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.
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

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 recog-
nized as specialists in internal medicine and its subspecialties. The vast
majority are in direct patient care. Due to the nature of the specialty, inter-
nists 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 finan-
cial 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 limita-
tions for these services in S. 350 are reasonable.

A serious concern with any catastrophic program is the potential to shift fur-
ther 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 adminis-
trative 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 ful-
fills 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 should be required to recommend to Congress adjustments in the copay-
ment 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 will 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 § 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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