state Medicaid programs are such that they discourage physicians and other providers Of service

from participating in the program. This tends to foster a separate system of second-class, and sometimes substandard, care for the poor--a prime example being the so-called "Medicaid mills." We think that adoption of the administrative and reimbursement methodology of the Medicare program under the new Title XIX is a step in the right direction. While the Medicare program is by no means optimal, it is clearly better than Medicaid. We believe this upgrading of coverage, along with the freedom of choice guaranteed by Section 1902, will help bring everyone back into the mainstream of our delivery system.

Many hard-working, low-income people have been denied coverage under Medicaid in the past. Their incomes are just above the eligibility limits, but too low for them to purchase adequate protection. The "spend-down" provision in Section 1932 allows, for purposes of determining eligibility in the new medical assistance program, an individual or family to subtract out-of-pocket medical care expenses from their income. We believe this provision will help alleviate one of the most troublesome gaps in our current system, and it does so on the basis of individual need. This is a general principle to which government funded social programs should adhere. ASIM strongly endorses Section 1932.

Our last comments on Title XIX relate to Section 1913 on "Copayment Requirements." It is our belief, both from reviewing scientific studies on the effect on copayment and, perhaps more importantly, from our dealings with our own patients, that some appropriate form of patient copayment is a necessary factor in cost control. This is supported by a recommendation made by the National Commission on the Cost of Medical Care, sponsored by the American Medical Association, which states "Insurance policies should include provisions through which the consumer shares in the cost of care received..." The purpose of a copayment should be to discourage unnecessary utilization without becoming a barrier to

needed medical care. Admittedly, determining the level of copayment which fulfills this purpose is not easy. Probably only with experience will we be able to adjust the copayment to the most desirable level. While the $3 copayment contained in Section 1913 is certainly a good starting level, we believe the Secretary shouid be required to recommend to Congress adjustments in the copayment level based on program experience.

Administration of Federal Health Programs. One of the most appealing aspects of S. 350 is the potential for administrative consolidation of the new medical assistance plan and any federal portion of the catastrophic health insurance plan with the Medicare program. This should not be construed as blanket endorsement of the way the Medicare program is administered. As noted earlier, it is by no means optimal. ASIM will continue to work for changes in the Medicare program when and where they are needed. But, if one intermediary were to use the same forms in administering all three programs, it would be a significant help in physicians' attempts to hold down increases in their overhead costs. Currently, physicians and their office staff spend a considerable amount of time completing health insurance claim forms and attempting to figure out, and help patients figure out, the complex reporting requirements of their health insurance programs. Therefore, ASIM supports those provisions that would make the administration of all federal health insurance programs more uniform and more efficient.

Title XV--Private Basic Health Insurance Certification

We believe that governmental certification to ensure certain minimum standards in private health insurance policies is appropriate. Because the majority of the population will not be covered by federal health insurance programs, it is important that private health insurance policies with adequate basic coverage be available. But, we have two serious objections to Title XV as written.

Under Section 1504, a health insurance policy could be certified only if the inpatient hospital deductible does not exceed $100 and the medical insurance copayment does not exceed 20 percent. By writing them as maximum standards, we believe they wiil encourage more first-dollar coverage being provided under basic health insurance policies. Such policies substantially reduce patient concern for the cost of his or her care.

As stated earlier, we believe some form of patient copayment is a necessary factor in cost control. We recommend that Section 1504 be modified to prohibit the certification of any health insurance policy unless that insurance company also offers at least one policy that calls for an approximate 20-percent patient copayment and a reasonable inpatient hospital deductible. It should also require that the cost of such policies be accurately reflected in lower premiums for those who choose such a plan.

Secondly, Section 1504(c)(7), as we understand it, states that any health insurance policy that reimburses at the Medicare determined levels will be paying reasonable charges. We adamantly oppose this provision. It makes the government the sole determiner of what is a reasonable charge. It is inappropriate for DHEW, through the regulatory process or simple administrative rulings, to have the authority to affect reimbursement levels in the private health insurance industry. Therefore, we strongly recommend that it be deleted.

Conclusion

ASIM supports enactment of legislation that would protect all Americans against the sometimes catastrophic costs of illness; would provide better health insurance coverage for the poor; and would encourage the availability of basic health insurance coverage through the private sector. We strongly urge serious

consideration of our recommended modifications, including the incorporation of the provisions identified in S. 748.

We are well aware that the current economic situation will bear heavily on all legislative decisions. If the catastrophic program and the new Title XIX cannot be afforded at the same time, we believe the catastrophic program should come first.

Mr. Chairman, we are pleased to have had the opportunity to express our views today and even more pleased that we could come in general support of the proposals before the Committee. We would be happy to answer any questions you may have.

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