91st Congress
2d Session

CONFIDENTIAL COMMITTEE PRINT

STAFF DATA WITH REGARD TO CATASTROPHIC ILLNESS INSURANCE

PREPARED BY THE STAFF

OF THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

RUSSELL B. LONG, *Chairman*

DECEMBER 2, 1970

Printed for the use of the Committee on Finance

U.S. GOVERNMENT PRINTING OFFICE

52-864 WASHINGTON : 1970

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I. Present Situation With Regard To Financing Catastrophic Illness

It is estimated that 20 to 30 percent of the population under age 65 have insurance against the costs of catastrophic illnesses through major medical or comprehensive medical plans.

This type of coverage is quite expensive. Typical premiums are in the range of $150 to $200 per year for the catastrophic coverage.

Comprehensive and major medical plans usually include high maximum benefits and coverage of a wide range of medical expenses, including in-patient hospital benefits, prescription drugs, physicians care, and private duty nursing. Most plans have a deductible which ranges from $100 to $500 to eliminate small medical bills. A coinsurance feature is included to encourage the judicious use of medical care. The usual range of maximum benefits is from $5,000 to $20,000 per spell of illness. Some plans offer higher lifetime maximum benefits of up to $150,000. Most plans have some limitation on coverage relating to mental illness, maternity benefits, and injuries due to accidents.

For those people without some type of catastrophic illness insurance protection, the costs of such an illness are borne by the patient himself, by State and local government welfare and medical care programs, by charity, or by physicians and hospitals through writing off bad debts.

II. Explanation of Senator Long's Proposal

A. Eligibility

All wage earners under 65 who are fully or currently insured under the social security program, their spouses and minor children, and persons under age 65 receiving disability benefits would be eligible for the catastrophic illness protection. This constitutes about 95 percent of all persons under 65.

Persons over 65 would not be covered, as these persons are protected under the medicare program, which in spite of its limit on hospital and extended-care days, is a program with a benefit structure adequate to meet the needs of all but a very small minority of beneficiaries.

The largest noncovered group would be those Federal employees who are not fully or currently insured under social security.

These employees are, however, eligible for both basic and catastrophic health insurance protection under the Federal Employees Health Benefits Act, with the Government paying about 40 percent of the costs of such coverage.

There are a small number of citizens who are still not covered by social security. The majority of these are domestic or agricultural workers who have not met the necessary coverage requirements.

B. Benefits

The benefits which would be provided under the plan would be the same as those currently provided under parts A and B of medicare except that there would be no upper limits on hospital days, ECF days, or home health visits.

Present medicare coverage in part A includes 90 days of hospital care, 100 days of extended care, and 100 home health visits. Part B coverage includes physician services, 100 home health visits, outpatient physical therapy services, and laboratory and X-ray services.

The major benefits excluded from medicare, and consequently excluded from this proposal, are nursing home care, prescription drugs, dental care, and full psychiatric coverage.

C. Deductible and Coinsurance

A deductible of substantial size is a major feature of this plan aimed at protecting against health costs so severe that they have a catastrophic impact on a family's finances. Under the approach, the program would not begin paying until after $2,000 in expenses had been incurred in a year, and the program would not cover the first 60 days of hospital care in a year. A deductible of this size leaves a substantial amount of basic health expenses to be financed directly and leaves substantial room for coverage by private insurance and other resources.

The two deductibles would be separate in order to improve the mesh with private insurance. Under this approach, the plan would begin paying for hospital care after the 60th day, regardless of whether the dollar deductible had been met; and similarly would begin paying after expenses of $2,000 had been incurred, regardless of whether the patient had been hospitalized.

As in part B of medicare, the plan could provide for a deductible carryover feature—applicable to both the dollar deductible and the hospital day deductible—under which expenses incurred (or hospital days used) during the last calendar quarter of a year would also count toward the satisfaction of the deductibles for the ensuing year. For example, an individual admitted to a hospital with a cardiac condition on December 10, 1971, and continuously hospitalized through February 19, 1972, would not, in the absence of the carryover provision, meet the hospital-day deductible unless he were to be hospitalized for at least another 10 days in 1972. With a carryover provision, however, the individual described above would have met the hospital deductible on January 30, 1972.

The plan would pay 80 percent of the cost of covered care and services, after the deductible was triggered, and the patient would pay a coinsurance of 20 percent. The coinsurance feature is intended to limit program costs, and to control the utilization of services since the beneficiary has the obligation to share in the costs of the services which he uses.

D. Internal Utilization and Cost Controls

The medicare program has a number of internal controls which are applied to services rendered under the program. As far as costs are concerned, the program pays audited "reasonable costs" as opposed

to billed charges for institutional services, and "reasonable charges" as opposed to arbitrary fees-for-service for other services.

Insofar as utilization is concerned, the necessity of the services rendered under the medicare program is subject to review by various formal review mechanisms. Additionally, the committee recently approved the "Bennett Amendment" which would make services rendered under medicare and medicaid subject to comprehensive and ongoing review by local Professional Standards Review Organizations.

The actuarial estimates for the cost of this proposal are based on the internal utilization and cost and charge controls of medicare being applied to the new program.

All of the above controls would be applied to reimbursement of expenses for services rendered under the proposed catastrophic illness insurance program.

In addition, the Office of the Inspector General (established under a committee amendment to H.R. 17550) would monitor the program.

E. Administration

The proposal contemplates using the same administrative mechanisms used for the administration of medicare.

Under medicare, intermediaries are used to administer part A of the program. Intermediaries are private insurance companies selected by the providers who are responsible for claims review, auditing of reasonable costs, and fiscal transactions.

Carriers are used to administer part B of the program, and are private insurance companies designated by the Secretary on an area-by-area basis throughout the country. They are responsible for claims review, establishment of reasonable allowances, and claims payment.

The carriers and intermediaries would be used in a parallel fashion in the administration of the program.

The determination of whether or not the deductible expenses had been met would be handled by social security in cooperation with the carriers and intermediaries. The proposed plan envisions establishing a minimum expense amount—for example, $1,000 to $1,500—before individual bills would be accepted. This would protect the administrative agencies from being inundated with paperwork.

The proposal also would encompass use of medicare's quality standards, in that the same conditions of participation which apply to institutions participating in medicare would apply to those participating in the catastrophic program.

F. Financing

The program could be financed on a $9,000 wage base with the following contribution schedule: 1972–74, 0.3 on employees and 0.3 on employers; 1975–79, 0.35; 1980 and after, 0.4. On a $12,000 base the schedule could be: 1972, 0.25; 1973–74, 0.3; 1975–84, 0.35; 1985 and after, 0.4.

Medicare has trust funds and tax rates which are separate from the other social security trust funds and tax rates. Medicare has a hospital insurance trust fund financed by employer and employee contributions, and a supplementary medical insurance trust fund financed half from monthly premiums paid by those who are enrolled in part B and half from general revenues.

The proposed catastrophic program would similarly have a separate trust fund in order to focus public and congressional attention closely on the costs and the adequacy of the financing of the programs.

G. Relationship to Medicaid

Medicaid is the present State-Federal program operative in all but two States that is intended to permit coverage of the basic health needs of categorical assistance recipients and the medically indigent. The benefit structure of medicaid varies from State to State but in general it is a basic rather than a catastrophic benefit package.

In essence, the catastrophic illness insurance program would be supplemental to medicaid with regard to public assistance recipients and the medically indigent in the same way in which it would be supplemental to private insurance for other citizens.

In addition, medicaid will continue to play a substantial role in financing the costs of skilled nursing home care.

H. Persons Affected by the Program

It is estimated that about 2½ percent of the approximately 49 million families in the United States incur medical expenses which would qualify them to receive benefits under the proposed plan.

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