CATASTROPHIC HEALTH INSURANCE AND MEDICAL ASSISTANCE REFORM

HEARINGS

BEFORE THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

NINETY-SIXTH CONGRESS

FIRST SESSION

ON

S. 350, S. 351, S. 748, S. 760

MARCH 27, 28, AND 29, 1979

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CATASTROPHIC HEALTH INSURANCE AND MEDICAL ASSISTANCE REFORM

TUESDAY, MARCH 27, 1979

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, D.C.

The committee met, pursuant to notice, at 10 a.m. in room 2221, Dirksen Senate Office Building, Hon. Russell B. Long, chairman of the subcommittee, presiding.

Present: Senators Long, Talmadge, Byrd of Virginia, Bentsen, Bowen, Dole, Packwood, Danforth, Chafee, and Heinz.

[The press release announcing these hearings and the bills S.350, S. 351, S. 748 and S. 760 follow:]

FINANCE COMMITTEE SCHEDULES HEARINGS ON HEALTH COST CONTAINMENT AND CATASTROPHIC HEALTH INSURANCE PROTECTION

Senator Russell B. Long (D., La.), Chairman of the Senate Committee on Finance, announced today the scheduling of hearings and "markup" sessions in two significant areas of health costs concern.

"Beginning on March 12," said Long, "the Subcommittee on Health, chaired by Senator Herman Talmadge, will hold hearings on pending cost control and reimbursement reform legislation—including the Medicare and Medicaid reform bill which Senators Talmadge and Dole expect to reintroduce shortly."

"At that hearing," Long indicated, "we would anticipate testimony being received concerning the Administration's proposal to constrain increases in hospital revenues generally—not just for Medicare and Medicaid."

"I expect that the full Finance Committee would, during the week of March 19 engage in a markup of health care cost control legislation," said Long.

"During the last week in March," stated the Committee Chairman, "we will hear testimony on pending catastrophic health insurance and medical assistance reform proposals (S. 350 and S. 351)." That would include, Long noted, the catastrophic health insurance bill which Senator Robert Dole is expected to introduce in the near future.

The Louisiana Democrat anticipates scheduling full Committee markup sessions on catastrophic health insurance and related provisions to take place prior to the Congressional Easter recess.

Senator Long stressed that those requesting an opportunity to testify should specify whether they wish to testify on: (a) the hearing on cost controls; or (b) the hearing on catastrophic health insurance.

The Chairman said that because an unusually large number of requests to testify are anticipated, the Committee will not be able to schedule all those who request to testify. Those persons who are not scheduled to appear in person to present oral testimony are invited to submit written statements. The Chairman emphasized that the views presented in such written statements will be as carefully considered by the Committee as if they were presented orally.

Witnesses who desire to testify at the hearings should submit a written request to Michael Stern, Staff Director, Committee on Finance, Room 2227 Dirksen Senate Office Building, Washington, D.C. 20510 by no later than the close of business on March 1, 1979 in the case of cost containment and March 15, 1979 in the case of catastrophic health insurance.

All parties who are scheduled to testify orally are urged to comply with the guidelines below:

Notification of witnesses.—Parties who have submitted written requests to testify will be notified as soon as possible as to the time and date they are scheduled to appear. Once a witness has been advised of the time and date of his appearance, rescheduling will not be permitted. If a witness is unable to testify at the time he is scheduled to appear, he may file a written statement for the record of the hearing.

Consolidated testimony.—The Chairman also stated that the Committee urges all witnesses who have a common position or with the same general interest to consolidate their testimony and designate a single spokesman to present their common viewpoint orally to the Committee. This procedure will enable the Committee to receive a wider expression of views on the total bill than it might otherwise obtain. The Chairman praised witnesses who in the past have combined their statements in order to conserve the time of the Committee.

Panel groups.—Groups with similar viewpoints but who cannot designate a single spokesman will be encouraged to form panels. Each panelist will be required to restrict his or her comments to no longer than a 10-minute summation of the principal points of the written statements. The panelists are urged to avoid repetition whenever possible in their presentations.

Legislative Reorganization Act.—The Chairman observed that the Legislative Reorganization Act of 1946, as amended, requires all witnesses appearing before the Committees of Congress to file in advance written statements of their proposed testimony, and to limit their oral presentations to brief summaries of their argument. The statute also directs the staff of each Committee to prepare digests of all testimony for the use of Committee Members.

Chairman Long stated that in light of this statute and in view of the large number of witnesses who desire to appear before the Committee in the limited time available for the hearing, all witnesses must comply with the following rules:

(1) All statements must be filed with the Committee at least 1 day in advance of the day on which the witness is to appear. If a witness is scheduled to testify on a Monday or Tuesday, he must file his written statement with the Committee by the Friday preceding his appearance.

(2) All witnesses must include with their written statements a summary of the principal points included in the statement.

(3) The written statements must be typed on letter-size paper (not legal size) and at least 100 copies must be submitted to the Committee.

(4) Witnesses are not to read their written statements to the Committee, but are to confine their 10-minute oral presentations to a summary of the points included in the statement.

(5) Not more than 10 minutes will be allowed for the oral summary.

Witnesses who fail to comply with these rules will forfeit their privilege to testify.

Written statements.—Witnesses who are not scheduled for oral presentation, and others who desire to present a statement to the Committee, are urged to prepare a written position of their views for submission and inclusion in the record of the hearings. He emphasized that these written statements would also be digested by the staff for presentation to the Committee during its executive sessions and that they would receive the same careful consideration by the Committee as though they had been delivered orally. These written statements should be submitted to Michael Stern, Staff Director, Committee on Finance, Room 2227 Dirksen Senate Office Building by March 11, 1979 in the case of cost containment and April 5, 1979 in the case of catastrophic health insurance.

96TH CONGRESS
1ST SESSION

S. 350

To amend the Social Security Act by adding thereto a new title XXI which will provide insurance against the costs of catastrophic illness, by replacing the medicaid program with a Federal medical assistance plan for low-income people, and by adding a new title XV thereto which will encourage and facilitate the availability, through private insurance carriers, of basic health insurance at reasonable premium charges, and for other purposes.

IN THE SENATE OF THE UNITED STATES

FEBRUARY 6 (legislative day, JANUARY 15), 1979

Mr. LONG (for himself, Mr. RIBICOFF, Mr. TALMADGE, Mr. YOUNG, Mr. MELCHER, Mr. CANNON, Mr. INOUYE, Mr. STAFFORD, and Mr. HATFIELD) introduced the following bill; which was read twice and referred to the Committee on Finance

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A BILL

To amend the Social Security Act by adding thereto a new title XXI which will provide insurance against the costs of catastrophic illness, by replacing the medicaid program with a Federal medical assistance plan for low-income people, and by adding a new title XV thereto which will encourage and facilitate the availability, through private insurance carriers, of basic health insurance at reasonable premium charges, and for other purposes.

II—E●

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*
3 That this Act may be cited as the "Catastrophic Health In-
4 surance and Medical Assistance Reform Act".

5 TITLE I—CATASTROPHIC ILLNESS INSURANCE

6 AMENDMENTS TO SOCIAL SECURITY ACT

7 SEC. 101. (a) The Social Security Act is amended by
8 adding after title XX the following new title:

9 "TITLE XXI—CATASTROPHIC HEALTH
10 INSURANCE PROGRAM

11 "PURPOSE OF TITLE

12 "SEC. 2101. The insurance program established by this
13 title is designed to provide protection to all individuals who
14 are citizens or permanent residents of the United States
15 against the costs of high-cost catastrophic illness. Each such
16 individual will be provided such protection either under the
17 Federal plan established by part A of this title, or under an
18 employer plan or a self-employed plan approved under part B
19 of this title.

20 "PART A—FEDERAL PLAN

21 "ELIGIBLE INDIVIDUALS

22 "SEC. 2102. (a) Every individual who—
23 "(1) is a resident of the United States, and
24 "(2) is a citizen of, or an alien lawfully admitted
25 for permanent residence in, the United States, or an

1 alien otherwise permanently residing in the United
2 States under color of law (including any alien who is
3 lawfully present in the United States as a result of the
4 application of the provisions of section 203(a)(7) or sec-
5 tion 212(d)(5) of the Immigration and Nationality Act),
6 shall (subject to section 2107) be entitled to catastrophic
7 health insurance benefits provided by this part for any period
8 which commences on or after January 1, 1981, and with
9 respect to which he is not covered by an employer plan or a
10 self-employed plan approved under part B.

11 "(b) For purposes of subsection (a), entitlement of an
12 individual to catastrophic health insurance benefits under this
13 part shall consist of entitlement to have payment made,
14 under and subject to the limitations in this title, to him or on
15 his behalf for the services described in section 2103(a) which
16 are furnished to him in the United States (or outside the
17 United States in the case of services specified in section
18 1814(f)).

19 "SCOPE OF BENEFITS

20 "SEC. 2103. (a) The benefits provided to an individual
21 by the insurance program established by this part shall con-
22 sist of entitlement to have payment made (subject to the pro-
23 visions of this part) on his behalf or to him for—

24 "(1) hospital and related services (as defined in
25 subsection (c)(1)) which are furnished to such individual

1 during a period with respect to which he has met the
2 deductible imposed by section 2104(b), and
3 "(2) medical and other health services (as defined
4 in subsection (c)(2)) which are furnished to such indi-
5 vidual during a period with respect to which he has
6 met the deductible imposed by section 2104(c).
7 "(b) Payment authorized under this part for any service
8 covered hereunder shall be made to the person to whom pay-
9 ment for such service would be made under title XVIII, if
10 such service were furnished to an individual who was covered
11 therefor under title XVIII.
12 "(c)(1) The term 'hospital and related services' means—
13 "(A) inpatient hospital services (as defined in sec-
14 tion 1861(b)),
15 "(B) post-hospital extended care services (as de-
16 fined in section 1861(i)), and
17 "(C) home health services (as defined in section
18 1861(m)).
19 "(2) The term 'medical and other health services'
20 means—
21 "(A) medical and other health services (as defined
22 in section 1861(s)),
23 "(B) home health services (as defined in section
24 1861(m)),

1 "(C) outpatient physical therapy services (as de-
2 fined in section 1861(p)), and
3 "(D) rural health clinic services (as defined in sec-
4 tion 1861(aa)).
5 "(d) Notwithstanding the preceding provisions of this
6 section, no payment may be made and no deductible shall be
7 incurred with respect to—
8 "(1) expenses incurred for items or services, if
9 pursuant to section 1862 (a), (b), or (d) payment may
10 not be made with respect to such items or services
11 under title XVIII, or
12 "(2) expenses incurred for post-hospital extended care
13 services furnished to an individual on any day during any
14 calendar year, if, prior to such day, there have been furnished
15 to such individual for 100 days during such year such serv-
16 ices with respect to which benefits under this part are pay-
17 able.
18 "PAYMENT AND DEDUCTIBLE
19 "SEC. 2104. (a)(1) Payment of benefits under this part
20 with respect to expenses incurred by an insured individual
21 shall be made from the Federal Catastrophic Health Insur-
22 ance Trust Fund.
23 "(2) For purposes of payment of benefits under this part
24 with respect to expenses incurred for health services fur-

1 nished to any insured individual, there shall be taken into
2 account—
3 "(A) in case of expenses incurred for hospital and
4 related services (as defined in section 2103(c)(1)), only
5 so much of such expenses as are incurred for such
6 services furnished during a period with respect to
7 which the deductible imposed by subsection (b) is met,
8 and
9 "(B) in case of expenses incurred for medical and
10 other health services (as defined in section 2103(c)(2)),
11 only so much of such expenses as are incurred for such
12 services furnished during a period with respect to
13 which the deductible imposed by subsection (c) is met;
14 and, with respect to the services to which the expenses so
15 taken into account are attributable, there shall be paid
16 (except where inconsistent with the provisions or purposes of
17 this part) an amount which shall be equal to (and determined
18 in the same manner as) the amount which would have been
19 payable for such service under title XVIII in the case of an
20 individual entitled to have payment made with respect there-
21 to under such title (as determined without regard to any pro-
22 vision of such title relating to deductibles or copayments).
23 "(b) The deductible imposed by this subsection with re-
24 spect to expenses incurred for hospital and related services

1 (as defined in section 2103(c)(1)) shall be met by an insured
2 individual—
3 "(1) for the period, in the calendar year, which
4 commences on the day following the 60th day, during
5 the calendar year and the last 3 months of the preced-
6 ing calendar year, in which such individual received in-
7 patient hospital services; and
8 "(2) for the period, in the calendar year, which is
9 prior to the first consecutive 90-day period therein in
10 which such individual is neither an inpatient in a hospi-
11 tal nor an inpatient in a skilled nursing facility, but
12 only if the first day for which such services in the cal-
13 endar year occurs not later than 90 days after the last
14 day with respect to which benefits were payable under
15 this part on account of inpatient hospital services fur-
16 nished to him in the preceding calendar year.
17 "(c)(1) The deductible imposed by this subsection with
18 respect to expenses incurred for medical and other health
19 services (as defined in section 2103(c)(2)) shall be met by an
20 insured individual—
21 "(A) for the period, in the calendar year, which
22 occurs after such individual has incurred, during such
23 year and the last 3 months of the preceding calendar
24 year, expenses (including expenses deemed under para-
25 graph (2) to be incurred by him, but excluding amounts

1 required to be excluded under paragraph (3)) for such
2 services of $2,000 (or, if higher, the amount deter-
3 mined under paragraph (4)); and
4 "(B) for the period, in the calendar year, which
5 occurs prior to the first 90-day period therein during
6 which such individual incurs for such services expenses
7 (including expenses deemed under paragraph (2) to be
8 incurred by him) the aggregate of which is less than
9 $500 (or, if greater, the amount determined under
10 paragraph (5)), but only if (i) during the last 3 months
11 of the preceding calendar year, such individual incurred
12 for such services expenses (including expenses deemed
13 under paragraph (2) to be incurred by the individual) of
14 at least $500 (or, if greater, the amount determined
15 under paragraph (5)), and (ii) such individual had met
16 (by reason of the application of clause (A)) for a period
17 in the preceding calendar year the deductible imposed
18 by this paragraph.
19 "(2)(A) In determining, for purposes of clauses (A) and
20 (B) of paragraph (1), the amount of expenses incurred by an
21 individual for medical and other health services furnished
22 during any period, there shall be deemed to have been in-
23 curred by such individual any expenses incurred for such
24 services furnished during such period to each other member
25 of such individual's family, but only if such other member is

1 (i) the spouse of the individual, (ii) a dependent of such indi-
2 vidual, (iii) the person (or the spouse of the person) of whom
3 such individual is a dependent, or (iv) a person who is a de-
4 pendent of the same person of whom such individual is a
5 dependent.

6 "(B) For purposes of subparagraph (A)—

7 "(i) the term 'dependent' shall have the meaning
8 assigned to it by regulations of the Secretary;

9 "(ii) the term 'family' means two or more individ-
10 uals who are (I) related by blood, marriage or adop-
11 tion, and (II) living in a place of residence maintained
12 by one or more of them as his or their own home (and
13 for purposes of this clause, a child under age 22 who is
14 absent from home for the purpose of attending an edu-
15 cational insitution as a full-time student shall be
16 deemed while so absent to be living in such place of
17 residence); and

18 "(iii) the term 'member', when used in reference
19 to a family means an individual described in clause (ii).

20 "(3) In determining, for purposes of paragraph (1)(A),
21 the amount of expenses incurred (or deemed to be incurred)
22 by an individual for medical and other health services in any
23 calendar year, there shall be disregarded all amounts in
24 excess of $500 incurred in connection with the treatment of

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1 mental, psychoneurotic, or personality disorders of such indi-
2 vidual.
3 "(4) The Secretary shall, between July 1 and October 1
4 of 1981 and of each year thereafter, determine and promul-
5 gate the deductible which shall be applicable for purposes of
6 paragraph (1)(A) in the succeeding calendar year. Such de-
7 ductible shall be equal to whichever of the following is the
8 higher:
9 "(A) $2,000, or
10 "(B) $2,000 multiplied by the ratio of the compo-
11 nent of the Consumer Price Index, prepared by the
12 Department of Labor for June of the year in which
13 such determination is made and promulgated, which
14 represents fees for physician services to such compo-
15 nent of such Consumer Price Index for the month of
16 June 1980, with such product, if not a multiple of
17 $100, being rounded to the nearest multiple of $100.
18 "(5) The Secretary shall between July 1 and October of
19 1981 and of each year thereafter, determine and promulgate
20 the amount which shall be applicable for purposes of para-
21 graph (1)(B) in the succeeding calendar year. Such amount
22 shall be equal to whichever of the following is the higher:
23 "(A) $500, or
24 "(B) $500 multiplied by the ratio of the compo-
25 nent of the Consumer Price Index, prepared by the

1 Department of Labor for June of the year in which
2 such determination is made and promulgated, which
3 represents fees for physician services to such compo-
4 nent of such Consumer Price Index for the month of
5 June 1980, with such product, if not a multiple of $50,
6 being rounded to the nearest multiple of $50.
7 "(e)(1) Payment for services under this title shall also be
8 subject to the limitations described in section 1812(e) and
9 section 1833(e).
10 "(2) payment under this part with respect to expenses
11 incurred in connection with the treatment of mental, psycho-
12 neurotic, and personality disorders shall not be made unless
13 such treatment consists of 'mental health care services' (as
14 defined in paragraph (3)).
15 "(3) As used in paragraph (2) the term 'mental health
16 care services' includes only care and services for mental con-
17 ditions—
18 "(A) which, if provided on an inpatient basis, con-
19 sist of a course of active care and treatment provided
20 in and by an accredited medical institution (as deter-
21 mined by the Secretary),
22 "(B) which, if provided on a partial hospitalization
23 basis, are provided (i) in and by an accredited medical
24 institution (as determined by the Secretary), or (ii) in
25 and by a qualified community mental health center (as

1 determined in accordance with regulations of the
2 Secretary),
3 "(C) which, if provided on an outpatient basis,
4 are—
5 "(i) provided by a qualified community
6 mental health center (as determined in accordance
7 with regulations of the Secretary), or
8 "(ii) provided by a psychiatrist;
9 except that such term does not include any outpatient serv-
10 ices provided by a psychiatrist, during a 12-month period, for
11 purposes of diagnosis or treatment of acute psychosis in
12 excess of (I) five visits, plus (II) such additional visits as shall
13 have been approved in advance by an appropriate profession-
14 al review mechanism upon a finding that, in the absence of
15 such additional visits, the patient will require institutional
16 care.
17 "(f)(1) Payment under this part with respect to expenses
18 incurred for blood, blood products, and procedures and
19 courses of treatment which are unusually extensive or com-
20 plex shall be subject to standards and criteria imposed by the
21 Secretary pursuant to paragraph (2).
22 "(2) The Secretary shall by regulations prescribe stand-
23 ards and criteria designed to assure that services consisting
24 of the furnishing of blood or blood products or the application
25 of procedures or courses of treatment, referred to in para-

1 graph (1), for which payment may be made under this part
2 will be provided only when, and to the extent that, such serv-
3 ices are appropriate to the health care needs of the patient.
4 "(g) Payment under this part may not be made for ex-
5 tended care services furnished to an individual during any
6 period for which such individual is entitled to hospital insur-
7 ance benefits under part A of title XVIII.

8 "CONDITIONS OF AND LIMITATIONS ON PAYMENT FOR
9 SERVICES

10 "SEC. 2105. (a) To the extent that payment may be
11 made for services described in section 2103(a)(1), the provi-
12 sions of sections 1814, 1815, 1816, 1833(f), and 1835 shall
13 apply.
14 (b) To the extent that payment may be made for serv-
15 ices described in section 2103(a)(2), the provisions of section
16 1842 shall apply.

17 "APPLICABILITY OF CERTAIN PROVISIONS OF, OR
18 RELATING TO, TITLE XVIII

19 "SEC. 2106. (a) The provisions of section 1861 (except
20 subsections (a) and (y)), 1866, 1867, 1869, 1870, 1871,
21 1872, 1873, 1874, 1875, 1876, 1877, 1878, and 1879 shall
22 apply with respect to this part to the same extent as they are
23 applicable with respect to title XVIII.
24 "(b) The provisions of section 402(a) of the Social Secu-
25 rity Amendments of 1967 and the provisions of section

1 222(a) of the Social Security Amendments of 1972 shall be
2 applicable to this part to the same extent as they are applica-
3 ble to title XVIII.

4 "TREATMENT OF BENEFITS UNDER OTHER PROGRAMS

5 "SEC. 2107. Any amount otherwise payable under this
6 part with respect to any item or service furnished to an indi-
7 vidual shall not be denied or reduced because a benefit with
8 respect to such item or service has been paid or is payable
9 under any other public or private insurance or health benefits
10 plan. Notwithstanding any other provision of law (other than
11 section 2104(g)), payment with respect to any item or service
12 furnished to any individual shall not be made under the Medi-
13 cal Assistance Plan for Low-Income People established by
14 title XIX or the insurance program established by part A or
15 B of title XVIII, if such individual is (or, upon filing a proper
16 claim, would be) entitled to have payment made under this
17 part with respect to such item or service.

18 "CONTRIBUTIONS WITH RESPECT TO STATE AND LOCAL
19 EMPLOYEES; APPROVED STATE LAWS

20 "SEC. 2108. (a) Contributions for the financial support
21 of the catastrophic health insurance program established by
22 this part shall be made by employers which are States (or
23 political subdivisions thereof) in the manner prescribed under
24 a State law approved by the Secretary of the Treasury under
25 subsection (b).

1 "(b)(1) The Secretary of the Treasury shall approve a
2 State law for purposes of this section only if such law—
3 "(A) provides that the State will pay into the
4 Treasury, with respect to wages paid to employees of
5 the State and employees of all political subdivisions of
6 the State, amounts equal to the amounts which such
7 State would be liable to pay with respect to the wages
8 of such employees under the catastrophic health insur-
9 ance protection tax imposed by section 3111(c) of the
10 Internal Revenue Code of 1954 if such State were a
11 private employer and all such employees were em-
12 ployed by it,
13 "(B) provides that any amounts so payable shall
14 be paid at the same time and subject to the same con-
15 ditions as taxes imposed by such section 3111(c) in the
16 case of a private employer,
17 "(C) is in such form and contains such other pro-
18 visions as the Secretary of the Treasury shall by regu-
19 lations provide, and
20 "(D) becomes effective on January 1, 1981.
21 "(2) At the earliest practicable date after the State law
22 of any State has been approved by the Secretary of the
23 Treasury, he shall certify to the Secretary of Health, Educa-
24 tion, and Welfare that such State law has been approved.

1 "(3) If the Secretary of the Treasury finds, after reason-
2 able notice and opportunity for hearing to a State, that—
3 "(A) the State law of such State, theretofore ap-
4 proved by him, has been repealed, or amended so that
5 it no longer meets the requirements imposed by para-
6 graph (1), or
7 "(B) the State has not substantially complied with
8 its obligations to make contributions into the Treasury
9 in accordance with the requirements imposed under
10 paragraph (1),
11 he shall withdraw the certification of such State law thereto-
12 fore approved by him and shall so notify the Secretary of
13 Health, Education, and Welfare.
14 "(c) If, for any period of time after December 31, 1981,
15 a State does not pay in full to the Treasury the amounts
16 specified in subsection (b)(1)(A), the Secretary of Health,
17 Education, and Welfare shall reduce payments otherwise
18 payable to such State under any other provisions of this Act
19 by the amount of such underpayment (including interest
20 thereon equal to the average of the rates of interest, from the
21 date due until paid, on obligations issued for purchase by the
22 Federal Catastrophic Health Insurance Trust Fund).

1 "FEDERAL CATASTROPHIC HEALTH INSURANCE TRUST
2 FUND

3 "SEC. 2109. (a) There is hereby created on the books of
4 the Treasury of the United States a trust fund to be known
5 as the Federal Catastrophic Health Insurance Trust Fund
6 (hereinafter in this section referred to as the 'trust fund'). The
7 trust fund shall consist of such amounts as may be deposited
8 in, or appropriated to, such fund as provided in this part.
9 There are hereby appropriated to the trust fund for the fiscal
10 year ending September 30, 1981, and for each fiscal year
11 thereafter, out of any moneys in the Treasury not otherwise
12 appropriated, amounts equivalent to 100 per centum of—
13 "(1) the taxes imposed by section 3111(c) of the
14 Internal Revenue Code of 1954 with respect to wages
15 reported to the Secretary of the Treasury or his dele-
16 gate pursuant to subtitle F of such Code after Decem-
17 ber 31, 1976, as determined by the Secretary of the
18 Treasury by applying the applicable rates of tax under
19 such sections to such wages, which wages shall be cer-
20 tified by the Secretary of Health, Education, and Wel-
21 fare on the basis of records of wages established and
22 maintained by the Secretary of Health, Education, and
23 Welfare in accordance with such reports;
24 "(2) the taxes imposed by section 1401(c) of the
25 Internal Revenue Code of 1954 with respect to self-

1 employment income reported to the Secretary of the
2 Treasury or his delegates on tax-returns under subtitle
3 F of such Code, as determined by the Secretary of the
4 Treasury by applying the applicable rate of tax under
5 such section to such self-employment income, which
6 self-employment income shall be certified by the Secre-
7 tary of Health, Education, and Welfare on the basis of
8 records of self-employment established and maintained
9 by the Secretary of Health, Education, and Welfare in
10 accordance with such return; and
11 "(3) the contributions made by States pursuant to
12 State laws approved under section 2108.
13 The amount appropriated by the preceding sentence shall be
14 transferred from time to time from the general fund in the
15 Treasury to the trust fund, such amounts to be determined on
16 the basis of estimates by the Secretary of the Treasury of the
17 taxes, specified in the preceding sentence, paid to or deposit-
18 ed into the Treasury; and proper adjustments shall be made
19 in amounts subsequently transferred to the extent prior esti-
20 mates were in excess of or were less than taxes specified in
21 such sentence.
22 "(b) With respect to the trust fund, there is hereby cre-
23 ated a body to be known as the 'board of trustees of the trust
24 fund' (hereinafter in this section referred to as the 'board of
25 trustees'), composed of the Secretary of the Treasury, the

1 Secretary of Labor, and the Secretary of Health, Education,
2 and Welfare, all ex officio. The Secretary of the Treasury
3 shall be the Managing Trustee of the board of trustees (here-
4 inafter in this section referred to as the 'Managing Trustee').
5 The Administrator of the Health Care Financing Administra-
6 tion shall serve as the secretary of the board of trustees. The
7 board of trustees shall meet not less frequently than once
8 each calendar year. It shall be the duty of the board of trust-
9 ees to—

10 "(1) hold the trust fund;

11 "(2) report to the Congress not later than the first
12 day of April of each year on the operation and status
13 of the trust fund during the preceding fiscal year and
14 on its expected operation and status during the current
15 fiscal year and the next 2 fiscal years;

16 "(3) report immediately to the Congress whenever
17 the board is of the opinion that the amount of the trust
18 fund is unduly small; and

19 "(4) review the general policies followed in man-
20 aging the trust fund, and recommend changes in such
21 policies, including necessary changes in the provisions
22 of law which govern the way in which the trust fund is
23 to be managed.

24 The report provided for in paragraph (2) shall include a state-
25 ment of the assets of, and the disbursements made from, the

1 trust fund during the preceding fiscal year, an estimate of the
2 expected income to, and disbursements to be made from, the
3 trust fund during the current fiscal year and each of the next
4 2 fiscal years, and a statement of the actuarial status of the
5 trust fund. Such report shall be printed as a House document
6 of the session of the Congress to which the report is made.
7 "(c) It shall be the duty of the Managing Trustee to
8 invest such portion of the trust fund as is not, in his judg-
9 ment, required to meet current withdrawals. Such invest-
10 ments may be made only in interest-bearing obligations of the
11 United States or in obligations guaranteed as to both princi-
12 pal and interest by the United States. For such purpose such
13 obligations may be acquired (1) on original issue at the issue
14 price, or (2) by purchase of outstanding obligations at the
15 market price. The purpose for which obligations of the
16 United States may be issued under the Second Liberty Bond
17 Act, as amended, are hereby extended to authorize the issu-
18 ance at par of public-debt obligations for purchase by the
19 trust fund. Such obligations issued for purchase by the trust
20 fund shall have maturities fixed with due regard for the needs
21 of the trust fund and shall bear interest at a rate equal to the
22 average market yield (computed by the Managing Trustee on
23 the basis of market quotations as of the end of the calendar
24 month next preceding the date of such issue) on all marketa-
25 ble interest-bearing obligations of the United States then

1 forming a part of the public debt which are not due or call-
2 able until after the expiration of 4 years from the end of such
3 calendar month; except that where such average market
4 yield is not a multiple of one-eighth of 1 per centum, the rate
5 of interest on such obligations shall be the multiple of one-
6 eighth of 1 per centum nearest such market yield. The Man-
7 aging Trustee may purchase other interest-bearing obliga-
8 tions of the United States or obligations guaranteed as to
9 both principal and interest by the United States, on original
10 issue or at the market price, only where he determines that
11 the purchase of such other obligations is in the public inter-
12 est.

13 "(d) Any obligations acquired by the trust fund (except
14 public debt obligations issued exclusively to the trust fund)
15 may be sold by the Managing Trustee at the market price,
16 and such public debt obligations may be redeemed at par plus
17 accrued interest.

18 "(e) The interest on, and the proceeds from the sale or
19 redemption of, any obligations held in the trust fund shall be
20 credited to and form a part of the trust fund.

21 "(f) There are authorized to be appropriated to the trust
22 fund from time to time such sums as the Secretary of Health,
23 Education, and Welfare deems necessary for any fiscal year,
24 on account of—

1 "(1) payment made or to be made during such
2 fiscal year from the trust fund with respect to individ-
3 uals who are entitled to benefits under part A of title
4 XVIII, or are eligible for health benefits provided
5 under title XIX,
6 "(2) the administrative expenses attributable to
7 providing benefits under this part to individuals re-
8 ferred to in paragraph (1), and
9 "(3) any loss in interest to the trust fund resulting
10 from the payment of such amounts,
11 in order to place the trust fund in the same position at the
12 end of such fiscal year in which it would have been if the
13 individuals referred to in paragraph (1) were not entitled to
14 the benefits provided under this part.
15 "(g) There shall be transferred periodically (but not less
16 often than once each fiscal year) to the trust fund from the
17 Federal Old-Age and Survivors Insurance Trust Fund and
18 from the Federal Disability Insurance Trust Fund amounts
19 equivalent to the amounts not previously so transferred
20 which the Secretary of Health, Education, and Welfare shall
21 have certified as overpayments pursuant to section 1870(b) of
22 this Act as made applicable to this title by section 2106.
23 "(h) The Managing Trustee shall also pay from time to
24 time from the Trust Fund such amounts as the Secretary of
25 Health, Education, and Welfare certifies are necessary to

1 make the payments provided for by this part, and the pay-
2 ments with respect to administrative expenses in accordance
3 with section 201(g)(1).
4 (i) There is authorized to be appropriated, out of any
5 moneys in the Treasury not otherwise appropriated, such re-
6 payable advances (without interest) as may be required to
7 assure prompt payment of benefits and administrative ex-
8 penses under this title and to provide a contingency reserve.
9 Such advances to the extent necessary shall be made availa-
10 ble through calendar year 1983.
11 "MEANING OF 'STATE', 'UNITED STATES'
12 "SEC. 2110. As used in this part—
13 "(a) the term 'State' includes the District of Co-
14 lumbia, the Commonwealth of Puerto Rico, the Virgin
15 Islands, Guam, and American Samoa, and
16 "(b) the term 'United States', when used in a geo-
17 graphical sense, means the States, the District of Co-
18 lumbia, the Commonwealth of Puerto Rico, the Virgin
19 Islands, Guam, American Samoa, and the Trust Terri-
20 tory of the Pacific Islands.
21 "PART B—EMPLOYER PLANS, AND SELF-EMPLOYED
22 PLANS
23 "EFFECT OF COVERAGE
24 "SEC. 2120. Any individual who would otherwise be
25 eligible for benefits under part A of this title shall not be

1 eligible for such benefits during any period for which he is
2 covered under an employer plan or a self-employed plan ap-
3 proved by the Secretary under this part, but shall instead be
4 entitled to the benefits provided under such approved plan.

5 "DEFINITIONS

6 "SEC. 2121. For purposes of this part—
7 "(a) The term 'employer plan' means—
8 "(1) an insurance policy, contract, or other ar-
9 rangement entered into between an employer and a
10 carrier under which the carrier, in consideration of pre-
11 miums or other periodic payments, undertakes to pro-
12 vide, pay for, or reimburse the costs of, health services
13 received by those of the employer's employees (and
14 those of the family members of such employees) who
15 are covered by the plan, or
16 "(2) a plan under which the employer, as a selfin-
17 sured employer (as defined in subsection (d)), under-
18 takes to provide, pay for, or reimburse the costs of,
19 health care services received by those of the employ-
20 er's employees (and those of the family members of
21 such employees) who are covered by the plan.
22 "(b) The term 'self-employed plan' means an insurance
23 policy, contract, or other arrangement entered into between a
24 self-employed individual and a carrier under which such car-
25 rier, in consideration of premiums or other periodic pay-

1 ments, undertakes to provide, pay for, or reimburse the costs
2 of, health services received by such individual (and those of
3 the family members of such individual who are covered by
4 the plan).

5 "(c) The term 'carrier' means a voluntary association,
6 corporation, partnership, or other nongovernmental organiza-
7 tion which is engaged in providing, paying for, or reimburs-
8 ing the costs of, health services under insurance policies or
9 contracts, medical or hospital service agreements, member-
10 ship or subscription contracts, or similar arrangements, in
11 consideration of premiums or other periodic charges payable
12 to the carrier.

13 "(d) The term 'self-insured employer' means an employ-
14 er who (either through outside administrators, including car-
15 riers, or otherwise) engages, without insurance arrangements
16 with a carrier, to provide, pay for, or reimburse the costs of,
17 health services for some of all of his employees.

18 "(e) The term 'employer' includes a State (or political
19 subdivision thereof) and the Federal Government.

20 "APPROVAL OF PLANS

21 "SEC. 2122. (a)(1) In order for an employer plan or a
22 self-employed plan to be approved by the Secretary under
23 this part—

24 "(A) such plan, in the case of any plan other than
25 an employer plan of a self-insured employer, must be a

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1 plan offered by a carrier which is approved by the Sec-
2 retary pursuant to subsection (c);
3 "(B) the coverage provided under such plan must
4 include, but shall not be limited to, a package of bene-
5 fits, which (in terms of scope of benefits and the condi-
6 tions of payment thereof) is the same as that provided
7 by the Federal catastrophic health insurance benefits
8 plan established by part A; except that the requirement
9 imposed by this clause shall not be construed to (i)
10 make applicable to the plan (or its administration) the
11 provisions of sections 1862 (b) or (d), 1815, 1816,
12 1842, 1866, 1869, 1870, 1972, or 2104(a)(1), and the
13 carrier offering such plan may utilize, in the adminis-
14 tration of the plan, payment and provider arrangements
15 of the kind which are employed by it in connection
16 with the administration of health insurance policies or
17 plans which are not approved under this part, (ii) re-
18 quire that such plan provide coverage for any occupa-
19 tional injury or disease or for any item or service for
20 which any benefit is payable under a workmen's com-
21 pensation law of the United States or a State, and (iii)
22 preclude the plan from making the benefits offered
23 thereunder subject to provision for coordination of
24 benefits provided under other plans (including the Fed-
25 eral plan established under part A), if such provision

1 for coordination of benefits is approved by the Secre-
2 tary as being consistent with prevailing practice within
3 the health insurance industry for the coordination of
4 benefits;
5 "(C) such plan (in the case of an employer plan)
6 (i) must cover all of the employees of such employer
7 (other than employees who perform service for less
8 than 25 hours per week, temporary employees or em-
9 ployees who are entitled, under section 226, to hospital
10 insurance benefits under part A of title XVIII), and (ii)
11 may, at the option of the employer, cover all of the
12 employees of the employer;
13 "(D) such plan must cover the spouse and de-
14 pendent family members of any employee (in the case
15 of an employer plan) or self-employed individual (in the
16 case of a self-employed plan) covered by the plan;
17 "(E) such plan (in the case of an employer plan)
18 must not require or permit any financial participation
19 in the cost of the plan by any individual covered there-
20 under;
21 "(F) such plan (in the case of an employer plan)
22 must provide that coverage (in the case of a new em-
23 ployee, his spouse, and dependent family members) will
24 begin not later than the first day of the first calendar
25 month which commences more than 30 days after the

1 date the employee's employment commences, and that
2 coverage of an employee (and of members of his family
3 who are covered by the plan) will not be terminated by
4 reason of the separation of the employee from his em-
5 ployment by such employer prior to 90 days after the
6 date of such separation, or (if earlier) the first day after
7 the date on which such employee first obtains coverage
8 under another employer plan approved under this part;
9 "(G) such plan, in the case of any employer plan
10 (other than an employer plan of a self-insured employ-
11 er) must be a plan under which there are available to
12 the employer arrangements for the pooling of risks
13 under the plan by which his employees are covered
14 and under the plans by which employees of other em-
15 ployers are covered so that the premium or other peri-
16 odic charge payable therefor to the carrier are deter-
17 mined on a class basis either (i) without regard to the
18 payments or reimbursements for health services re-
19 ceived by the employer's employees (and family mem-
20 bers of such employees) covered by the plan, or (ii)
21 without regard to the payments or reimbursements for
22 health services received by the employer's employees
23 (and family members of such employees) in excess of a
24 specified amount agreed to between the employer and
25 the carrier of payments or reimbursements as to any

1 one individual or family and under which the premium
2 or other periodic charge made under such arrangement
3 is specifically identified to the purchaser;

4 "(H) the premium or other periodic charge im-
5 posed for the pooling arrangements described in clause
6 (G) shall (in case of any plan other than an employer
7 plan of a self-insured employer) be stated, to the em-
8 ployer or self-employed individual subscribing to the
9 plan, in annual (or more frequent) billings or renewal
10 notices which shall be expressed in such a manner as
11 to facilitate a comparison of such premium or charge
12 with the amount allowable on account of such plan as
13 a tax credit under section 1403 or section 3114, as the
14 case may be, of the Internal Revenue Code of 1954.

15 "(2) In any case where, pursuant to one or more collec-
16 tive bargaining agreements, health insurance responsibilities
17 for one or more groups (but not all) of the employees of an
18 employer have been placed with a labor organization, the
19 Secretary may waive the requirement imposed by paragraph
20 (1)(C)(i) with respect to such group or groups of the employ-
21 er's employees for such period as may be necessary to enable
22 the employer and the labor organizations with which he has
23 collective bargaining agreements a reasonable opportunity so
24 to arrange health insurance coverage of the employees of the
25 employer as to meet the requirement imposed by paragraph

1 (1)(C)(i). The Secretary shall provide technical assistance to,
2 and recommend procedures to be employed by, such em-
3 ployer and such organizations in meeting such requirement.
4 "(3) Approval of the Secretary of any plan (other than
5 an employer plan of a self-insured employer) shall not be
6 denied because such plan is provided under arrangements
7 with carriers involving the plans of two or more employers in
8 the same industry or under a trust or trade association ar-
9 rangement.
10 "(b)(1) No employer plan or self-employed plan shall be
11 approved by the Secretary except on the basis of an applica-
12 tion for approval submitted by the employer or self-employed
13 individual (or by a carrier on such person's behalf) to the
14 Secretary, which application shall be in such form and con-
15 tain such information and assurances as the Secretary shall
16 by regulations require.
17 "(2) Applications for approval may contain provision for
18 recommendations of approval, by the insurance department
19 or similar agency of the State involved; and the Secretary
20 may employ any such recommendations as a basis for expe-
21 diting approval of the application with respect to which such
22 recommendations are made.
23 "(3)(A) The Secretary shall not approve any application
24 of an employer plan by a self-insured employer unless such
25 application contains or is supported by proof and assurances

1 satisfactory to the Secretary that the employer has the finan-
2 cial ability to discharge his obligations under the plan and has
3 the administrative ability effectively to discharge such obliga-
4 tions.

5 "(B) The Secretary may, as a condition of approval of
6 an employer plan by a self-insured employer, require the em-
7 ployer to deposit in a depository designated by the Secretary
8 either an indemnity bond or securities (at the option of the
9 employer) of a kind and in an amount determined by the Sec-
10 retary, and subject to such conditions as the Secretary may
11 prescribe (which shall include authorization to the Secretary
12 in case of default of the employer's obligations to provide
13 benefits under the plan to sell any of such securities sufficient
14 to discharge such obligations or to bring suit upon such bonds
15 to procure the prompt discharge of such obligations).

16 "(c)(1) As used in this section—

17 "(A) the term 'catastrophic health insurance'
18 means a health insurance policy or plan which provides
19 the coverage which is required pursuant to subsection
20 (a)(1)(B); and

21 "(B) the term 'carrier' includes any nonprofit hos-
22 pital or medical service corporation.

23 "(2)(A) In order for a carrier to be approved by the
24 Secretary under this subsection, the carrier must—

1 "(i) offer, in each State in which such carrier does
2 health insurance business, catastrophic health insur-
3 ance to all individuals and groups on an annual or
4 shorter contract basis, with the option of the policy-
5 holder to renew at the expiration of the term of the
6 policy, and with provision that the coverage so offered
7 will not be discontinued or denied in the case of any
8 individual or group except for failure to make timely
9 payment of premium therefor;
10 "(ii) provide claims determination procedures with
11 respect to catastrophic health insurance benefits which
12 (I) comply with the requirements imposed by section
13 503 of the Employee Retirement Income Security Act
14 of 1974 and the regulations issued thereunder by the
15 Secretary of Labor and (II) are consistent with those
16 employed by the carrier in its noncatastrophic health
17 insurance business and which in general are at least as
18 favorable to claimants as those employed under the
19 Federal plan established by part A, and
20 "(iii) operate in accordance with procedures satis-
21 factory to the Secretary for meeting its obligations
22 with respect to policies of catastrophic health insurance
23 and for disposition of unearned premiums on such poli-
24 cies in the event of the discontinuance of such policies

1 or the withdrawal of its status as an approved carrier
2 by the Secretary.
3 "(B) In order to better enable carriers to meet the re-
4 quirements imposed by subparagraph (A)(ii), the Secretary
5 shall provide to carriers, offering approved plans under this
6 part, reasonable access to claim data developed under the
7 Federal plan established by part A.
8 "(d) Approval of a plan by the Secretary under this sec-
9 tion shall not have the effect of causing such plan to be a
10 'governmental plan', as that term is employed in and for pur-
11 poses of title I of the Employee Retirement Income Security
12 Act of 1974, if such plan would, in the absence of such ap-
13 proval, not be a 'governmental plan', as that term is so em-
14 ployed.
15 "(e)(1) It shall not be unlawful, under any antitrust law,
16 for any carrier or group of carriers to enter into or participate
17 in any pool, reinsurance, or other residual market arrange-
18 ment, or for any carrier to carry on any activity which is
19 necessary or appropriate to discharge its functions under any
20 such arrangement, if and to the extent that, such arrange-
21 ment and the activities taken pursuant thereto are confined to
22 the offering and administration of plans approved by the Sec-
23 retary under this section.
24 "(2) As used in paragraph (1), the term 'antitrust law'
25 means the Federal Trade Commission Act, each statute re-

1 ferred to in section 4 of that Act (15 U.S.C. 44) as an Anti-
2 trust Act, any other statute of the United States in pari ma-
3 teria, and any law of any State or political subdivision thereof
4 which prohibits or restrains contracts, combinations, or other
5 arrangements in restraint of trade.

6 "CERTIFICATIONS TO THE SECRETARY OF THE TREASURY

7 "SEC. 2123. (a) Whenever the Secretary approves, or
8 withdraws approval of, any employer plan or self-employed
9 plan under this part, he shall submit a certification of his
10 action to the Secretary of the Treasury.

11 "(b)(1) The Secretary shall, prior to January 1, of each
12 calendar year, certify to the Secretary of the Treasury the
13 Table of Values of Catastrophic Health Insurance Coverage
14 which shall be in effect for such calendar year, together with
15 such additional data as may be needed by the Secretary of
16 the Treasury in connection with the administration of sec-
17 tions 42, 1403, and 3114 of the Internal Revenue Code of
18 1954.

19 "(2) The table of values referred to in paragraph (1)
20 shall be developed, for each calendar year, by the Secretary
21 and shall, except for such adjustments as the Secretary shall
22 deem to be necessary, be the same as the Table of Values of
23 Catastrophic Health Insurance Coverage which is prepared
24 and recommended to the Secretary for such year by the Ac-
25 tuarial Committee established pursuant to section 2124.

1 "(3) Such table of values developed by the Secretary
2 shall be made available to all carriers who offer catastrophic
3 health insurance plans approved under section 2122 and to
4 all other interested persons.

5 "ACTUARIAL COMMITTEE

6 "SEC. 2124. (a)(1) There is hereby established an Actu-
7 arial Committee which shall consist of five individuals, who
8 are not otherwise in the employ of the United States, ap-
9 pointed by the Secretary.

10 "(2)(A) Members of the Committee shall be persons who
11 are qualified to perform the functions and duties of the Com-
12 mittee. No individual shall be a member of the Committee
13 unless he (i) is enrolled, or meets the conditions for enroll-
14 ment (other than those relating to pension experience), as an
15 actuary in the Joint Board for the Enrollment of Actuaries
16 established by section 3041 of the Employee Retirement
17 Income Security Act of 1974, and (ii) has significant actuar-
18 ial experience in the field of health insurance.

19 "(B) At no time shall more than two members of the
20 Committee be in the employ of a carrier (as defined in section
21 2122(c)(1)(B)) which does health insurance business.

22 "(3) Members of the Committee shall serve for terms of
23 4 years, except that of those first appointed, one shall be
24 appointed for a term of 1 year, one shall be appointed for a
25 term of 2 years, one shall be appointed for a term of 3 years,

1 and two shall be appointed for terms of 4 years. A member
2 may be reappointed, but no member may serve for more than
3 2 successive terms. A member appointed to fill a vacancy
4 shall be appointed only for the unexpired term of his prede-
5 cessor. A majority of the members of the Committee shall
6 constitute a quorum thereof and action taken by the Commit-
7 tee shall be by majority vote of those present and voting. The
8 Secretary shall, from time to time, designate a member of the
9 Committee to serve as Chairman thereof.

10 "(4) The Secretary shall furnish to the Committee an
11 executive secretary and such secretarial, clerical, and other
12 services as may be required to enable the Committee to carry
13 out its duties and functions.

14 "(b)(1) Members of the Committee shall each be entitled
15 to receive the daily equivalent of the annual rate of basic pay
16 in effect for grade GS-18 of the General Schedule for each
17 day (including traveltime) during which they are engaged in
18 the actual performance of duties vested in the Committee.

19 "(2) While away from their homes or regular places of
20 business in the performance of services for the Committee,
21 members of the Committee shall be allowed travel expenses,
22 including per diem in lieu of subsistence, in the same manner
23 as persons employed intermittently in the Government are
24 allowed expenses under section 5703(b) of title 5 of the
25 United States Code.

1 "(c) Section 14(a) of the Federal Advisory Committee
2 Act shall not apply to the Actuarial Committee established
3 pursuant to this section.
4 "(d)(1) It shall be the duty and function of the Commit-
5 tee to prepare and recommend to the Secretary, not later
6 than October 1 of each year, a Table of Values of Cata-
7 strophic Health Insurance Coverage which shall be in effect
8 for the calendar year commencing on the following January
9 1.
10 "(2) Such table of values shall establish, for each State,
11 the actuarial value of one year's catastrophic health insur-
12 ance coverage for one individual, as estimated for the calen-
13 dar year for which such table of values is to be in effect, and
14 shall be designed (with the use of a table of adjustment fac-
15 tors) to enable employers, carriers, and others involved with
16 plans approved under section 2122 to determine the actuarial
17 value of the catastrophic health insurance coverage provided
18 under any such plan.
19 "(3) The value of catastrophic health insurance cover-
20 age shall be established by the Committee according to the
21 best data and information available to it on the basis of the
22 expected costs or charges for health care services, the ex-
23 pected utilization of health care services by all persons
24 having such coverage, the expected administration and claim
25 payment expenses (including an allowance for risk) applicable

1 to plans providing such coverage, and such other information
2 as the Committee determines to be relevant. In establishing
3 such value of coverage in any State, the Committee shall
4 employ appropriate adjustment factors, which shall be ap-
5 plied uniformly within the State, to reflect significant cost
6 differences related to geographic variations and the age and
7 dependency characteristics of individuals covered under plans
8 providing such coverage.

9 "(4) The term 'catastrophic health insurance', as used in
10 this section, means health insurance provided under plans ap-
11 proved under section 2122 which provides that minimum
12 coverage necessary to meet the requirement imposed in sec-
13 tion 2122(a)(1)(B).

14 "(e)(1) The Committee shall have the further duty (A) of
15 reviewing (by random claim or data sample or otherwise) the
16 marketing and rating practices of plans approved under sec-
17 tion 2122 with a view to determining whether such practices
18 unduly or inappropriately restrict, for particular groups, the
19 availability of coverage under plans approved under such sec-
20 tion, and (B) upon request of the Secretary of the Treasury,
21 to assist him in establishing procedures designed to assure
22 the proper administration of sections 42, 1403, and 3114 of
23 the Internal Revenue Code of 1954.

1 "(2) The Committee shall report to the Secretary its
2 findings resulting from its review functions, together with
3 such recommendations as it may have based on such findings.
4 (b) Section 201(g) of the Social Security Act is amended
5 by—
6 (1) inserting after "title XVIII" the first time it
7 appears the following: "and the Federal Catastrophic
8 Health Insurance Trust Fund established by title
9 XXI"; and
10 (2) inserting after "title XVIII" each time it ap-
11 pears therein after the first time the following: "and
12 title XXI".
13 AMENDMENTS TO INTERNAL REVENUE CODE OF 1954
14 SEC. 102. (a)(1) Section 1401 of the Internal Revenue
15 Code of 1954 (relating to rate of social security tax on self-
16 employment income) is amended by adding at the end thereof
17 the following new subsection:
18 "(c) CATASTROPHIC HEALTH INSURANCE.—In addi-
19 tion to the taxes imposed by the preceding subsections, there
20 shall be imposed for each taxable year which begins after
21 December 31, 1980, on the self-employment income of every
22 individual a tax which is equal to 1 percent of the amount of
23 the self-employment income of such individual for such tax-
24 able year."

1 (2) Such Code is further amended by (A) redesignating
2 section 1403 thereof (relating to miscellaneous provisions) as
3 section 1404, and (B) by adding after section 1402 thereof
4 the following new section:

5 "SEC. 1403. CREDIT AGAINST CATASTROPHIC HEALTH INSUR-
6 ANCE TAX.

7 "(a) ACTUARIAL VALUE OF CATASTROPHIC HEALTH
8 INSURANCE COVERAGE UNDER APPROVED PLANS FOR THE
9 SELF-EMPLOYED.—If, during any part of the taxable year
10 the taxpayer has secured for himself (or for himself and mem-
11 bers of his family) catastrophic health insurance coverage
12 under a plan which is approved by the Secretary of Health,
13 Education, and Welfare under section 2122 of the Social Se-
14 curity Act, the taxpayer may, to the extent provided in this
15 subsection and subsection (b), credit against the tax imposed
16 by section 1401(c) for such taxable year an amount equal to
17 the actuarial value of such coverage, as determined under the
18 appropriate Table of Values of Catastrophic Health Insur-
19 ance Coverage certified by such Secretary pursuant to sec-
20 tion 2123(b) of such Act.

21 "(b) LIMIT ON CREDITS.—The total credits allowed a
22 taxpayer under this section shall not exceed 100 percent of
23 the tax against which such credits are allowable.".

1 (3) The table of sections for chapter 2 of subtitle A of
2 such Code is amended by striking out the last item and in-
3 serting in lieu thereof the following:

"Sec. 1403. Credit against catastrophic health insurance tax.
"Sec. 1404. Miscellaneous provisions.".

4 (b)(1) Section 3111 of such Code (relating to rate of
5 social security tax on employers) is amended by adding at the
6 end thereof the following new subsection:

7 "(c) CATASTROPHIC HEALTH INSURANCE.—

8 "(1) In addition to the taxes imposed by the pre-
9 ceding subsections, there is hereby imposed on every
10 employer an excise tax, with respect to having individ-
11 uals in his employ, equal to 1 percent of the wages (as
12 defined in section 3121(a)) paid after December 31,
13 1980, by him with respect to employment (as defined
14 in paragraph (2)).

15 "(2) The term 'employment', as used in paragraph
16 (1), shall have the same meaning as when that term is
17 used for purposes of subsections (a) and (b), except that
18 the provisions of section 3121(b) shall be applied with-
19 out regard to the exclusions specified in paragraphs (5),
20 (6), (8), and (9) thereof.".

21 (2) Such Code is further amended by adding after sec-
22 tion 3113 thereof the following new section:

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1 "SEC. 3114. CREDIT AGAINST CATASTROPHIC HEALTH INSUR-
2 ANCE TAX.
3 "(a) ACTUARIAL VALUE OF CATASTROPHIC HEALTH
4 INSURANCE COVERAGE FOR EMPLOYEES UNDER AP-
5 PROVED EMPLOYER PLANS.—If, during any period the tax-
6 payer has secured for any or all of his employees (and for
7 family members of such employees) catastrophic health insur-
8 ance coverage under an employer plan approved by the Sec-
9 retary of Health, Education, and Welfare under section 2122
10 of the Social Security Act, the taxpayer may, to the extent
11 provided in this subsection and subsection (b), credit against
12 the tax imposed by section 3111(c) for such period an amount
13 equal to the actuarial value of such coverage, as determined
14 under the appropriate Table of Values of Catastrophic Health
15 Insurance Coverage certified by such Secretary pursuant to
16 section 2123(b) of such Act.
17 "(b) LIMIT ON CREDITS.—The total credits allowed to
18 a taxpayer under this section shall not exceed 100 percent of
19 the tax against which such credits are allowable.
20 "(c) PAYMENTS BY STATES.—For purposes of this sec-
21 tion, any State which has a State law approved by the Secre-
22 tary of the Treasury under section 2108 of the Social Secu-
23 rity Act shall be deemed to be a taxpayer to which the tax
24 imposed by section 3111(c) applies, and any payments which
25 such State is obligated to make to the Treasury pursuant to

1 such State law shall be deemed to be an obligation to pay
2 such tax.".
3 (3) The table of sections for subchapter B of chapter 21
4 of subtitle C of such Code is amended by adding immediately
5 after the last item the following:

"Sec. 3114. Credit against catastrophic health insurance tax.".

6 (c)(1)(A) Subpart A of part IV of subchapter A of chap-
7 ter 1 of the Internal Revenue Code of 1954 (relating to cred-
8 its allowed) is amended by renumbering section 42 as 43, and
9 by inserting after section 41 the following new section:
10 "SEC. 42. CATASTROPHIC HEALTH INSURANCE TAX.
11 "There shall be allowed to the taxpayer, as a credit
12 against the tax imposed by this chapter for the taxable year,
13 an amount equal to 50 percent of the aggregate of the
14 amounts of the tax, imposed by sections 1401(c) and 3111(c),
15 paid by the taxpayer during the taxable year. For purposes of
16 this section, any credit allowed the taxpayer for the taxable
17 year under section 1403 shall be regarded as an amount of
18 the tax, imposed by section 1401(c), paid by the taxpayer for
19 the taxable year; and any credit allowed the taxpayer for the
20 taxable year under section 3114 shall be regarded as an
21 amount of the tax, imposed by section 3111(c), paid by the
22 taxpayer for the taxable year. Any amounts allowed as a
23 credit under this section shall not be allowed as a deduction
24 under section 164. A State which, for the taxable year, has

1 made contributions pursuant to a State law approved under
2 section 2108 of the Social Security Act shall be regarded as
3 a taxpayer for purposes of this section.".
4 (B) The table of sections for such subpart is amended by
5 striking out the last item and inserting in lieu thereof the
6 following:

"Sec. 42. Catastrophic health insurance tax.
"Sec. 43. Overpayment of tax.".

7 (2) Section 6201(a)(4) of such Code (relating to assess-
8 ment authority) is amended by—
9 (A) inserting "or 42" after "section 39" in the
10 caption of such sections; and
11 (B) striking out "oil," and inserting in lieu thereof
12 "oil) or section 42 (relating to catastrophic health in-
13 surance tax),".
14 (3) Section 6401(b) of such Code (relating to excessive
15 credits) is amended by—
16 (A) inserting after "lubricating oil)" the following:
17 ", and 42 (relating to catastrophic health insurance
18 tax),"; and
19 (B) striking out "sections 31 and 39" and insert-
20 ing in lieu thereof "sections 31, 39, and 42".
21 TITLE II—MEDICAL ASSISTANCE PLAN FOR
22 LOW-INCOME PEOPLE
23 SEC. 201. (a) Effective October 1, 1980, title XIX of
24 the Social Security Act is amended to read as follows:

1 "TITLE XIX—MEDICAL ASSISTANCE PLAN
2 FOR LOW-INCOME PEOPLE
3 "PART A—GENERAL PROVISIONS
4 "PURPOSE
5 "SEC. 1901. It is the purpose of this title to provide, for
6 low-income individuals and members of low-income families,
7 assistance toward the costs of necessary hospital, skilled
8 nursing facility, medical, and other health care services.
9 "FREE CHOICE BY PATIENT GUARANTEED
10 "SEC. 1902. Any individual entitled to benefits under
11 this title may obtain health services provided hereunder from
12 any institution, agency, or person qualified to participate
13 under this title in accordance with reimbursement and service
14 requirements if such institution, agency, or person undertakes
15 to provide him such services. The provisions of the preceding
16 sentence shall not be applicable in the jurisdiction of Puerto
17 Rico, the Virgin Islands, or Guam for any period with re-
18 spect to which there is in effect an election (submitted to the
19 Secretary in such form and manner as he shall by regulations
20 prescribe) by the Governor of such jurisdiction that such pro-
21 visions not be applicable to such jurisdiction.
22 "OPTION OF INDIVIDUALS TO OBTAIN OTHER HEALTH
23 INSURANCE PROTECTION
24 "SEC. 1903. Nothing contained in this title shall be con-
25 strued to preclude any State from providing, or any individu-

1 al from purchasing or securing (through collective bargaining
2 or otherwise), protection against the cost of any health
3 services.

4 "PART B—DESCRIPTION OF MEDICAL ASSISTANCE PLAN

5 "ELIGIBLE INDIVIDUALS

6 "SEC. 1910. (a) Every 'medicaid eligible' (as defined in
7 section 1916 (a)) shall be eligible for the health benefits pro-
8 vided under this title in the manner prescribed by section
9 1916. Every individual who—

10 "(1) is (A) a low-income individual, or (B) a
11 member of a low-income family,

12 "(2) is a resident of the United States, and is
13 either (A) a citizen or (B) an alien lawfully admitted
14 for permanent residence or otherwise permanently re-
15 siding in the United States under color of law (includ-
16 ing any alien who is lawfully present in the United
17 States as a result of the application of the provisions of
18 section 203(a)(7) or section 212(d)(5) of the Immigra-
19 tion and Nationality Act), and

20 "(3) has filed (in the case of a low-income individ-
21 ual), or has had filed in his behalf by an appropriate
22 person an application under this title (filed in such form
23 and manner and containing such information as the
24 Secretary shall by regulations prescribe),

1 shall be eligible for the health benefits provided under this
2 title for the benefit period (as determined under subsection
3 (d)(2)) to which such application is applicable; except that no
4 such individual shall be entitled to such benefits on account of
5 services received by him during any period with respect to
6 which he does not meet the condition imposed by paragraph
7 (2) of this subsection.

8 "(b) Whenever the Secretary approves any application
9 (referred to in subsection (a)(3)), he shall issue a health bene-
10 fits card to each individual who, by reason of such applica-
11 tion, is eligible for a benefit period to the health benefits pro-
12 vided by this title. Such health benefits card which shall be
13 used to assist in identifying an eligible individual, shall identi-
14 fy the individual or family member to whom it is issued (by
15 name, sex, age, and social security account number and such
16 criteria as the Secretary shall by regulations prescribe) as
17 being eligible for such benefits for such period.

18 "(c) An application (referred to in subsection (a)(3)) on
19 behalf of the members of a low-income family shall be filed by
20 the head of such family or by such other appropriate person
21 as the Secretary shall by regulations specify.

22 "(d)(1)(A) Any application (referred to in subsection
23 (a)(3)) shall be filed with respect to—

24 (i) the coverage year in which the application is
25 filed, or

1 "(ii) the coverage year immediately following the
2 coverage year in which the application is filed and
3 which begins not later than 60 days after the date on
4 which such application is filed.
5 "(B) As used in this subsection and section 1911, the
6 term 'coverage year' means the 12-month period beginning
7 April 1 of any year.
8 "(2) The benefit period of any individual resulting from
9 the filing of an application (referred to in subsection (a)(3)),
10 shall commence—
11 "(A) on the first day of the first month in which
12 the application is filed, or
13 "(B) if earlier, the first day of the third month
14 prior to the month in which the application is filed and
15 in which such individual or the family of which he is a
16 member first met the conditions imposed by section
17 1910(a) (1) and (2),
18 and shall end on whichever of the following is earlier—
19 "(C) the close of the coverage year with respect
20 to which such application is filed, or
21 "(D) such date as may be specified in regulations
22 of the Secretary (promulgated in accordance with the
23 provisions of section 1911(d)), if such individual, prior
24 to the date referred to in clause (C), ceases to meet the
25 applicable condition imposed by subsection (a)(1), or

1 fails to submit reports which the Secretary deems to be
2 necessary or useful to enable him to determine whether
3 such individual continues to meet the conditions im-
4 posed by subsection (a) (1) and (2);
5 except that, if on the date that any individual's benefit period
6 would (as determined under the preceding provisions of this
7 paragraph) end, such individual is an inpatient in a health
8 care institution (which is a hospital, skilled nursing facility, or
9 intermediate care facility) participating under title XVIII or
10 this title, such individual's benefit period shall not end until
11 the day following the first day, after such date, that such
12 individual either is no longer an inpatient in or no longer
13 requires care in such an institution.

14 "DETERMINATIONS OF ELIGIBILITY

15 "SEC. 1911. (a) Whenever an application (referred to in
16 section 1910(a)(3)) has been filed by or on behalf of an indi-
17 vidual or on behalf of the members of a family, the determi-
18 nation of whether such individual or such family meets the
19 applicable condition imposed by section 1910(a) (1) (A) or (B)
20 shall be based on the actual income of the individual or family
21 for the 2-month period immediately preceding the date of
22 filing of the application and the prospective income of the
23 individual or family for the 2-month period immediately fol-
24 lowing such date.

1 "(b) An individual shall be deemed, for purposes of sub-
2 section (a), to have no income for the 2-month period immedi-
3 ately preceding the date of the filing of an application (re-
4 ferred to in section 1910(a)(3)) if—

5 "(1) at the time such application is filed by such
6 individual, he is not a member of a family, and

7 "(2) during all of such 2-month period (A) such
8 individual was a member of a family, (B) was not regu-
9 larly employed, and (C) was not the head of such
10 family.

11 "(c) The Secretary, in determining (for purposes of sub-
12 section (a)) the prospective income of any individual or
13 family, may take into account current income (if any) and
14 other relevant factors (including, in appropriate cases, actual
15 income for preceding periods).

16 "(d) An individual (referred to in section 1910(d)(2)(D))
17 shall be deemed not to have ceased to meet the applicable
18 condition imposed by section 1910(a)(1) in a current coverage
19 year because the income of such individual or of the family of
20 which he is a member, as the case may be, has increased, if
21 such income, as so increased, does not exceed 120 per
22 centum of the maximum amount of income which such indi-
23 vidual (or such family) can receive while still being a 'low-
24 income' individual or family (as the case may be). The pre-
25 ceding sentence shall apply also to decreases in family

1 income maximums brought about by a diminution in the
2 number of members thereof, except that a diminution in the
3 number of members of a family of not more than one such
4 member during a benefit period shall not affect the eligibility
5 of the remaining members of such family during the remain-
6 der of such benefit period.

7 "SCOPE OF BENEFITS

8 "SEC. 1912. The benefits provided to an individual eli-
9 gible in any benefit period under this title shall consist of
10 eligibility to have payment made (subject to the provisions of
11 this title) on his behalf for—
12 "(a) necessary inpatient hospital services for not
13 more than 60 days during a benefit period;
14 "(b) medical and other health services;
15 "(c) skilled nursing facility services;
16 "(d) home health services;
17 "(e) intermediate care services;
18 "(f) mental health services;
19 "(g) pre-natal and well-baby care;
20 "(h) family planning counseling, services, and
21 supplies;
22 "(i) in the case of eligible children under age 18,
23 early and periodic screening, diagnosis, and treatment;
24 and

1 "(j) payment of any premium imposed under part
2 B of title XVIII for coverage under the insurance pro-
3 gram established by such part;
4 and to have reimbursement made to him in an amount equal
5 to one-half of the amount (i) of the actuarial value, as deter-
6 mined under the appropriate Table of Values of Catastrophic
7 Health Insurance Coverage certified by the Secretary pursu-
8 ant to section 2123(b), of catastrophic health insurance cov-
9 erage for any period for such individual (or such individual
10 and family members) under a self-employed plan approved by
11 the Secretary under section 2122, and (ii) paid by such indi-
12 vidual (and by family members) as taxes imposed on his or
13 their self-employment income by section 1401(c) of the Inter-
14 nal Revenue Code of 1954.

15 "COPAYMENT REQUIREMENTS

16 "SEC. 1913. (a)(1) Any individual or family who, for
17 any coverage year, is eligible for the health benefits provided
18 by this title shall be responsible for the first $3 of the cost
19 incurred for a visit for physicians' services (other than as an
20 inpatient) if such visit is not for the purpose of securing ap-
21 propriate well-baby care, family planning services, or serv-
22 ices described in section 1912(i). Such $3 copayment shall be
23 applicable only to each of the first ten visits of any individual
24 or family for physicians' services. In the case of an individual
25 covered under title XVIII, the copayment or deductible re-

1 quirements of this section shall apply to the extent they are
2 less than the copayment required under title XVIII.
3 "(2) In the case of any individual who—
4 "(A) is, for any benefit period, entitled to the
5 health benefits provided under this title,
6 "(B) is not a member of a family or is a member
7 of a family all of whose members meet the require-
8 ments of subparagraph (C),
9 "(C) for a continuous period in excess of 60 days
10 (whether or not in the same benefit period), is an inpa-
11 tient in an institution which is a hospital, skilled nurs-
12 ing facility, or intermediate care facility,
13 there shall be imposed in each month (which begins after
14 such period) in which he is an inpatient in such an institution
15 a special copayment, with respect to health care services in
16 such institution to which he is entitled under this title during
17 each month, equal to the amount by which his cash income
18 for such month exceeds $50.
19 "(b) The amount payable under this title with respect to
20 physicians' services where a copayment is required by sub-
21 section (a)(1) or (a)(2) shall be reduced by an amount (if any)
22 equal to the copayment imposed.
23 "RESIDUAL NATURE OF BENEFITS
24 "SEC. 1914. Amounts otherwise payable under this title
25 with respect to any item or service specified in clauses (a)

1 through (i) of section 1912 provided to an individual during
2 any benefit period shall be reduced by the amount which is
3 paid (or upon claim by the individual, or a person claiming on
4 his behalf, would be payable) under any other public or pri-
5 vate insurance or health care benefits plan by which such
6 individual is covered (including the insurance program estab-
7 lished by title XVIII, the program established by part A of
8 title XXI, and any workmen's compensation law), except
9 that payments under this title shall be primary in the case of
10 a State program designed to supplement (through higher
11 income tests) the eligiblity of this program.

12 "SPECIAL PROVISIONS RELATING TO MEDICAID ELIGIBLES

13 "SEC. 1915. (a) For purposes of this section and the
14 first sentence of section 1910(a), the term 'medicaid eligible'
15 means an individual (whether as a member of a family or
16 otherwise) who, for any month after December 1980 and
17 prior to October 1981, was determined to be eligible for as-
18 sistance under a State plan approved under this XIX (as in
19 effect prior to October 1, 1981).

20 "(b) Notwithstanding any other provision of this title,
21 any individual who is a medicaid eligible shall (subject to
22 subsection (c)) be eligible for the health insurance provided by
23 this title for any period after September 1981 if, for such
24 period, such individual—

1 "(1) meets the requirements imposed (or deemed
2 by Federal law to be imposed) as a condition of eligi-
3 bility for assistance under the State plan under which
4 his status as a medicaid eligible is established, as such
5 plan was in effect for September 1981,
6 "(2) does not meet such requirements but would
7 meet such requirements except for the amount of his
8 income (or the income of the family of which he is a
9 member), if his income (or the income of the family of
10 which he is a member) does not exceed 105 per
11 centum of the maximum applicable income standard
12 imposed as a condition of eligibility under such require-
13 ments as in effect for September 1980, or (if greater)
14 for September 1981,
15 except that no individual shall, by reason of the provisions of
16 this subsection, be deemed to be eligible for health benefits
17 under this title unless such individual meets the requirements
18 of section 1910(a)(2) and there has been filed (in the manner
19 provided by section 1910(a)(3)) by or on behalf of such indi-
20 vidual an application for benefits under this title with respect
21 to such period.

1 "PART C—CONDITIONS AND LIMITATIONS ON PAYMENT,
2 AND ADMINISTRATION

3 "BASIS FOR PAYMENT FOR HEALTH SERVICES

4 "SEC. 1920. (a) Except as is otherwise provided in sub-
5 section (d), covered health care services provided to individ-
6 uals insured under this title shall, in the case such services
7 are provided by a provider of service (as defined in section
8 1861(u)) or an intermediate care facility, be paid for on the
9 basis of the reasonable cost subject to the limitations other-
10 wise provided under title XVIII for such services and, in the
11 case such services are provided by a person (other than a
12 provider of service or an intermediate care facility), be paid
13 on the basis of the reasonable charge (subject to the limita-
14 tions with respect thereto imposed under title XVIII).

15 "(b) In the event that such amounts are not payable due
16 to the failure of the individual or family to enroll in a health
17 insurance plan for which he or such family was otherwise
18 eligible, and to the extent such coverage would have been in
19 effect during the benefits period, and in which his or such
20 family's premium or rate liability was 25 per centum or less
21 (or failure to enroll in part B of title XVIII) amounts other-
22 wise payable under this title shall be reduced by not more
23 than $250 in a benefit period.

1 "(c) As used in subsection (a), the term 'reasonable cost'
2 shall have the same meaning as when such term is employed
3 in title XVIII.
4 "(d)(1) To the extent that the regulations of the Secre-
5 tary promulgated pursuant to paragraph (2) are applicable to
6 a skilled nursing facility or an intermediate care facility, cov-
7 ered services furnished by such facility shall be paid on the
8 cost-related basis established under such regulations rather
9 than on the basis of reasonable cost.
10 "(2) In the interest of the efficient and economical ad-
11 ministration of this title, the Secretary shall promulgate regu-
12 lations under which covered services furnished by all or one
13 or more types or classes of skilled nursing facilities or inter-
14 mediate care facilities in any area (consisting of one or more
15 States) will be paid for on a reasonable cost-related basis, as
16 determined in accordance with methods and standards pre-
17 scribed in such regulations.
18 "CONDITIONS OF AND LIMITATION ON PAYMENT FOR
19 SERVICES
20 "SEC. 1921. (a) Services and the payment therefor
21 under this title are subject to the same conditions and limita-
22 tions as those imposed by sections 1814, 1834, and 1835
23 with respect to services, and the payment therefor, provided
24 under title XVIII.

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1 "(b) No payment shall be made under this title to any
2 person on account of any health care service furnished by
3 such person to an individual who is covered under this title
4 for such service unless such person accepts the amount of
5 such payment, together with any co-payment required under
6 section 1913 with respect to such service, as payment in full
7 for such service. Whenever payment under this title is made
8 in supplementation of a payment made under any insurance
9 program (whether public or private) for a service, the amount
10 of the payment under this title shall not be in excess of
11 amount which would be paid had such service been provided
12 under this title, and no person accepting such payment as
13 payment for such service shall charge any amount in excess
14 of the amount so paid to the individual receiving such service.
15 "(c) If any eligible individual (as determined under sec-
16 tion 1910) who is a low-income individual or a member of a
17 low-income family (as determined without regard to section
18 1932) is enrolled in—
19 "(1) a health maintenance organization which
20 meets the applicable requirements of section 1876, or
21 "(2) an organization which (A) provides medical
22 and other health services (or arranges for their avail-
23 ability) on a prepayment basis, and (B) receives and
24 prior to September 1, 1973, received, payments under

1 part B of title XVIII under the authority contained in
2 section 1833(a)(1)(A),
3 the Secretary may, in lieu of making payments for health
4 benefits on behalf of such individual as provided in other pro-
5 visions of this title, make payment therefor in the manner
6 authorized by section 1876 for any period, during which he is
7 so enrolled, and for which he is such an eligible individual.
8 "(c) Payments under this title may not be made for
9 services provided by any group practice unit unless such unit
10 meets the applicable requirements of section 1876.
11 "ADMINISTRATION AND QUALITY CONTROL
12 "SEC. 1922. (a) The provisions of this title shall (subject
13 to the provisions of section 702(b)) be administered by the
14 Secretary.
15 "(b) The provisions of title XVIII (and other provisions
16 of law applicable to the health insurance programs estab-
17 lished by such title, including part B of title XI) relating to
18 utilization and professional review and conditions of partici-
19 pation required with respect to persons or providers of health
20 services under title XVIII, shall be applicable to all health
21 services provided under this title.
22 "(c) To the maximum extent practicable, the Secretary,
23 in the administration of this title, shall utilize and otherwise
24 coordinate with the procedures employed in the administra-
25 tion of the health insurance programs established by title

1 XVIII (including the procedures for certification of providers
2 of service), and shall have the same authority (except as oth-
3 erwise specifically provided) as that conferred upon him with
4 respect to the administration of the insurance programs es-
5 tablished by title XVIII.

6 "REQUIREMENTS FOR CARRIERS AND INTERMEDIARIES

7 "SEC. 1923. (a) The Secretary, in the administration of
8 this title, shall, whenever he determines that the interests of
9 quality of service to eligible individuals or program economy,
10 or efficiency of administration would be furthered, require
11 consolidation of activities on the part of carriers (utilized pur-
12 suant to authority contained in section 1842) and agencies or
13 organizations (utilized pursuant to authority contained in sec-
14 tion 1816) in geographic regions with minimum size popula-
15 tions of individuals covered under this title and under the
16 insurance programs established by title XVIII.

17 "(b) No private carrier or other organization shall after
18 the 3-year period which commences on the date of enactment
19 of this section, be utilized in the administration of this title or
20 title XVIII unless such carrier or other organization is an
21 'approved carrier' under section 1505.

22 "MEDICAL COVERAGE TRUST FUND

23 "SEC. 1924. (a) There is hereby created on the books of
24 the Treasury of the United States a trust fund to be known
25 as the Medical Coverage Trust Fund (hereinafter in this sec-

1 tion referred to as the 'Trust Fund'). The Trust Fund shall
2 consist of such gifts and bequests as may be made as pro-
3 vided in section 201(i)(1), and such amounts as may be de-
4 posited in, or appropriated to, such fund as provided in sec-
5 tions 1925 and 1926.

6 "(b) With respect to the Trust Fund, there is hereby
7 created a body to be known as the Board of Trustees of the
8 Trust Fund (hereinafter in this section referred to as the
9 'Board of Trustees') composed of the Secretary of the Treas-
10 ury, the Secretary of Labor, and the Secretary of Health,
11 Education, and Welfare, all ex officio. The Secretary of the
12 Treasury shall be the Managing Trustee of the Board of
13 Trustees (hereinafter in this section referred to as the 'Man-
14 aging Trustee'). The Commissioner of Social Security shall
15 serve as the Secretary of the Board of Trustees. The Board
16 of Trustees shall meet not less frequently than once each
17 calendar year. It shall be the duty of the Trustee to—

18 "(1) hold the Trust Fund;

19 "(2) report to the Congress not later than the first
20 day of July of each year on the operation and status of
21 the Trust Fund during the preceding fiscal year and on
22 its expected operation and status during the current
23 fiscal year and the next 2 fiscal years;

1 "(3) report immediately to the Congress whenever
2 the Board is of the opinion that the amount of the
3 Trust Fund is unduly small; and
4 "(4) review the general policies followed in man-
5 aging the Trust Fund, and recommend changes in such
6 policies, including necessary changes in the provisions
7 of law which govern the way in which the Trust Fund
8 is to be managed.
9 The report provided for in paragraph (2) shall include a state-
10 ment of the assets of, and the disbursements made from, the
11 Trust Fund during the preceding fiscal year, an estimate of
12 disbursements to be made from the Trust Funds during the
13 current coverage year and each of the next 2 fiscal years.
14 Such report shall be printed as a House document of the
15 session of the Congress to which the report is made.
16 "(c) The Managing Trustee shall pay from time to time
17 from the Trust Fund such amounts as the Secretary of
18 Health, Education, and Welfare certifies are necessary to
19 make the payments of benefits provided for in this title, and
20 the payments with respect to administrative expenses in ac-
21 cordance with section 201(g)(1).

1 "STATE CONTRIBUTIONS TO MEDICAL COVERAGE TRUST
2 FUND, AND TO CATASTROPHIC HEALTH INSURANCE
3 TRUST FUND

4 "SEC. 1925. (a) In order for individuals residing in any
5 State to receive for any period the benefits provided by this
6 title, there must be in effect for such period an agreement
7 between such State and the Secretary entered into under this
8 section.

9 "(b) Any agreement between the Secretary and a State
10 under this section shall provide that the State will (subject to
11 subsection (c)) pay, with respect to each fiscal year for which
12 such agreement is in effect, to the Secretary of the Treasury
13 at such time or times as may be specifed in the agreement,
14 an amount equal to—

15 "(1) in case such State is a State which (for the
16 fiscal year ending September 30, 1980, or September
17 30, 1981, had in effect a State plan approved under
18 title XIX, as in effect prior to the effective date of the
19 program established by this title) the sum of the fol-
20 lowing:

21 "(A) an amount equal to (i) the total amount
22 expended from non-Federal funds for the purpose
23 of providing (under such State plan to persons eli-
24 gible under such plan) services of the types for
25 which coverage is provided by this title, for the

1 four-quarter period ending September 30, 1980,
2 or (ii) if greater, the total amount expended from
3 non-Federal funds for such purpose for the four-
4 quarter period ending September 30, 1981, plus
5 "(B) an amount equal to one-half of (i) the
6 total amount expended (as determined by the Sec-
7 retary) from non-Federal public funds for the pur-
8 pose of providing, for individuals not covered
9 under such plan but who are eligible under this
10 title, services of the types for which coverage is
11 provided by this title, for the four-quarter period
12 ending September 30, 1980, or (ii) if greater, the
13 total amount expended (as determined by the Sec-
14 retary) from non-Federal funds for such purpose
15 for the four-quarter period ending September 30,
16 1981; and
17 "(2) in case such State did not, for the fiscal year
18 ending September 30, 1980, or September 30, 1981,
19 have in effect a State plan referred to in paragraph (1),
20 (A) the total amount expended (as determined by the
21 Secretary) from non-Federal funds for the purpose of
22 providing services of the types for which coverage is
23 provided by this title for persons eligible under this
24 title, for the four-quarter period ending September 30,
25 1980, or (B) if greater, the total amount expended (as

1 determined by the Secretary) from non-Federal funds
2 for such purpose for the four-quarter period ending
3 September 30, 1981.
4 "(c) The amount payable by any State under subsection
5 (b) with respect to a coverage year shall be reduced by an
6 amount equal to one-half of the amount expended by such
7 State during such coverage year from non-Federal funds in
8 providing to individuals in such State services of a type—
9 "(1) which is not covered under this title, but
10 "(2) with respect to the cost of which there could
11 have been Federal financial participation under title
12 XIX (as in effect prior to the effective date of the pro-
13 gram established by this title) if such type of service
14 had been included in a State's plan approved under
15 such title XIX.
16 "(d) Amounts paid to the Secretary of the Treasury
17 under this section shall be deposited by him in the Medical
18 Coverage Trust Fund.
19 "APPROPRIATIONS TO MEDICAL COVERAGE TRUST FUND
20 "SEC. 1926. There are authorized to be appropriated
21 for each fiscal year to the Medical Coverage Trust Fund such
22 sums as may be necessary to carry out the program estab-
23 lished by this title.

1 "MINIMUM PAYMENTS

2 "SEC. 1927. If the amount payable to an insured indi-
3 vidual at any particular time as benefits under this title is less
4 than $5, no payment shall be made to him until such time as
5 the payment to which he is entitled as such benefits is $5 or
6 more.

7 "OPTOMETRISTS' SERVICES PROVIDED IN CERTAIN STATES

8 "SEC. 1928. In the case of any State which—
9 "(1) does not provide for the payment of optom-
10 etrists' services furnished to individuals who are eligi-
11 ble for benefits under the medical assistance plan for
12 low-income people established by this title,
13 "(2) during all or some part of the 2-year period
14 ending on the effective date of such medical assistance
15 plan, did provide, under its State plan approved under
16 title XIX (as in effect prior to such effective date),
17 payment of optometrists' services,
18 the term 'physicians' services', as employed in such medical
19 assistance plan established by this title, shall, with respect to
20 individuals residing in such State, be deemed to include any
21 service which is furnished by an optometrist, if—
22 "(3) such service is one which an optometrist is
23 legally authorized to perform,
24 "(4) such service would constitute 'physicians'
25 services', as that term is employed in such medical as-

1 sistance plan established by this title, if it had been
2 performed by a physician.

3 "PART D—DEFINITIONS AND MISCELLANEOUS
4 PROVISIONS

5 "MEANING OF 'LOW-INCOME INDIVIDUAL' AND 'MEMBER
6 OF A LOW-INCOME FAMILY'

7 "SEC. 1930. (a) For purposes of section 1910(a)(1)(A),
8 the term 'low-income individual' means an individual—
9 "(1) who is not a member of a family (as deter-
10 mined under subsection (b)(1)), and
11 "(2) whose income is at a rate of not more than
12 $3,000 for the calendar year 1981 or any calendar
13 year thereafter.
14 "(b) For purposes of section 1910(a)(1)(B)—
15 "(1) the term 'family' means two or more individ-
16 uals who are—
17 "(A) related by blood, marriage, or adoption,
18 and
19 "(B) living in a place of residence maintained
20 by one or more of them as his or their own home;
21 "(2) the term 'member', when used in reference to
22 a family, means an individual described in paragraph
23 (1), and
24 "(3) the term 'low-income', when used in refer-
25 ence to a family, means a family, the aggregate income

1 of all the members of which is at a rate of not more
2 than—
3 "(A) in case there are only two members of
4 such family, $4,200, or
5 "(B) in case there are only three members of
6 such family, $4,800, or
7 "(C) in case there are only four members of
8 such family, $5,400, or
9 "(D) in case there are more than four mem-
10 bers of such family, an amount equal to $5,400
11 plus $400 for each member of such family in
12 excess of four.
13 "(c) The Secretary may prescribe the circumstances
14 under which, consistent with the purposes of this title and in
15 the same manner as authorized in section 1611(d), the gross
16 income of an individual or family from a trade or business
17 (including farming) will be considered sufficiently large to
18 cause such individual or family not to be regarded as a 'low-
19 income individual', or a 'low-income family', even though
20 such individual's or family's income does not exceed the ap-
21 plicable dollar amount prescribed in subsection (a)(2) or (b)(3).
22 "(d) In the case of jurisdictions of the Commonwealth of
23 Puerto Rico, the Virgin Islands, and Guam, the amounts set
24 forth in subsection (b)(3) (A), (B), (C), and (D) shall each be
25 deemed to be reduced to such amount as the Secretary deter-

1 mines to be appropriate to assure that the ratio of individuals
2 and families in any such jurisdiction who meet the criteria for
3 low income (for purposes of this title) to the total population
4 of such jurisdiction is not greater than the ratio of individuals
5 in that State of the United States which has the highest such
6 ratio of individuals who meet such criteria to the total popu-
7 lation of such State.

8 "MEANING OF 'INCOME'

9 "SEC. 1931. (a) For purposes of this title, 'income'
10 means (subject to subsection (b)) both earned income and un-
11 earned income; and—

12 "(1) 'earned income' means only—

13 "(A) wages as determined under section
14 203(f)(5)(C); and

15 "(B) 'net earnings from self-employment', as
16 defined in section 211 (without application of the
17 second and third sentences following subsection
18 (a)(10), and the last paragraph of subsection (a)),
19 including earnings for services described in para-
20 graphs (4), (5), and (6) of subsection (c); and

21 "(2) 'unearned income' means all other income,
22 including—

23 "(A) support and maintenance furnished in
24 cash,

1 "(B) any payments received as an annuity,
2 pension, retirement, or disability benefit; including
3 veterans' compensation and pensions; workmen's
4 compensation payments; old-age, survivors, and
5 disability insurance benefits; railroad retirement
6 annuities and pensions; and unemployment insur-
7 ance benefits,
8 "(C) cash gifts, support and alimony pay-
9 ments, and inheritances, and
10 "(D) rents, dividends, interest, and royalties.
11 "(b)(1) In determining, for purposes of this section, the
12 income of any individual or family, for any period of time,
13 there shall be excluded—
14 "(A) the aggregate value of any cash gifts which
15 do not exceed $240, if such period of time is equal to
16 12 months, or, if such period of time is less than 12
17 months, then an amount which bears the same ratio to
18 $240 as such period bears to 12 months, and
19 "(B) any scholarship, grant, fellowship, or loan
20 received for use in paying for tuition, books, and relat-
21 ed fees at any educational (including technical or voca-
22 tional education) institution.
23 "(2) For purposes of paragraph (1) and subsection (a)—
24 "(A) a loan of $240 or more (or aggregate there-
25 of) shall be regarded as a gift if such loan—

1 "(i) is unsecured (or is without adequate se-
2 curity), or
3 "(ii) has no maturity date; and
4 "(B) in the case of a loan which—
5 "(i) bears no interest, or
6 "(ii) bears interest at a rate which is not
7 more than one-half of the prevailing rate of inter-
8 est imposed with respect to similar loans,
9 the recipient of such loan shall be regarded as having
10 received, as a gift, an amount, with respect to any
11 period of time, equal to the excess of—
12 "(iii) the amount of interest which would
13 have been payable by him, with respect to such
14 period, on such loan if such loan bore a rate of
15 interest equal to the prevailing rate of interest im-
16 posed (as of the time such loan was made) with
17 respect to similar loans, over
18 "(iv) the amount of interest (if any) payable
19 by him, with respect to such period, on such loan.
20 "SPEND-DOWN REQUIREMENT
21 "SEC. 1932. (a) For purposes of determining eligibility,
22 the amount of the income of any individual or family (as de-
23 termined under section 1931) shall be reduced by an amount
24 equal to such individual's or family's incurred health care ex-
25 penses to the extent such expenses constitute a legal obliga-

1 tion and are not payable by any other third party payor
2 (whether public or private) (as determined under subsection
3 (b)) for the benefit period with respect to which such individ-
4 ual's or family's income is determined.

5 "(b)(1) The term 'health care expenses', when applied to
6 any individual or family, means (subject to paragraphs (2)
7 and (3)) reasonable expenditures by or on behalf of such indi-
8 vidual or the members of such family (as the case may be) for
9 any of the following:

10 "(A) inpatient hospital services (including services
11 in an institution for tuberculosis or mental diseases),

12 "(B) outpatient hospital services,

13 "(C) other laboratory and X-ray services,

14 "(D) skilled nursing facility services,

15 "(E) physicians' services furnished by a physician
16 (as defined in section 1861(r)(1)), whether furnished in
17 the office, the patient's home, a hospital, or a skilled
18 nursing facility, or elsewhere,

19 "(F) optometrists' and podiatrists' services,

20 "(G) home health services,

21 "(H) private duty nursing services,

22 "(I) clinic services,

23 "(J) dental services,

24 "(K) physical therapy, speech, pathology, and au-
25 diology services,

1 "(L) prescribed drugs, dentures, durable medical
2 equipment and related supplies, and prosthetic devices,
3 and eyeglasses prescribed by a physician skilled in dis-
4 eases of the eye or by an optometrist,
5 "(M) other rehabilitation services,
6 "(N) intermediate care facility services,
7 "(O) inpatient psychiatric hospital services,
8 "(P) health insurance premiums, or
9 "(Q) ambulance service.
10 "(2) For purposes of paragraph (1), the expenditure for
11 any item or service specified therein means—
12 "(A) in case payment for such item or service has
13 been made prior to the time the determination of
14 health care expenses (which includes such item or
15 service) is made, the amount actually paid for such
16 item or service,
17 "(B) in case payment for such item or service has
18 not been made at such time and such item or service is
19 of a type which is covered under the health coverage
20 plan established by this title, whichever of the follow-
21 ing is the lesser:
22 "(i) the actual charge for such item or serv-
23 ice, or
24 "(ii) the reasonable charge or reasonable cost
25 (as the case may be) for such item or service as

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1 determined under this title when such item or
2 service is provided as an item or service covered
3 under such health plan.

4 "(3) The term 'health care expenses' also includes an
5 amount equal to one-half of the amount (A) of insurance pre-
6 miums paid by or on behalf of an individual for catastrophic
7 health insurance coverage for such individual (or for such in-
8 dividual and family members) under a self-employed plan ap-
9 proved by the Secretary under section 2122, and (B) paid by
10 an individual as taxes imposed on his self-employment
11 income by section 1401(c) of the Internal Revenue Code of
12 1954.

13 "(c) The health care expenses (as determined under the
14 preceding provisions of this section) may, in the case of any
15 individual, be determined on a prospective basis for any
16 future period for which such individual's income (or the
17 income of the family of which an individual is a member) is
18 determined, but only if such individual is determined (in ac-
19 cordance with regulations of the Secretary) to be an individu-
20 al who, on the basis of his recent past medical history, can be
21 expected, for such future period to require inpatient institu-
22 tional care for all or a substantial part of such future period.

1 "INPATIENT HOSPITAL SERVICES

2 "SEC. 1933. For purposes of this title, the term 'inpa-
3 tient hospital services' shall have the meaning assigned to
4 such term by section 1861(b).

5 "HOSPITAL

6 "SEC. 1934. For purposes of this title, the term 'hospi-
7 tal' means an institution which meets the requirements set
8 forth in clauses (1) through (9) of section 1861(e).

9 "MEDICAL AND OTHER HEALTH SERVICES

10 "SEC. 1935. For purposes of this title, the term 'medi-
11 cal and other health services' shall have the meaning as-
12 signed to such term in so much of section 1861(s) as precedes
13 the last sentence thereof; except that such term shall include
14 (1) such physician's and other services, diagnostic X-ray
15 tests, diagnostic laboratory tests, and other diagnostic tests
16 as are involved in providing appropriate well-baby care (as
17 determined in accordance with regulations of the Secretary)
18 and (2) outpatient rehabilitation services.

19 "SKILLED NURSING FACILITY SERVICES

20 "SEC. 1936. For purposes of this title, the term 'skilled
21 nursing facility services' means the items and services which
22 (1) are described in clauses (1) through (7) of section 1861(h),
23 and (2) are furnished by a skilled nursing facility; excluding,
24 however, any item of service if it would not be included

1 under section 1861(b), if furnished to an inpatient of a
2 hospital.

3 "SKILLED NURSING FACILITY

4 "SEC. 1937. For purposes of this title, the term 'skilled
5 nursing facility' means an institution (or a distinct part of an
6 institution) which meets the criteria set forth in section
7 1861(j).

8 "HOME HEALTH SERVICES

9 "SEC. 1938. For purposes of this title, the term 'home
10 health services' shall have the meaning assigned to such term
11 in section 1861(m); except that the term 'skilled nursing fa-
12 cility', as used in clause (7) of such section, shall be deemed
13 to include a skilled nursing facility (as defined in section
14 1937); except that such term shall not include any term or
15 service if it would not be included under section 1932 if fur-
16 nished to an inpatient of a hospital.

17 "HOME HEALTH AGENCY

18 "SEC. 1939. For purposes of this title, the term 'home
19 health agency' shall have the meaning assigned to such term
20 in section 1861(o).

21 "PHYSICIANS' SERVICES

22 "SEC. 1940. For purposes of this title, the term 'physi-
23 cians' services' means professional services performed by
24 physicians, including surgery, consultation, and home, office,

1 and institutional calls (but not including services which are
2 included within the definition of inpatient hospital services).

3 "PHYSICIAN

4 "SEC. 1941. For purposes of this title, the term 'physi-
5 cian' shall have the meaning assigned to such term in section
6 1861(r)(1).

7 "MEANING OF CERTAIN OTHER TERMS

8 "SEC. 1942. For purposes of this title, any term
9 which—

10 "(1) is defined in section 1861;

11 "(2) is employed in provisions which, by refer-
12 ence, are used in defining any of the terms defined in
13 sections 1932 through 1940; and

14 "(3) is not otherwise defined in this section;

15 shall, insofar as such term is applicable to the provisions of
16 this title and except as the Secretary (in order to carry out
17 the purposes of this title) shall otherwise by regulations pro-
18 vide, have the meaning assigned to it in section 1861.

19 "INTERMEDIATE CARE FACILITY

20 "SEC. 1943. (a) For purposes of this title, the term 'in-
21 termediate care facility' means an institution which (1) is li-
22 censed under State law to provide, on a regular basis, health-
23 related care and services to individuals who do not require
24 the degree of care and treatment which a hospital or skilled
25 nursing facility is designed to provide, but who because of

1 their mental or physical condition require care and services
2 (above the level of room and board) which can be made avail-
3 able to them only through institutional facilities, (2) meets
4 such standards prescribed by the Secretary as he finds appro-
5 priate for the proper provision of such care, and (3) meets
6 such standards of safety and sanitation as are established
7 under regulations of the Secretary in addition to those appli-
8 cable to nursing facilities under State law.
9 "(b) The term 'intermediate care facility' also in-
10 cludes—
11 "(1) any skilled nursing facility or hospital which
12 meets the requirements of subsection (a);
13 "(2) a Christian Science sanatorium operated, or
14 listed and certified, by the First Church of Christ, Sci-
15 entist, Boston, Massachusetts, but only with respect to
16 institutional services deemed appropriate by the
17 Secretary;
18 "(3) any institution which is located on an Indian
19 reservation, if such institution is certified by the Secre-
20 tary as meeting the requirements of clauses (2) and (3)
21 of subsection (a) and providing the care and services
22 required under clause (1) of such subsection; and
23 "(4) with respect to intermediate care services de-
24 scribed in section 1944(b), the public institution (or dis-
25 tinct part thereof) providing such services.

1 "INTERMEDIATE CARE SERVICES

2 "SEC. 1944. (a) For purposes of this title, the term 'in-
3 termediate care services' means services provided by an in-
4 termediate care facility to an inpatient thereof, but only if (1)
5 such individual meets the conditions referred to in section
6 1943(a), and (2) such services are required to meet the needs
7 of such individual because of such condition.

8 "(b) The term 'intermediate care services' also includes
9 services in a public institution (or distinct part thereof) for the
10 mentally retarded or persons with related conditions, but only
11 if—

12 "(1) the primary purpose of such institution (or
13 distinct part thereof) is to provide health or rehabilita-
14 tive services for mentally retarded individuals and
15 which meet such standards as may be prescribed by
16 the Secretary; and

17 "(2) the mentally retarded individual with respect
18 to whom a request for payment under this title is made
19 is receiving active treatment under a program of active
20 treatment designed to meet the needs of such
21 individual.

22 "MENTAL HEALTH CARE SERVICES

23 "SEC. 1945. (a) The term 'mental-health care services'
24 includes only care and services for mental conditions—

1 "(1) which, if provided on an inpatient basis, con-
2 sist of a course of active care and treatment provided
3 in and by an accredited medical institution (as deter-
4 mined by the Secretary),
5 "(2) which, if provided on a partial hospitalization
6 basis, are provided (A) in and by an accredited medical
7 institution (as determined by the Secretary), or (B) in
8 and by a qualified community mental health center (as
9 determined in accordance with regulations of the Sec-
10 retary), or
11 "(3) which, if provided on an outpatient basis,
12 are—
13 "(A) provided by a qualified community
14 mental health center (as determined in accordance
15 with regulations of the Secretary), or
16 "(B) provided by a pyschiatrist;
17 except that such terms shall not include any outpatient serv-
18 ices provided by a psychiatrist, during any 12-month period,
19 for purposes of diagnosis or treatment of acute phychosis in
20 excess of (i) five visits, plus (ii) such additional visits as shall
21 have been approved in advance by an appropriate profession-
22 al review mechanism upon a finding that, in the absence of
23 such additional visits, the patient will require institutional
24 care.

1 "(b)(1) The term 'mental health services', in the case of
2 services provided on an outpatient basis by a qualified mental
3 health center (as determined in accordance with regulations
4 of the Secretary) or by a psychiatrist, includes any drug
5 which is prescribed for a patient by the physician under
6 whose direction such patient is receiving such services, but
7 only if—
8 "(A) such drug is included on the list (referred to
9 in paragraph (2)) and is prescribed in accordance with
10 the criteria indicated in such list, and
11 "(B) such physician determines that unless such
12 patient receives such drug, such patient can reasonably
13 be expected to require institutional care.
14 "(2) The Secretary is authorized (after consultation with
15 appropriate professional individuals and organizations) to
16 compile and publish (and from time to time revise) a list of
17 drugs which he has determined to be effective in the treat-
18 ment of various mental conditions. Such list shall indicate,
19 with respect to each drug included therein, the particular
20 mental conditions with respect to which such drug is effec-
21 tive, and the appropriate dosage (in terms of quantity and
22 intervals at which such drug shall be administered) of such
23 drug.

1 "OUTPATIENT REHABILITATION SERVICES

2 "SEC. 1946. (a) For purposes of this title, the term 'out-
3 patient rehabilitation services' means physical therapy,
4 speech pathology, occupational therapy, and medical-social
5 services furnished by a provider of services, a clinic, rehabili-
6 tation agency (including a single service rehabilitation
7 agency), or a public health agency, or by others under an
8 arrangement with, and under the supervision of, such provid-
9 er, clinic, rehabilitation agency, or public health agency, to
10 an individual as an outpatient—
11 "(1) who is under the care of a physician, and
12 "(2) with respect to whom a plan prescribing the
13 type, amount, and duration of such services that are to
14 be furnished to such individual has been established,
15 and is periodically reviewed by a physician;
16 excluding, however—
17 "(3) any item of service if it would not be includ-
18 ed under 'inpatient hospital services' if furnished to an
19 inpatient in a hospital; and
20 "(4) any such service—
21 "(A) if furnished by a clinic or rehabilitation
22 agency, or by others under arrangements with
23 such clinic or agency, unless such clinic or reha-
24 bilitation agency—

1 "(i) provides an adequate program of
2 such services for outpatients and has the
3 facilities and personnel required for such pro-
4 gram or required for the supervision of such
5 a program, in accordance with such require-
6 ments as the Secretary may specify,
7 "(ii) has policies, established by a group
8 of professional personnel, including one or
9 more physicians (associated with the clinic or
10 rehabilitation agency) and one or more quali-
11 fied physical therapists or speech patholo-
12 gists (as may be appropriate) to govern the
13 services (referred to in clause (i)) it provides,
14 "(iii) maintains clinical records on all
15 patients,
16 "(iv) if such clinic or agency is situated
17 in a State in which State or applicable local
18 law provides for the licensing of institutions
19 of this nature, (I) is licensed pursuant to
20 such law, or (II) is approved by the agency
21 of such State or locality responsible for li-
22 censing institutions of this nature, as meeting
23 the standards established for such licensing;
24 and

1 "(v) meets such other conditions relat-
2 ing to the health and safety of individuals
3 who are furnished services by such clinic or
4 agency on an outpatient basis, as the Secre-
5 tary may find necessary, or
6 "(B) if furnished by a public health agency,
7 unless such agency meets such other conditions
8 relating to health and safety of individuals who
9 are furnished services by such agency on an out-
10 patient basis, as the Secretary may find neces-
11 sary. The term 'outpatient rehabilitative services'
12 also includes rehabilitation services furnished an
13 individual by a physical therapist or speech pa-
14 thologist (in his office or in such individual's
15 home) who meets licensing and other standards
16 prescribed by the Secretary in regulations, other-
17 wise than under an arrangement with and under
18 the supervision of a provider of services, clinic,
19 rehabilitation agency, or public health agency, if
20 the furnishing of such services meets such condi-
21 tions relating to health and safety as the Secre-
22 tary may find necessary.

1 "PROHIBITION AGAINST EXCLUSION BY EMPLOYERS OF
2 CERTAIN EMPLOYEES FROM COVERAGE UNDER
3 GROUP HEALTH INSURANCE PLANS

4 "SEC. 1947. (a) If any employer provided for some or
5 all of his employees coverage under a group health insurance
6 plan, it shall be unlawful for such employer to exclude from
7 coverage under such plan any employee of such employer
8 if—

9 "(1) such employee belongs to a category of em-
10 ployees who would ordinarily be eligibile for coverage
11 under such plan, and

12 "(2) such employee is excluded from coverage
13 under such plan because of the coverage provided
14 under this title.

15 "(b) Any person violating the provisions of subsection
16 (a) shall be fined not more than $10,000 and imprisoned for
17 not more than one year.".

18 (b)(1) Section 201(i)(1) of the Social Security Act is
19 amended by striking out "and the Federal Supplementary
20 Medical Insurance Trust Fund" and inserting in lieu thereof
21 "the Federal Supplementary Medical Insurance Trust Fund,
22 and the Medical Coverage Trust Fund".

23 (2) Section 201(g)(1)(A) of such Act is amended—

24 (A) by inserting "the Medical Coverage Trust
25 Fund, and" immediately after "shall include also", and

1 (B) by inserting "title XIX," immediately after
2 "title XVI," wherever it appears therein.

3 TITLE III—PRIVATE BASIC HEALTH INSURANCE
4 CERTIFICATION PROGRAM

5 SEC. 301. The Social Security Act is amended by
6 adding after title XIV thereof the following new title:

7 "TITLE XV—PRIVATE BASIC HEALTH
8 INSURANCE CERTIFICATION

9 "PURPOSE

10 "SEC. 1501. It is the purpose of this title to encourage
11 and facilitate the availability to the public of private basic
12 health insurance coverage at a reasonable premium charge
13 by—

14 "(a) establishing a procedure whereby health in-
15 surance policies offered by private insurers may be cer-
16 tified by the Secretary as meeting minimum standards
17 with respect to adequacy of coverage, conditions of
18 payment, opportunity for enrollment, and reasonable-
19 ness of premium charges,

20 "(b) facilitating arrangements whereby basic
21 health insurance policies meeting such standards can
22 be offered through pools of private insurers, and

23 "(c) encouraging States, through their laws and
24 regulations pertaining to the health insurance industry,
25 to facilitate the offering, within the State, of such basic

1 health insurance coverage by carriers doing health in-
2 surance business within the State.

3 "CERTIFICATION OF BASIC PRIVATE HEALTH INSURANCE
4 POLICIES

5 "SEC. 1502. (a) Any insurer which desires to have a
6 health insurance policy certified for use in one or more States
7 specified by the insurer may (in accordance with regulations
8 of the Secretary) provide to the Secretary, for his examina-
9 tion and certification, any health insurance policy.

10 "(b)(1) If the Secretary, after examining any such policy
11 and evaluating any data submitted in connection with such
12 policy, determines that such policy meets the standards pre-
13 scribed in section 1504, he shall certify such policy for use in
14 each State which has in effect a basic health insurance facili-
15 tation program (as defined in section 1510).

16 "(2)(A) The certification by the Secretary of any such
17 policy shall be conditioned upon such policy's continuing to
18 meet the standards prescribed in section 1504; and no policy
19 shall be deemed to have been certified by the Secretary under
20 this title for any period for which it fails to meet such
21 standards.

22 "(B) The Secretary shall establish procedures whereby
23 any insurer having secured the Secretary's certification of
24 any policy offered by such insurer shall from time to time
25 provide to the Secretary (i) relevant data with respect to such

1 policy in order for the Secretary to determine whether such
2 policy continues to meet the standards prescribed in section
3 1504, and (ii) such data and information as the Secretary
4 may require in order to assure proper coordination of the
5 administration of titles XIX and XXI.
6 "(c) Notwithstanding the preceding provisions of this
7 section, the Secretary shall not certify any health insurance
8 policy of any insurer for use in any State unless such insurer
9 furnishes assurances satisfactory to the Secretary that such
10 insurer (whether as a member of a health reinsurance or
11 other residual market arrangement or otherwise) will make
12 generally available, in each geographic area of the State in
13 which the insurer does health insurance business, to all indi-
14 viduals and family members the following two health insur-
15 ance policies: (i) a policy which meets the standards of sec-
16 tion 1504, and (ii) a policy which, if it were issued in combi-
17 nation with a plan meeting the minimum coverage necessary
18 to meet the requirement imposed by section 2122(a)(1)(B),
19 would, in the aggregate, meet the standards of section 1504.
20 "UTILIZATION OF STATE AGENCIES FOR CERTIFICATION
21 OF POLICIES
22 "SEC. 1503. If any State has in effect a basic health
23 insurance facilitation program (as defined in section 1510),
24 the Secretary shall, if such State is willing to do so, enter
25 into an agreement with such State whereby the agency re-

1 sponsible for the regulation of the health insurance industry
2 within such State will, on behalf of the Secretary, make such
3 determinations regarding whether basic health insurance
4 policies meet the requirements for certification under this
5 title, as may be specified by the Secrtary. Such agreement
6 shall provide that the agency will be reimbursed for its rea-
7 sonable expenses incurred in carrying out activities specified
8 in the agreement.

9 "STANDARDS WITH RESPECT TO BASIC HEALTH
10 INSURANCE POLICIES

11 "SEC. 1504. (a) The Secretary shall not certify under
12 this title any insurance policy offered (or to be offered) by an
13 insurer unless he finds that—
14 "(1) such policy provides—
15 "(A) inpatient hospital coverage (without any
16 deductible in excess of $100 or copayment by the
17 insured person) for at least 60 days during any
18 policy year,
19 "(B) medical coverage which shall include
20 home, office, hospital, and other institutional care
21 provided by physicians,
22 "(C) with respect to medical coverage,
23 that—
24 "(i) subject to clauses (ii) and (iii), pay-
25 ment in full shall be made with respect to

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1 not less than the first $2,000 of reasonable
2 expenses incurred by any insured person for
3 any policy year for services with respect to
4 which coverage applies,
5 "(ii) the copayment required of any in-
6 sured person with respect to such reasonable
7 expenses shall not exceed 20 per centum
8 thereof, and
9 "(iii) in the case of any deductible appli-
10 cable to the payment of such reasonable ex-
11 penses for any benefit year or benefit period
12 of not less than 12-months duration, such de-
13 ductible shall not exceed $50 for any insured
14 person, and that, for purposes of computing
15 such deductible for any calendar, policy, or
16 other fixed benefit year or period, the insured
17 person shall be given credit for any deduct-
18 ible applied toward such expenses for the
19 last 3 months of the preceding policy year,
20 "(D) in case such policy is a group policy,
21 there will be no exclusion from coverage or limi-
22 tation on payment on account of any medical con-
23 dition (including any preexisting condition) or any
24 waiting period prior to the beginning of coverage
25 with respect to any such condition,

1 "(E) in case such policy is an individual
2 policy (including a policy for an individual and
3 members of his family), there will be no exclusion
4 from coverage on account of any medical condi-
5 tion (including any preexisting condition) other
6 than pregnancy, and there will be no waiting
7 period prior to the beginning of coverage with re-
8 spect to any preexisting condition which is greater
9 than 90 days after the date the policy is issued,
10 "(F) in case such policy covers an individual
11 and members of his family, coverage will be pro-
12 vided for all dependent unmarried children in the
13 family under age 22, and coverage will be auto-
14 matically extended, at birth to any newborn and
15 upon adoption to any newly adopted, child of such
16 individual or his spouse,
17 "(G) in case such policy is a group policy
18 which covers all or a certain category of employ-
19 ees of any employer, that—
20 "(i) coverage will not be terminated
21 with respect to any employee (and members
22 of such employee's family, if such policy
23 covers such members) because of the termi-
24 nation of such employee's employment prior

1 to the expiration of 31 days after the date of
2 such termination,
3 "(ii) the insurer offering such policy will
4 afford to any employee covered by such
5 policy whose employment has been terminat-
6 ed a reasonable opportunity to secure, from
7 such insurer a basic private health insurance
8 policy which has been approved under this
9 title,
10 "(iii) there will be a periodic open en-
11 rollment period of at least 31 days (which
12 shall occur not less often than once during
13 each policy year) in which all eligible em-
14 ployees, who are not covered by such policy
15 because of failure to elect coverage at the
16 time of initial employment or during previous
17 open enrollment periods, can secure coverage
18 thereunder,
19 "(2) the premium charge for such policy is such
20 that there is not an unreasonable ratio of expenses to
21 premiums (as determined under subsection (d)); and
22 "(3) there is established an appropriate (but differ-
23 ent) premium rate for such policy when it is offered to
24 cover (A) a single individual, (B) a married couple, or
25 (C) a family.

1 "(b) The Secretary, in determining whether any com-
2 prehensive prepaid group practice plan is eligible for certifi-
3 cation under this section, shall, in lieu of the standards im-
4 posed by subsection (a), develop and apply criteria which
5 assure that such plan meets requirements which are, on an
6 actuarial and benefit basis, at least equivalent to such
7 standards.

8 "(c) Notwithstanding the provisions of subsections (a)
9 and (b), the Secretary shall not withhold approval under this
10 title of any health insurance policy solely because such policy
11 excludes—

12 "(1) charges for services or supplies in connection
13 with an occupational disease or injury,

14 "(2) items or services for which the insured indi-
15 vidual furnished such items or services has no legal ob-
16 ligation to pay, and which no other person (by reason
17 of such individual's membership in a prepayment plan
18 or otherwise) has a legal obligation to provide or pay
19 for,

20 "(3) any item or service to the extent that pay-
21 ment has been made, or can reasonably be expected to
22 be made (as determined in accordance with regula-
23 tions), with respect to such item or service, under a
24 workmen's compensation law or plan of the United
25 States or a State,

1 "(4) charges for services or supplies with respect
2 to which benefits are provided under title XVIII or
3 title XXI,

4 "(5) items or services which are not reasonable
5 and necessary for the diagnosis or treatment of illness
6 or injury, pregnancy, or to improve the functioning of a
7 malformed body member,

8 "(6) charges for care, treatment, services, or sup-
9 plies, provided to any individual, to the extent that the
10 payment of benefits with respect thereto is prohibited
11 by any applicable law of the jurisdiction in which such
12 individual is residing at the time he receives such care,
13 treatment, services, or supplies,

14 "(7) charges for care, treatment, or supplies pro-
15 vided to any individual, to the extent that they are not
16 reasonably priced (except that, for purposes of this
17 paragraph, the charge for any item or service shall be
18 deemed to be reasonable, if such charge is not in
19 excess of the allowable charge therefor under the
20 XVIII or XXI),

21 "(8) charges in connection with routine physical
22 checkups,

23 "(9) expenses incurred for items or services,
24 where such expenses are for cosmetic surgery or are
25 incurred in connection therewith, except as required for

1 the prompt repair of accidental injury or for improve-
2 ment of the functioning of a malformed body member,
3 "(10) charges made by a hospital for the profes-
4 sional services of any resident physician or intern to
5 the extent that such charges are in excess of the actual
6 cost incurred by the hospital in providing such services,
7 "(11) charges for the professional services of a
8 psychiatrist to the extent that such charges exceed
9 $400 in a policy year, or
10 "(12) amounts which represent deductible and co-
11 insurance provisions and which generally result in ag-
12 gregate benefit coverage which is at least equal to the
13 actuarial equivalent of the benefit coverage resulting
14 from the application of the deductible and coinsurance
15 provisions in section 1504(a)(1).
16 "(d)(1) With respect to policies submitted to the Secre-
17 tary for his certification under this title, the Secretary shall
18 establish (after considering the size of the groups to be cov-
19 ered by any such policy and the nature of the insurer) appro-
20 priate reasonable ratios of expenses to premiums imposed for
21 coverage thereunder. In the case of individual policies such
22 ratios shall be the same as those established by the Secretary
23 for group policies covering the smallest groups. After making
24 an initial determination with respect to any such policy, the
25 Secretary shall periodically thereafter review and make a re-

1 determination of such ratios based on actual expenses there-
2 under and the actual premium charges made for the period
3 with respect to which the review is made, in order to deter-
4 mine whether such policy continues to meet the requirements
5 for certification.

6 "(2) In determining the appropriate reasonable ratio of
7 expenses to premiums imposed with respect to any particular
8 health insurance policy offered by an insurer, the Secretary
9 shall, in his determinations of such ratio, give consideration
10 to the average ratio, with respect to group policies generally
11 underwritten by insurers (classified on the basis of nonprofit
12 or profitmaking) with respect to policies excluding those
13 which are not certified under this title.

14 "APPROVED CARRIER

15 "SEC. 1505. For purposes of sections 1923(b), 1816,
16 and 1842, an 'approved carrier' is an insurer which the Sec-
17 retary has found (1) to offer one or more health insurance
18 policies approved under section 1502 to the general public in
19 each geographic or normal service area in which such insurer
20 offers health insurance policies (including any which are not
21 approved under this title) and (2) to employ effective proce-
22 dures and practices designed to assure, through means con-
23 sistent with efficient practices within the insurance industry,
24 appropriate controls of utilization of health care services and

1 the costs and charges imposed therefor with respect to which
2 it will financially participate.

3 "ANTITRUST EXEMPTION

4 "SEC. 1506. (a) It shall not be unlawful under any anti-
5 trust law for any insurer to enter into any contract, combina-
6 tion, or other arrangement with any other insurer or group of
7 insurers for the sole purpose of establishing or participating
8 in an insurance pool, reinsurance, or other residual market,
9 arrangement whereby there will be offered to the public
10 health insurance policies approved under section 1502, if
11 such contract, combination, or other arrangement is approved
12 by the Secretary, as being consistent with the purposes of
13 this title, before any party to the contract, combination, or
14 other arrangement has carried out any activity, or refrained
15 from carrying out any activity, under its terms (other than
16 such activity as may be necessary to negotiate the contract,
17 combinataion, or other arrangement and to apply for approv-
18 al of the same under this section). The Secretary shall not
19 approve any contract, combination, or other arrangement
20 under which the parties thereto agree to act in a manner
21 which constitutes a violation of any such law for which no
22 exemption is provided under the preceding sentence or for
23 purposes other than the purposes for which the exemption
24 contained in the preceding sentence is established. Nothing
25 contained in this subsection shall exempt from any antitrust

1 law any predatory pricing or practice, or any other conduct
2 in the otherwise exempt activities of two or more such insur-
3 ers under a contract, combination, or other arrangement ap-
4 proved under this section which would be unlawful under any
5 such law if engaged in by only one such insurer.

6 "(b) For purposes of this section, the term 'antitrust
7 law' means the Federal Trade Commission Act, each statute
8 referred to in section 4 of that Act (15 U.S.C. 44) as an
9 Antitrust Act, any other statute of the United States in pari
10 materia, and any law of any State or political subdivision
11 thereof which prohibits or restrains contracts, combinations,
12 or other arrangements in restraint of trade.

13 "ESTABLISHMENT OF EMBLEM TO INDICATE
14 CERTIFICATION

15 "SEC. 1507. (a) The Secretary shall cause to be de-
16 signed an appropriate emblem which may be used as an indi-
17 cation that certification of an insurance policy under this title
18 has been made by the Secretary; and any insurer which has
19 secured certification of an insurance policy by the Secretary
20 under this title may have printed thereon such emblem, and
21 may, in advertising such policy to potential subscribers, state
22 that such policy has received such a certification.

23 "REPORT TO CONGRESS

24 "SEC. 1508. The Secretary shall, at the earliest practi-
25 cable date (but not later than 60 days) after the expiration of

1 the three-year period which commences on the date of enact-
2 ment of this section, submit to the Congress a report indicat-
3 ing (1) the extent to which basic private health insurance
4 policies certified by the Secretary under this title are actually
5 and generally available to the residents of each State, and (2)
6 the extent to which residents in each State are covered by
7 such policies.

8 "DUTY OF SECRETARY TO MAKE AVAILABLE INDIVIDUAL
9 AND FAMILY HEALTH INSURANCE POLICIES ON A
10 COST BASIS

11 "SEC. 1509. (a) The Secretary shall offer a standard
12 health insurance policy, which meets the applicable criteria
13 prescribed under this title with respect to approved basic
14 health insurance policies, to individuals, married couples, and
15 families living in any State (1) which does not have in effect a
16 basic health insurance facilitation program (as found by the
17 Secretary under section 1510, and (2) in which there is not
18 actually and generally available one or more approved basic
19 health insurance policies approved under this title.

20 "(b) The premiums imposed under any such policy shall
21 be in an amount designed to cover the costs (inclusive of
22 administrative costs and appropriate reserves which will be
23 incurred in furnishing the benefits provided in the policy.

1 "(c) No such policy shall be offered in any area prior to
2 the expiration of the 3-year period which commences on the
3 date of enactment of this title.

4 "(d) Premiums collected by the Secretary for insurance
5 policies offered by him under this section shall be deposited in
6 an Insurance Revolving Fund, and moneys in such fund shall
7 be available, without fiscal year limitation, for the payment of
8 claims under such policies.

9 "(e) For the purpose of providing a contingency reserve
10 for the insurance program established by this section, there is
11 authorized to be appropriated such sums as may be neces-
12 sary; and any sums appropriate for such purpose shall remain
13 available for the purpose of making repayable advances
14 (without interest) to the Insurance Revolving Fund author-
15 ized to be established under subsection (d).

16 "(f) The Secretary, in making payment for services cov-
17 ered under any insurance policy issued pursuant to this sec-
18 tion, shall utilize the payments methodology and administra-
19 tive mechanism employed by him for making payment for
20 services covered under the insurance programs established by
21 title XVIII.

22 "BASIC HEALTH INSURANCE FACILITATION PROGRAM

23 "SEC. 1510. (a) For purposes of this title, a State shall
24 be regarded as having in effect a basic health insurance facili-
25 tation program only if the Secretary, after examining the per-

1 tinent laws and regulations of such State governing the doing
2 of health insurance business within the State by carriers, de-
3 termines that such laws and regulations—
4 "(1) require the establishment of one or more
5 health reinsurance or other residual market arrange-
6 ment to be utilized by such carriers in connection with
7 the offering within the State of basic health insurance
8 policies which meet the standards for certification by
9 the Secretary established by this title,
10 "(2) require all such carriers to be members of a
11 health reinsurance or other residual market arrange-
12 ment and provide that losses, under any such arrange-
13 ment, will be shared by all members thereof on a pro
14 rata basis in proportion to their respective shares of
15 the total health insurance premium earned in the State
16 during the calendar year,
17 "(3) provide that premiums charged for policies
18 issued to individuals or family members under any such
19 health reinsurance or other residual market arrange-
20 ment shall not be less than 125 per centum nor more
21 than 150 per centum of the average group rate for the
22 same coverage under a group policy covering ten lives,
23 and
24 "(4) otherwise encourage and facilitate the offer-
25 ing of such policies within the State by all carriers

1 doing health insurance business therein on a basis
2 which is fair and equitable to each such carrier.
3 "(b) The Secretary is authorized, upon the request of
4 any State, to provide appropriate technical assistance to aid
5 the State in developing a program which meets the condi-
6 tions prescribed in subsection (a).".

7 TITLE IV—OTHER AMENDMENTS

8 PROGRAM IMMUNIZATIONS

9 SEC. 401. (a) Section 1861(s) of the Social Security Act
10 is amended—
11 (1) by striking out "and" at the end of paragraph
12 (8),
13 (2) by striking out the period at the end of para-
14 graph (9) and inserting in lieu thereof "; and",
15 (3) by inserting immediately after paragraph (9)
16 the following new paragraph:
17 "(10) such immunizations as the Secretary deter-
18 mines are appropriate, but only if provided on a sched-
19 uled allowance basis (as determined under regulations
20 of the Secretary).", and
21 (4) by redesignating paragraphs (10) through (13)
22 as paragraphs (11) through (14), respectively.
23 (b) Section 1864(a) of such Act is amended by striking
24 out "paragraphs (10) and (11)" and inserting in lieu thereof
25 "paragraphs (12) and (13)".

1 (c) Section 1862(a)(7) of such Act is amended by insert-
2 ing immediately after "(7)" the following: "except as pro-
3 vided in section 1861(s)(10),".
4 (d) The amendments made by this section shall apply
5 only with respect to services furnished on or after the first
6 day of the month following the month in which this section is
7 enacted.

8 MENTAL HEALTH SERVICES

9 SEC. 402. (a) Section 1833(c) of the Social Security Act
10 is amended—
11 (1) by striking out "$312.50" and inserting in lieu
12 thereof "$500", and
13 (2) by striking out "62½ per centum" and insert-
14 ing in lieu thereof "80 per centum".
15 (b) Section 1812 of such Act is amended—
16 (1) by striking out subsection (c) thereof,
17 (2) in subsection (b) thereof, by striking out "(sub-
18 ject to subsection (c))", and
19 (3) in subsection (e) thereof, by striking out "sub-
20 sections (b), (c), and (d)" and inserting in lieu thereof
21 "subsections (b) and (d)".
22 (c) The amendments made by subsection (a) shall be ef-
23 fective only with respect to services furnished after Decem-
24 ber 31, 1980. The amendments made by subsection (b) shall

1 be effective only with respect to services furnished after De-
2 cember 31, 1981.

3 AMOUNT OF PREMIUMS FOR HOSPITAL INSURANCE
4 COVERAGE

5 SEC. 403. (a)(1) The second sentence of section
6 1818(d)(2) of the Social Security Act is amended by striking
7 out "Such amount shall be equal to $33, multiplied by" and
8 inserting in lieu thereof "Such amount shall be equal to 50
9 per centum of the product of $33 multiplied by".

10 (2) The amendment made by paragraph (1) shall be ap-
11 plicable in the case of premiums imposed on and after July 1,
12 1979.

13 (b) In addition to other moneys appropriated to the Fed-
14 eral Hospital Insurance Trust Fund, there shall be appropri-
15 ated from time to time, with respect to periods commencing
16 after June 30, 1979, amounts equal to 100 per centum of the
17 amounts deposited in such Fund pursuant to section 1818(f)
18 of the Social Security Act from premiums payable for such
19 period.

20 PAYMENT FOR EXTENDED CARE SERVICES

21 SEC. 404. Section 1861(v)(E) of the Social Security Act
22 is amended to read as follows:

23 "(E)(i) In the case of services furnished by a skilled
24 nursing facility with respect to which payment for services
25 furnished under title XIX is made on a cost-related basis

1 pursuant to the provisions of section 1920(d)(2), such regula-
2 tions may provide for the use of rates which are the same as
3 the rates obtaining for such services under title XIX (except
4 that such rates may be increased by the Secretary on a class
5 or size of institution, or on a geographical basis by a percent-
6 age factor not in excess of 10 per centum to take into ac-
7 count determinable items or services or other requirements
8 under this title not otherwise included in the computation of
9 such rates under title XIX): *Provided*, That no such regula-
10 tions shall become effective prior to the 60th day following
11 the date on which the Secretary submits to the Congress a
12 copy thereof together with a full and complete description of
13 the methodology which would be employed in the determina-
14 tion of rates pursuant thereto, and an evaluation by the Sec-
15 retary and by the Comptroller General of such methodology
16 in terms of the extent to which the employment thereof will
17 promote the efficient and economical administration of this
18 title and equitable treatment to and between skilled nursing
19 facilities furnishing services for which payment may be made
20 hereunder.".

21 EXTENSION OF COVERAGE UNDER RENAL DISEASE
22 PROGRAM

23 SEC. 405. Section 226(e) of the Social Security Act is
24 amended by adding at the end thereof the following: "For
25 purposes of the preceding sentence, any individual, who on or

1 after the date of enactment of this sentence fails to meet the
2 condition imposed by clause (2) of such sentence, shall be
3 deemed to meet such condition. There are authorized to be
4 appropriated, from time to time, to the Federal Hospital In-
5 surance Trust Fund and to the Federal Supplementary Medi-
6 cal Insurance Trust Fund such sums as may be necessary (as
7 based on estimates of the Secretary) to place each such Fund
8 in the same financial condition that it would have occupied
9 had the preceding sentence not been enacted.".

10 ENCOURAGEMENT OF PHILANTHROPIC SUPPORT FOR
11 HEALTH CARE

12 SEC. 406. Part A of title XI of the Social Security Act
13 is amended by adding after section 1131 the following new
14 section:

15 "ENCOURAGEMENT OF PHILANTHROPIC SUPPORT FOR
16 HEALTH CARE

17 "SEC. 1134. (a) It is the policy of the Congress that
18 philanthropic support for health care be encouraged and ex-
19 panded, especially in support of experimental and innovative
20 efforts to improve the health care delivery system and access
21 to health care services.

22 "(b)(1) For purposes of determining, under title XVIII
23 or XIX, the reasonable costs of any service furnished by a
24 provider of health services—

1 "(A) except as provided in paragraph (2), unre-
2 stricted grants, gifts, and endowments and income
3 therefrom, shall not be deducted from the operating
4 costs of such provider, and
5 "(B) grants, gifts, and endowment income desig-
6 nated by a donor for paying specific operating costs of
7 such provider shall be deducted from the particular op-
8 erating costs or group of costs involved.
9 "(2) Income from endowments and investments may be
10 used to reduce interest expense, if such income is from an
11 unrestricted gift or grant and is commingled with other funds,
12 except that in no event shall any such interest expense be
13 reduced below zero by any such income.".

96TH CONGRESS
1ST SESSION
S. 351

To amend the Social Security Act by adding thereto a new title XXI which will provide insurance against the costs of catastrophic illness and by adding a new title XV thereto which will encourage and facilitate the availability, through private insurance carriers, of basic health insurance at reasonable premium charges, and for other purposes.

IN THE SENATE OF THE UNITED STATES

FEBRUARY 6 (legislative day, JANUARY 15), 1979

Mr. LONG (for himself, Mr. TALMADGE, Mr. YOUNG, Mr. MELCHER, Mr. CANNON, Mr. INOUYE, Mr. STAFFORD, Mr. PERCY, Mr. STONE, Mr. HATFIELD, and Mr. MATHIAS) introduced the following bill; which was read twice and referred to the Committee on Finance

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A BILL

To amend the Social Security Act by adding thereto a new title XXI which will provide insurance against the costs of catastrophic illness and by adding a new title XV thereto which will encourage and facilitate the availability, through private insurance carriers, of basic health insurance at reasonable premium charges, and for other purposes.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

II—E

1 That this Act may be cited as the "Catastrophic Health In-
2 surance Act".

3 TITLE I—CATASTROPHIC ILLNESS INSURANCE

4 AMENDMENTS TO SOCIAL SECURITY ACT

5 SEC. 101. (a) The Social Security Act is amended by
6 adding after title XX the following new title:

7 "TITLE XXI—CATASTROPHIC HEALTH
8 INSURANCE PROGRAM

9 "PURPOSE OF TITLE

10 "SEC. 2101. The insurance program established by this
11 title is designed to provide protection to all individuals who
12 are citizens or permanent residents of the United States
13 against the costs of high-cost catastrophic illness. Each such
14 individual will be provided such protection either under the
15 Federal plan established by part A of this title, or under an
16 employer plan or a self-employed plan approved under part B
17 of this title.

18 "PART A—FEDERAL PLAN

19 "ELIGIBLE INDIVIDUALS

20 "SEC. 2102. (a) Every individual who—
21 "(1) is a resident of the United States, and
22 "(2) is a citizen of, or an alien lawfully admitted
23 for permanent residence in, the United States, or an
24 alien otherwise permanently residing in the United
25 States under color of law (including any alien who is

1 lawfully present in the United States as a result of the
2 application of the provisions of section 203(a)(7) or sec-
3 tion 212(d)(5) of the Immigration and Nationality Act),
4 shall (subject to section 2107) be entitled to catastrophic
5 health insurance benefits provided by this part for any period
6 which commences on or after January 1, 1981, and with
7 respect to which he is not covered by an employer plan or a
8 self-employed plan approved under part B.

9 "(b) For purposes of subsection (a), entitlement of an
10 individual to catastrophic health insurance benefits under this
11 part shall consist of entitlement to have payment made,
12 under and subject to the limitations in this title, to him or on
13 his behalf for the services described in section 2103(a) which
14 are furnished to him in the United States (or outside the
15 United States in the case of services specified in section
16 1814(f)).

17 "SCOPE OF BENEFITS

18 "SEC. 2103. (a) The benefits provided to an individual
19 by the insurance program established by this part shall con-
20 sist of entitlement to have payment made (subject to the pro-
21 visions of this part) on his behalf or to him for—

22 "(1) hospital and related services (as defined in
23 subsection (c)(1)) which are furnished to such individual
24 during a period with respect to which he has met the
25 deductible imposed by section 2104(b), and

1 "(2) medical and other health services (as defined
2 in subsection (c)(2)) which are furnished to such indi-
3 vidual during a period with respect to which he has
4 met the deductible imposed by section 2104(c).

5 "(b) Payment authorized under this part for any service
6 covered hereunder shall be made to the person to whom pay-
7 ment for such service would be made under title XVIII, if
8 such service were furnished to an individual who was covered
9 therefor under title XVIII.

10 "(c)(1) The term 'hospital and related services' means—

11 "(A) inpatient hospital services (as defined in sec-
12 tion 1861(b)),

13 "(B) post-hospital extended care services (as de-
14 fined in section 1861(i)), and

15 "(C) home health services (as defined in section
16 1861(m)).

17 "(2) The term 'medical and other health services'
18 means—

19 "(A) medical and other health services (as defined
20 in section 1861(s)),

21 "(B) home health services (as defined in section
22 1861(m)),

23 "(C) outpatient physical therapy services (as de-
24 fined in section 1861(p)), and

1 "(D) rural health clinic services (as defined in sec-
2 tion 1861(aa)).
3 "(d) Notwithstanding the preceding provisions of this
4 section, no payment may be made and no deductible shall be
5 incurred with respect to—
6 "(1) expenses incurred for items or services, if
7 pursuant to section 1862 (a), (b), or (d) payment may
8 not be made with respect to such items or services
9 under title XVIII, or
10 "(2) expenses incurred for post-hospital extended
11 care services furnished to an individual on any day
12 during any calendar year, if, prior to such day, there
13 have been furnished to such individual for 100 days
14 during such year such services with respect to which
15 benefits under this part are payable.
16 "PAYMENT AND DEDUCTIBLE
17 "SEC. 2104. (a)(1) Payment of benefits under this part
18 with respect to expenses incurred by an insured individual
19 shall be made from the Federal Catastrophic Health Insur-
20 ance Trust Fund.
21 "(2) For purposes of payment of benefits under this part
22 with respect to expenses incurred for health services fur-
23 nished by any insured individual, there shall be taken into
24 account—

1 "(A) in case of expenses incurred for hospital and
2 related services (as defined in section 2103(c)(1)), only
3 so much of such expenses as are incurred for such
4 services furnished during a period with respect to
5 which the deductible imposed by subsection (b) is met,
6 and

7 "(B) in case of expenses incurred for medical and
8 other health services (as defined in section 2103(c)(2)),
9 only so much of such expenses as are incurred for such
10 services furnished during a period with respect to
11 which the deductible imposed by subsection (c) is met;
12 and, with respect to the services to which the expenses so
13 taken into account are attributable, there shall be paid
14 (except where inconsistent with the provisions or purposes of
15 this part) an amount which shall be equal to (and determined
16 in the same manner as) the amount which would have been
17 payable for such service under title XVIII in the case of an
18 individual entitled to have payment made with respect there-
19 to under such title (as determined without regard to any pro-
20 vision of such title relating to deductibles or copayments).

21 "(b) The deductible imposed by this subsection with re-
22 spect to expenses incurred for hospital and related services
23 (as defined in section 2103(c)(1)) shall be met by an insured
24 individual—

1 "(1) for the period, in the calendar year, which
2 commences on the day following the 60th day, during
3 the calendar year and the last 3 months of the preced-
4 ing calendar year, in which such individual received in-
5 patient hospital services; and
6 "(2) for the period, in the calendar year, which is
7 prior to the first consecutive 90-day period therein in
8 which such individual is neither an inpatient in a hospi-
9 tal nor an inpatient in a skilled nursing facility, but
10 only if the first day for which such services in the cal-
11 endar year occurs not later than 90 days after the last
12 day with respect to which benefits were payable under
13 this part on account of inpatient hospital services fur-
14 nished to him in the preceding calendar year.
15 "(c)(1) The deductible imposed by this subsection with
16 respect to expenses incurred for medical and other health
17 services (as defined in section 2103(c)(2)) shall be met by an
18 insured individual—
19 "(A) for the period, in the calendar year, which
20 occurs after such individual has incurred, during such
21 year and the last 3 months of the preceding calendar
22 year, expenses (including expenses deemed under para-
23 graph (2) to be incurred by him, but excluding amounts
24 required to be excluded under paragraph (3)) for such

1 services of $2,000 (or, if higher, the amount deter-
2 mined under paragraph (4)); and
3 "(B) for the period, in the calendar year, which
4 occurs prior to the first 90-day period therein during
5 which such individual incurs for such services expenses
6 (including expenses deemed under paragraph (2) to be
7 incurred by him) the aggregate of which is less than
8 $500 (or, if greater, the amount determined under
9 paragraph (5)), but only if (i) during the last 3 months
10 of the preceding calendar year, such individual incurred
11 for such services expenses (including expenses deemed
12 under paragraph (2) to be incurred by the individual) of
13 at least $500 (or, if greater, the amount determined
14 under paragraph (5)), and (ii) such individual had met
15 (by reason of the application of clause (A)) for a period
16 in the preceding calendar year the deductible imposed
17 by this paragraph.
18 "(2)(A) In determining, for purposes of clauses (A) and
19 (B) of paragraph (1), the amount of expenses incurred by an
20 individual for medical and other health services furnished
21 during any period, there shall be deemed to have been in-
22 curred by such individual any expenses incurred for such
23 services furnished during such period to each other member
24 of such individual's family, but only if such other member is
25 (i) the spouse of the individual, (ii) a dependent of such indi-

1 vidual, (iii) the person (or the spouse of the person) of whom
2 such individual is a dependent, or (iv) a person who is a de-
3 pendent of the same person of whom such individual is a
4 dependent.

5 "(B) For purposes of subparagraph (A)—

6 "(i) the term 'dependent' shall have the meaning
7 assigned to it by regulations of the Secretary;

8 (ii) the term 'family' means two or more individ-
9 uals who are (I) related by blood, marriage or adop-
10 tion, and (II) living in a place of residence maintained
11 by one or more of them as his or their own home (and
12 for purposes of this clause, a child under age 22 who is
13 absent from home for the purpose of attending an edu-
14 cational institution as a full-time student shall be
15 deemed while so absent to be living in such place of
16 residence); and

17 "(iii) the term 'member', when used in reference
18 to a family means an individual described in clause (ii).

19 "(3) In determining, for purposes of paragraph (1) (A),
20 the amount of expenses incurred (or deemed to be incurred)
21 by an individual for medical and other health services in any
22 calendar year, there shall be disregarded all amounts in
23 excess of $500 incurred in connection with the treatment of
24 mental, psychoneurotic, or personality disorders of such indi-
25 vidual.

1 "(4) The Secretary shall, between July 1 and October 1
2 of 1981 and of each 1981 and of each year thereafter, deter-
3 mine and promulgate the deductible which shall be applicable
4 for purposes of paragraph (1)(A) in the succeeding calendar
5 year. Such deductible shall be equal to whichever of the fol-
6 lowing is the higher:
7 "(A) $2,000, or
8 "(B) $2,000 multiplied by the ratio of the compo-
9 nent of the Consumer Price Index, prepared by the
10 Department of Labor for June of the year in which
11 such determination is made and promulgated, which
12 represents fees for physician services to such compo-
13 nent of such Consumer Price Index for the month of
14 June 1980, with such product, if not a multiple of
15 $100, being rounded to the nearest multiple of $100.
16 "(5) The Secretary shall between July 1 and October of
17 1981 and of each year thereafter, determine and promulgate
18 the amount which shall be applicable for purposes of para-
19 graph (1)(B) in the succeeding calendar year. Such amount
20 shall be equal to whichever of the following is the higher:
21 "(A) $500, or
22 "(B) $500 multiplied by the ratio of the compo-
23 nent of the Consumer Price Index, prepared by the
24 Department of Labor for June of the year in which
25 such determination is made and promulgated, which

1 represents fees for physician services to such compo-
2 nent of such Consumer Price Index for the month of
3 June 1980, with such product, if not a multiple of $50,
4 being rounded to the nearest multiple of $50.

5 "(e)(1) Payment for services under this title shall also be
6 subject to the limitations described in section 1812(e) and
7 section 1833(e).

8 "(2) payment under this part with respect to expenses
9 incurred in connection with the treatment of mental, psycho-
10 neurotic, and personality disorders shall not be made unless
11 such treatment consists of 'mental health care services' (as
12 defined in paragraph (3)).

13 "(3) As used in paragraph (2) the term 'mental health
14 care services' includes only care and services for mental con-
15 ditions—

16 "(A) which, if provided on an inpatient basis, con-
17 sist of a course of active care and treatment provided
18 in and by an accredited medical institution (as deter-
19 mined by the Secretary),

20 "(B) which, if provided on a partial hospitalization
21 basis, are provided (i) in and by an accredited medical
22 institution (as determined by the Secretary), or (ii) in
23 and by a qualified community mental health center (as
24 determined in accordance with regulations of the Sec-
25 retary),

1 "(C) which, if provided on an outpatient basis,
2 are—
3 "(i) provided by a qualified community
4 mental health center (as determined in accordance
5 with regulations of the Secretary), or
6 "(ii) provided by a psychiatrist;
7 except that such term does not include any outpatient serv-
8 ices provided by a psychiatrist, during a 12-month period, for
9 purposes of diagnosis or treatment of acute psychosis in
10 excess of (I) five visits, plus (II) such additional visits as shall
11 have been approved in advance by an appropriate profession-
12 al review mechanism upon a finding that, in the absence of
13 such additional visits, the patient will require institutional
14 care.
15 "(f)(1) Payment under this part with respect to expenses
16 incurred for blood, blood products, and procedures and
17 courses of treatment which are unusually extensive or com-
18 plex shall be subject to standards and criteria imposed by the
19 Secretary pursuant to paragraph (2).
20 "(2) The Secretary shall by regulations prescribe stand-
21 ards and criteria designed to assure that services consisting
22 of the furnishing of blood or blood products or the application
23 of procedures or courses of treatment, referred to in para-
24 graph (1), for which payment may be made under this part

1 will be provided only when, and to the extent that, such serv-
2 ices are appropriate to the health care needs of the patient.
3 "(g) Payment under this part may not be made for ex-
4 tended care services furnished to an individual during any
5 period for which such individual is entitled to hospital insur-
6 ance benefits under part A of title XVIII.

7 "CONDITIONS OF AND LIMITATIONS ON PAYMENT FOR
8 SERVICES

9 "SEC. 2105. (a) To the extent that payment may be
10 made for services described in section 2103(a)(1), the provi-
11 sions of sections 1814, 1815, 1816, 1833(f), and 1835 shall
12 apply.
13 "(b) To the extent that payment may be made for serv-
14 ices described in section 2103(a)(2), the provisions of section
15 1842 shall apply.

16 "APPLICABILITY OF CERTAIN PROVISIONS OF, OR
17 RELATING TO, TITLE XVIII

18 "SEC. 2106. (a) The provisions of section 1861 (except
19 subsections (a) and (y)), 1866, 1867, 1869, 1870, 1871,
20 1872, 1873, 1874, 1875, 1876, 1877, 1878, and 1879 shall
21 apply with respect to this part to the same extent as they are
22 applicable with respect to title XVIII.
23 "(b) The provisions of section 402(a) of the Social Secu-
24 rity Amendments of 1967 and the provisions of section
25 222(a) of the Social Security Amendments of 1972 shall be

1 applicable to this part to the same extent as they are applica-
2 ble to title XVIII.

3 "TREATMENT OF BENEFITS UNDER OTHER PROGRAMS

4 "SEC. 2107. Any amount otherwise payable under this
5 part with respect to any item or service furnished to an indi-
6 vidual shall not be denied or reduced because a benefit with
7 respect to such item or service has been paid or is payable
8 under any other public or private insurance or health benefits
9 plan. Notwithstanding any other provision of law (other than
10 section 2104(g)), payment with respect to any item or service
11 furnished to any individual shall not be made under the insur-
12 ance program established by part A or B of title XVIII, if
13 such individual is (or, upon filing a proper claim, would be)
14 entitled to have payment made under this part with respect
15 to such item or service.

16 "CONTRIBUTIONS WITH RESPECT TO STATE AND LOCAL
17 EMPLOYEES; APPROVED STATE LAWS

18 "SEC. 2108. (a) Contributions for the financial support
19 of the catastrophic health insurance program established by
20 this part shall be made by employers which are States (or
21 political subdivisions thereof) in the manner prescribed under
22 a State law approved by the Secretary of the Treasury under
23 subsection (b).

24 "(b)(1) The Secretary of the Treasury shall approve a
25 State law for purposes of this section only if such law—

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1 "(A) provides that the State will pay into the
2 Treasury, with respect to wages paid to employees of
3 the State and employees of all political subdivisions of
4 the State, amounts equal to the amounts which such
5 State would be liable to pay with respect to the wages
6 of such employees under the catastrophic health insur-
7 ance protection tax imposed by section 3111(c) of the
8 Internal Revenue Code of 1954 if such State were a
9 private employer and all such employees were em-
10 ployed by it,
11 "(B) provides that any amounts so payable shall
12 be paid at the same time and subject to the same con-
13 ditions as taxes imposed by such section 3111(c) in the
14 case of a private employer,
15 "(C) is in such form and contains such other pro-
16 visions as the Secretary of the Treasury shall by regu-
17 lations provide, and
18 "(D) becomes effective on January 1, 1981.
19 "(2) At the earliest practicable date after the State law
20 of any State has been approved by the Secretary of the
21 Treasury, he shall certify to the Secretary of Health, Educa-
22 tion, and Welfare that such State law has been approved.
23 "(3) If the Secretary of the Treasury finds, after reason-
24 able notice and opportunity for hearing to a State, that—

1 "(A) the State law of such State, theretofore ap-
2 proved by him, has been repealed, or amended so that
3 it no longer meets the requirements imposed by para-
4 graph (1), or

5 "(B) the State has not substantially complied with
6 its obligations to make contributions into the Treasury
7 in accordance with the requirements imposed under
8 paragraph (1),

9 he shall withdraw the certification of such State law thereto-
10 fore approved by him and shall so notify the Secretary of
11 Health, Education, and Welfare.

12 "(c) If, for any period of time after December 31, 1981,
13 a State does not pay in full to the Treasury the amounts
14 specified in subsection (b)(1)(A), the Secretary of Health,
15 Education, and Welfare shall reduce payments otherwise
16 payable to such State under any other provisions of this Act
17 by the amount of such underpayment (including interest
18 thereon equal to the average of the rates of interest, from the
19 date due until paid, on obligations issued for purchase by the
20 Federal Catastrophic Health Insurance Trust Fund).

21 "FEDERAL CATASTROPHIC HEALTH INSURANCE TRUST
22 FUND

23 "SEC. 2109. (a) There is hereby created on the books of
24 the Treasury of the United States a trust fund to be known
25 as the Federal Catastrophic Health Insurance Trust Fund

1 (hereinafter in this section referred to as the 'trust fund'). The
2 trust fund shall consist of such amounts as may be deposited
3 in, or appropriated to, such fund as provided in this part.
4 There are hereby appropriated to the trust fund for the fiscal
5 year ending September 30, 1981, and for each fiscal year
6 thereafter, out of any moneys in the Treasury not otherwise
7 appropriated, amounts equivalent to 100 per centum of—
8 "(1) the taxes imposed by section 3111(c) of the
9 Internal Revenue Code of 1954 with respect to wages
10 reported to the Secretary of the Treasury or his dele-
11 gate pursuant to subtitle F of such Code after Decem-
12 ber 31, 1976, as determined by the Secretary of the
13 Treasury by applying the applicable rates of tax under
14 such sections to such wages, which wages shall be cer-
15 tified by the Secretary of Health, Education, and Wel-
16 fare on the basis of records of wages established and
17 maintained by the Secretary of Health, Education, and
18 Welfare in accordance with such reports;
19 "(2) the taxes imposed by section 1401(c) of the
20 Internal Revenue Code of 1954 with respect to self-
21 employment income reported to the Secretary of the
22 Treasury or his delegates on tax returns under subtitle
23 F of such Code, as determined by the Secretary of the
24 Treasury by applying the applicable rate of tax under
25 such section to such self-employment income, which

1 self-employment income shall be certified by the Secre-
2 tary of Health, Education, and Welfare on the basis of
3 records of self-employment established and maintained
4 by the Secretary of Health, Education, and Welfare in
5 accordance with such return; and
6 "(3) the contributions made by States pursuant to
7 State laws approved under section 2108.
8 The amount appropriated by the preceding sentence shall be
9 transferred from time to time from the general fund in the
10 Treasury to the trust fund, such amounts to be determined on
11 the basis of estimates by the Secretary of the Treasury of the
12 taxes, specified in the preceding sentence, paid to or de-
13 posited into the Treasury; and proper adjustments shall be
14 made in amounts subsequently transferred to the extent prior
15 estimates were in excess of or were less than taxes specified
16 in such sentence.
17 "(b) With respect to the trust fund, there is hereby cre-
18 ated a body to be known as the 'board of trustees of the trust
19 fund' (hereinafter in this section referred to as the 'board of
20 trustees'), composed of the Secretary of the Treasury, the
21 Secretary of Labor, and the Secretary of Health, Education,
22 and Welfare, all ex officio. The Secretary of the Treasury
23 shall be the Managing Trustee of the board of trustees (here-
24 inafter in this section referred to as the 'Managing Trustee').
25 The Administrator of the Health Care Financing Administra-

1 tion shall serve as the secretary of the board of trustees. The
2 board of trustees shall meet not less frequently than once
3 each calendar year. It shall be the duty of the board of
4 trustees to—
5 "(1) hold the trust fund;
6 "(2) report to the Congress not later than the first
7 day of April of each year on the operation and status
8 of the trust fund during the preceding fiscal year and
9 on its expected operation and status during the current
10 fiscal year and the next 2 fiscal years;
11 "(3) report immediately to the Congress whenever
12 the board is of the opinion that the amount of the trust
13 fund is unduly small; and
14 "(4) review the general policies followed in man-
15 aging the trust fund, and recommend changes in such
16 policies, including necessary changes in the provisions
17 of law which govern the way in which the trust fund is
18 to be managed.
19 The report provided for in paragraph (2) shall include a state-
20 ment of the assets of, and the disbursements made from, the
21 trust fund during the preceding fiscal year, an estimate of the
22 expected income to, and disbursements to be made from, the
23 trust fund during the current fiscal year and each of the next
24 2 fiscal years, and a statement of the actuarial status of the

1 trust fund. Such report shall be printed as a House document
2 of the session of the Congress to which the report is made.
3 "(c) It shall be the duty of the Managing Trustee to
4 invest such portion of the trust fund as is not, in his judg-
5 ment, required to meet current withdrawals. Such invest-
6 ments may be made only in interest-bearing obligations of the
7 United States or in obligations guaranteed as to both princi-
8 pal and interest by the United States. For such purpose such
9 obligations may be acquired (1) on original issue at the issue
10 price, or (2) by purchase of outstanding obligations at the
11 market price. The purpose for which obligations of the
12 United States may be issued under the Second Liberty Bond
13 Act, as amended, are hereby extended to authorize the issu-
14 ance at par of public-debt obligations for purchase by the
15 trust fund. Such obligations issued for purchase by the trust
16 fund shall have maturities fixed with due regard for the needs
17 of the trust fund and shall bear interest at a rate equal to the
18 average market yield (computed by the Managing Trustee on
19 the basis of market quotations as of the end of the calendar
20 month next preceding the date of such issue) on all marketa-
21 ble interest-bearing obligations of the United States then
22 forming a part of the public debt which are not due or call-
23 able until after the expiration of 4 years from the end of such
24 calendar month; except that where such average market
25 yield is not a multiple of one-eighth of 1 per centum, the rate

1 of interest on such obligations shall be the multiple of one-
2 eighth of 1 per centum nearest such market yield. The Man-
3 aging Trustee may purchase other interest-bearing obliga-
4 tions of the United States or obligations guaranteed as to
5 both principal and interest by the United States, on original
6 issue or at the market price, only where he determines that
7 the purchase of such other obligations is in the public inter-
8 est.

9 "(d) Any obligations acquired by the trust fund (except
10 public debt obligations issued exclusively to the trust fund)
11 may be sold by the Managing Trustee at the market price,
12 and such public debt obligations may be redeemed at par plus
13 accrued interest.

14 "(e) The interest on, and the proceeds from the sale or
15 redemption of, any obligations held in the trust fund shall be
16 credited to and form a part of the trust fund.

17 "(f) There are authorized to be appropriated to the trust
18 fund from time to time such sums as the Secretary of Health,
19 Education, and Welfare deems necessary for any fiscal year,
20 on account of—

21 "(1) payment made or to be made during such
22 fiscal year from the trust fund with respect to individ-
23 uals who are entitled to benefits under part A of title
24 XVIII,

1 "(2) the administrative expenses attributable to
2 providing benefits under this part to individuals re-
3 ferred to in paragraph (1), and
4 "(3) any loss in interest to the trust fund resulting
5 from the payment of such amounts,
6 in order to place the trust fund in the same position at the
7 end of such fiscal year in which it would have been if the
8 individuals referred to in paragraph (1) were not entitled to
9 the benefits provided under this part.
10 "(g) There shall be transferred periodically (but not less
11 often than once each fiscal year) to the trust fund from the
12 Federal Old-Age and Survivors Insurance Trust Fund and
13 from the Federal Disability Insurance Trust Fund amounts
14 equivalent to the amounts not previously so transferred
15 which the Secretary of Health, Education, and Welfare shall
16 have certified as overpayments pursuant to section 1870(b) of
17 this Act as made applicable to this title by section 2106.
18 "(h) The Managing Trustee shall also pay from time to
19 time from the Trust Fund such amounts as the Secretary of
20 Health, Education, and Welfare certifies are necessary to
21 make the payments provided for by this part, and the pay-
22 ments with respect to administrative expenses in accordance
23 with section 201(g)(1).
24 "(i) There is authorized to be appropriated, out of any
25 moneys in the Treasury not otherwise appropriated, such re-

1 payable advances (without interest) as may be required to
2 assure prompt payment of benefits and administrative ex-
3 penses under this title and to provide a contingency reserve.
4 Such advances to the extent necessary shall be made availa-
5 ble through calendar year 1983.

6 "MEANING OF 'STATE', 'UNITED STATES'

7 "SEC. 2110. As used in this part—
8 "(a) the term 'State' includes the District of Co-
9 lumbia, the Commonwealth of Puerto Rico, the Virgin
10 Islands, Guam, and American Samoa, and
11 "(b) the term 'United States', when used in a geo-
12 graphical sense, means the States, the District of Co-
13 lumbia, the Commonwealth of Puerto Rico, the Virgin
14 Islands, Guam, American Samoa, and the Trust Terri-
15 tory of the Pacific Islands.

16 "PART B—EMPLOYER PLANS, AND SELF-EMPLOYED
17 PLANS

18 "EFFECT OF COVERAGE

19 "SEC. 2120. Any individual who would otherwise be
20 eligible for benefits under part A of this title shall not be
21 eligible for such benefits during any period for which he is
22 covered under an employer plan or a self-employed plan ap-
23 proved by the Secretary under this part, but shall instead be
24 entitled to the benefits provided under such approved plan.

1 "DEFINITIONS

2 "SEC. 2121. For purposes of this part—

3 "(a) The term 'employer plan' means—

4 "(1) an insurance policy, contract, or other ar-
5 rangement entered into between an employer and a
6 carrier under which the carrier, in consideration of pre-
7 miums or other periodic payments, undertakes to pro-
8 vide, pay for, or reimburse the costs of, health services
9 received by those of the employer's employees (and
10 those of the family members of such employees) who
11 are covered by the plan, or

12 "(2) a plan under which the employer, as a self-
13 insured employer (as defined in subsection (d)), under-
14 takes to provide, pay for, or reimburse the costs of,
15 health care services received by those of the employ-
16 er's employees (and those of the family members of
17 such employees) who are covered by the plan.

18 "(b) The term 'self-employed plan' means an insurance
19 policy, contract, or other arrangement entered into between a
20 self-employed individual and a carrier under which such car-
21 rier, in consideration of premiums or other periodic pay-
22 ments, undertakes to provide, pay for, or reimburse the costs
23 of, health services received by such individual (and those of
24 the family members of such individual who are covered by
25 the plan).

1 "(c) The term 'carrier' means a voluntary association,
2 corporation, partnership, or other nongovernmental organiza-
3 tion which is engaged in providing, paying for, or reimburs-
4 ing the costs of, health services under insurance policies or
5 contracts, medical or hospital service agreements, member-
6 ship or subscription contracts, or similar arrangements, in
7 consideration of premiums or other periodic charges payable
8 to the carrier.

9 "(d) The term 'self-insured employer' means an employ-
10 er who (either through outside administrators, including car-
11 riers, or otherwise) engages, without insurance arrangements
12 with a carrier, to provide, pay for, or reimburse the costs of,
13 health services for some or all of his employees.

14 "(e) The term 'employer' includes a State (or political
15 subdivision thereof) and the Federal Government.

16 "APPROVAL OF PLANS

17 "SEC. 2122. (a)(1) In order for an employer plan or a
18 self-employed plan to be approved by the Secretary under
19 this part—

20 "(A) such plan, in the case of any plan other than
21 an employer plan of a self-insured employer, must be a
22 plan offered by a carrier which is approved by the Sec-
23 retary pursuant to subsection (c);

24 "(B) the coverage provided under such plan must
25 include, but shall not be limited to, a package of bene-

1 fits, which (in terms of scope of benefits and the condi-
2 tions of payment thereof) is the same as that provided
3 by the Federal catastrophic health insurance benefits
4 plan established by part A; except that the requirement
5 imposed by this clause shall not be construed to (i)
6 make applicable to the plan (or its administration) the
7 provisions of sections 1862 (b) or (d), 1815, 1816,
8 1842, 1866, 1869, 1870, 1972, or 2104(a)(1), and the
9 carrier offering such plan may utilize, in the adminis-
10 tration of the plan, payment and provider arrangements
11 of the kind which are employed by it in connection
12 with the administration of health insurance policies or
13 plans which are not approved under this part, (ii) re-
14 quire that such plan provide coverage for any occupa-
15 tional injury or disease or for any item or service for
16 which any benefit is payable under a workmen's com-
17 pensation law of the United States or a State, and (iii)
18 preclude the plan from making the benefits offered
19 thereunder subject to provision for coordination of
20 benefits provided under other plans (including the Fed-
21 eral plan established under part A), if such provision
22 for coordination of benefits is approved by the Secre-
23 tary as being consistent with prevailing practice within
24 the health insurance industry for the coordination of
25 benefits;

1 "(C) such plan (in the case of an employer plan)
2 (i) must cover all of the employees of such employer
3 (other than employes who perform service for less than
4 25 hours per week, temporary employees or employees
5 who are entitled, under section 226, to hospital insur-
6 ance benefits under part A of title XVIII), and (ii)
7 may, at the option of the employer, cover all of the
8 employees of the employer;
9 "(D) such plan must cover the spouse and de-
10 pendent family members of any employee (in the case
11 of an employer plan) or self-employed individual (in the
12 case of a self-employed plan) covered by the plan;
13 "(E) such plan (in the case of an employer plan)
14 must not require or permit any financial participation
15 in the cost of the plan by any individual covered there-
16 under;
17 "(F) such plan (in the case of an employer plan)
18 must provide that coverage (in the case of a new em-
19 ployee, his spouse, and dependent family members) will
20 begin not later than the first day of the first calendar
21 month which commences more than 30 days after the
22 date the employee's employment commences, and that
23 coverage of an employee (and of members of his family
24 who are covered by the plan) will not be terminated by
25 reason of the separation of the employee from his em-

1 ployment by such employer prior to 90 days after the
2 date of such separation, or (if earlier) the first day after
3 the date on which such employee first obtains coverage
4 under another employer plan approved under this part;
5 "(G) such plan, in the case of any employer plan
6 (other than an employer plan of a self-insured employ-
7 er) must be a plan under which there are available to
8 the employer arrangements for the pooling of risks
9 under the plan by which his employees are covered
10 and under the plans by which employees of other em-
11 ployers are covered so that the premium or other peri-
12 odic charge payable therefor to the carrier are deter-
13 mined on a class basis either (i) without regard to the
14 payments or reimbursements for health services re-
15 ceived by the employer's employees (and family mem-
16 bers of such employees) covered by the plan, or (ii)
17 without regard to the payments or reimbursements for
18 health services received by the employer's employees
19 (and family members of such employees) in excess of a
20 specified amount agreed to between the employer and
21 the carrier of payments or reimbursements as to any
22 one individual or family and under which the premium
23 or other periodic charge made under such arrangement
24 is specifically identified to the purchaser;

1 "(H) the premium or other periodic charge im-
2 posed for the pooling arrangements described in clause
3 (G) shall (in case of any plan other than an employer
4 plan of a self-insured employer) be stated, to the em-
5 ployer or self-employed individual subscribing to the
6 plan, in annual (or more frequent) billings or renewal
7 notices which shall be expressed in such a manner as
8 to facilitate a comparison of such premium or charge
9 with the amount allowable on account of such plan as
10 a tax credit under section 1403 or section 3114, as the
11 case may be, of the Internal Revenue Code of 1954.
12 "(2) In any case where, pursuant to one or more collec-
13 tive bargaining agreements, health insurance responsibilities
14 for one or more groups (but not all) of the employees of an
15 employer have been placed with a labor organization, the
16 Secretary may waive the requirement imposed by paragraph
17 (1)(C)(i) with respect to such group or groups of the employ-
18 er's employees for such period as may be necessary to enable
19 the employer and the labor organizations with which he has
20 collective bargaining agreements a reasonable opportunity so
21 to arrange health insurance coverage of the employees of the
22 employer as to meet the requirement imposed by paragraph
23 (1)(C)(i). The Secretary shall provide technical assistance to,
24 and recommend procedures to be employed by, such employ-
25 er and such organizations in meeting such requirement.

1 "(3) Approval of the Secretary of any plan (other than
2 an employer plan of a self-insured employer) shall not be
3 denied because such plan is provided under arrangements
4 with carriers involving the plans of two or more employers in
5 the same industry or under a trust or trade association ar-
6 rangement.

7 "(b)(1) No employer plan or self-employed plan shall be
8 approved by the Secretary except on the basis of an applica-
9 tion for approval submitted by the employer or self-employed
10 individual (or by a carrier on such person's behalf) to the
11 Secretary, which application shall be in such form and con-
12 tain such information and assurances as the Secretary shall
13 by regulations require.

14 "(2) Applications for approval may contain provision for
15 recommendations of approval, by the insurance department
16 or similar agency of the State involved; and the Secretary
17 may employ any such recommendations as a basis for expe-
18 diting approval of the application with respect to which such
19 recommendations are made.

20 "(3)(A) The Secretary shall not approve any application
21 of an employer plan by a self-insured employer unless such
22 application contains or is supported by proof and assurances
23 satisfactory to the Secretary that the employer has the finan-
24 cial ability to discharge his obligations under the plan and has

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1 the administrative ability effectively to discharge such obliga-
2 tions.
3 "(B) The Secretary may, as a condition of approval of
4 an employer plan by a self-insured employer, require the em-
5 ployer to deposit in a depository designated by the Secretary
6 either an indemnity bond or securities (at the option of the
7 employer) of a kind and in an amount determined by the Sec-
8 retary, and subject to such conditions as the Secretary may
9 prescribe (which shall include authorization to the Secretary
10 in case of default of the employer's obligations to provide
11 benefits under the plan to sell any of such securities sufficient
12 to discharge such obligations or to bring suit upon such bonds
13 to procure the prompt discharge of such obligations).
14 "(c)(1) As used in this section—
15 "(A) the term 'catastrophic health insurance'
16 means a health insurance policy or plan which provides
17 the coverage which is required pursuant to subsection
18 (a)(1)(B); and
19 "(B) the term 'carrier' includes any nonprofit hos-
20 pital or medical service corporation.
21 "(2)(A) In order for a carrier to be approved by the
22 Secretary under this subsection, the carrier must—
23 "(i) offer, in each State in which such carrier does
24 health insurance business, catastrophic health insur-
25 ance to all individuals and groups on an annual or

1 shorter contract basis, with the option of the policy-
2 holder to renew at the expiration of the term of the
3 policy, and with provision that the coverage so offered
4 will not be discontinued or denied in the case of any
5 individual or group except for failure to make timely
6 payment of premium therefor;
7 "(ii) provide claims determination procedures with
8 respect to catastrophic health insurance benefits which
9 (I) comply with the requirements imposed by section
10 503 of the Employee Retirement Income Security Act
11 of 1974 and the regulations issued thereunder by the
12 Secretary of Labor and (II) are consistent with those
13 employed by the carrier in its catastrophic health in-
14 surance business and which in general are at least as
15 favorable to claimants as those employed under the
16 Federal plan established by part A, and
17 "(iii) operate in accordance with procedures satis-
18 factory to the Secretary for meeting its obligations
19 with respect to policies of catastrophic health insurance
20 and for disposition of unearned premiums on such poli-
21 cies in the event of the discontinuance of such policies
22 or the withdrawal of its status as an approved carrier
23 by the Secretary.
24 "(B) In order to better enable carriers to meet the re-
25 quirements imposed by subparagraph (A)(ii), the Secretary

1 shall provide to carriers, offering approved plans under this
2 part, reasonable access to claim data developed under the
3 Federal plan established by part A.

4 "(d) Approval of a plan by the Secretary under this sec-
5 tion shall not have the effect of causing such plan to be a
6 'governmental plan', as that term is employed in and for pur-
7 poses of title I of the Employee Retirement Income Security
8 Act of 1974, if such plan would, in the absence of such ap-
9 proval, not be a 'governmental plan', as that term is so em-
10 ployed.

11 "(e)(1) It shall not be unlawful, under any antitrust law,
12 for any carrier or group of carriers to enter into or participate
13 in any pool, reinsurance, or other residual market arrange-
14 ment, or for any carrier to carry on any activity which is
15 necessary or appropriate to discharge its functions under any
16 such arrangement, if and to the extent that, such arrange-
17 ment and the activities taken pursuant thereto are confined to
18 the offering and administration of plans approved by the Sec-
19 retary under this section.

20 "(2) As used in paragraph (1), the term 'antitrust law'
21 means the Federal Trade Commission Act, each statute re-
22 ferred to in section 4 of that Act (15 U.S.C. 44) as an Anti-
23 trust Act, any other statute of the United States in pari ma-
24 teria, and any law of any State or political subdivision thereof

1 which prohibits or restrains contracts, combinations, or other
2 arrangements in restraint of trade.

3 "CERTIFICATIONS TO THE SECRETARY OF THE TREASURY

4 "SEC. 2123. (a) Whenever the Secretary approves, or
5 withdraws approval of, any employer plan or self-employed
6 plan under this part, he shall submit a certification of his
7 action to the Secretary of the Treasury.

8 "(b)(1) The Secretary shall, prior to January 1, of each
9 calendar year, certify to the Secretary of the Treasury the
10 Table of Values of Catastrophic Health Insurance Coverage
11 which shall be in effect for such calendar year, together with
12 such additional data as may be needed by the Secretary of
13 the Treasury in connection with the administration of sec-
14 tions 42, 1403, and 3114 of the Internal Revenue Code of
15 1954.

16 "(2) The table of values referred to in paragraph (1)
17 shall be developed, for each calendar year, by the Secretary
18 and shall, except for such adjustments as the Secretary shall
19 deem to be necessary, be the same as the Table of Values of
20 Catastrophic Health Insurance Coverage which is prepared
21 and recommended to the Secretary for such year by the Ac-
22 tuarial Committee established pursuant to section 2124.

23 "(3) Such table of values developed by the Secretary
24 shall be made available to all carriers who offer catastrophic

1 health insurance plans approved under section 2122 and to
2 all other interested persons.

3 "ACTUARIAL COMMITTEE

4 "SEC. 2124. (a)(1) There is hereby established an Actu-
5 arial Committee which shall consist of five individuals, who
6 are not otherwise in the employ of the United States, ap-
7 pointed by the Secretary.

8 "(2)(A) Members of the Committee shall be persons who
9 are qualified to perform the functions and duties of the Com-
10 mittee. No individual shall be a member of the Committee
11 unless he (i) is enrolled, or meets the conditions for enroll-
12 ment (other than those relating to pension experience), as an
13 actuary in the Joint Board for the Enrollment of Actuaries
14 established by section 3041 of the Employee Retirement
15 Income Security Act of 1974, and (ii) has significant actuar-
16 ial experience in the field of health insurance.

17 "(B) At no time shall more than two members of the
18 Committee be in the employ of a carrier (as defined in section
19 2122(c)(1)(B)) which does health insurance business.

20 "(3) Members of the Committee shall serve for terms of
21 4 years, except that of those first appointed, one shall be
22 appointed for a term of 1 year, one shall be appointed for a
23 term of 2 years, one shall be appointed for a term of 3 years,
24 and two shall be appointed for terms of 4 years. A member
25 may be reappointed, but no member may serve for more than

1 2 successive terms. A member appointed to fill a vacancy
2 shall be appointed only for the unexpired term of his prede-
3 cessor. A majority of the members of the Committee shall
4 constitute a quorum thereof and action taken by the Commit-
5 tee shall be by majority vote of those present and voting. The
6 Secretary shall, from time to time, designate a member of the
7 Committee to serve as Chairman thereof.

8 "(4) The Secretary shall furnish to the Committee an
9 executive secretary and such secretarial, clerical, and other
10 services as may be required to enable the Committee to carry
11 out its duties and functions.

12 "(b)(1) Members of the Committee shall each be entitled
13 to receive the daily equivalent of the annual rate of basic pay
14 in effect for grade GS-18 of the General Schedule for each
15 day (including traveltime) during which they are engaged in
16 the actual performance of duties vested in the Committee.

17 "(2) While away from their homes or regular places of
18 business in the performance of services for the Committee,
19 members of the Committee shall be allowed travel expenses,
20 including per diem in lieu of subsistence, in the same manner
21 as persons employed intermittently in the Government are
22 allowed expenses under section 5703(b) of title 5 of the
23 United States Code.

1 "(c) Section 14(a) of the Federal Advisory Committee
2 Act shall not apply to the Actuarial Committee established
3 pursuant to this section.

4 "(d)(1) It shall be the duty and function of the Commit-
5 tee to prepare and recommend to the Secretary, not later
6 than October 1 of each year, a Table of Values of Cata-
7 strophic Health Insurance Coverage which shall be in effect
8 for the calendar year commencing on the following January
9 1.

10 "(2) Such table of values shall establish, for each State,
11 the actuarial value of one year's catastrophic health insur-
12 ance coverage for one individual, as estimated for the calen-
13 dar year for which such table of values is to be in effect, and
14 shall be designed (with the use of a table of adjustment fac-
15 tors) to enable employers, carriers, and others involved with
16 plans approved under section 2122 to determine the actuarial
17 value of the catastrophic health insurance coverage provided
18 under any such plan.

19 "(3) The value of catastrophic health insurance cover-
20 age shall be established by the Committee according to the
21 best data and information available to it on the basis of the
22 expected costs or charges for health care services, the ex-
23 pected utilization of health care services by all persons
24 having such coverage, the expected administration and claim
25 payment expenses (including an allowance for risk) applicable

1 to plans providing such coverage, and such other information
2 as the Committee determines to be relevant. In establishing
3 such value of coverage in any State, the Committee shall
4 employ appropriate adjustment factors, which shall be ap-
5 plied uniformly within the State, to reflect significant cost
6 differences related to geographic variations and the age and
7 dependency characteristics of individuals covered under plans
8 providing such coverage.

9 "(4) The term 'catastrophic health insurance', as used in
10 this section, means health insurance provided under plans ap-
11 proved under section 2122 which provides that minimum
12 coverage necessary to meet the requirement imposed in sec-
13 tion 2122(a)(1)(B).

14 "(e)(1) The Committee shall have the further duty (A) of
15 reviewing (by random claim or data sample or otherwise) the
16 marketing and rating practices of plans approved under sec-
17 tion 2122 with a view to determining whether such practices
18 unduly or inappropriately restrict, for particular groups, the
19 availability of coverage under plans approved under such sec-
20 tion, and (B) upon request of the Secretary of the Treasury,
21 to assist him in establishing procedures designed to assure
22 the proper administration of sections 42, 1403, and 3114 of
23 the Internal Revenue Code of 1954.

24 "(2) The Committee shall report to the Secretary its
25 findings resulting from its review functions, together with

1 such recommendations as it may have based on such find-
2 ings."
3 (b) Section 201(g) of the Social Security Act is amended
4 by—
5 (1) inserting after "title XVIII" the first time it
6 appears the following: "and the Federal Catastrophic
7 Health Insurance Trust Fund established by title
8 XXI", and
9 (2) inserting after "title XVII" each time it ap-
10 pears therein after the first time the following: "and
11 title XXI".
12 AMENDMENTS TO INTERNAL REVENUE CODE OF 1954
13 SEC. 102. (a)(1) Section 1401 of the Internal Revenue
14 Code of 1954 (relating to rate of social security tax on self-
15 employment income) is amended by adding at the end thereof
16 the following new subsection:
17 "(c) CATASTROPHIC HEALTH INSURANCE.—In addi-
18 tion to the taxes imposed by the preceding subsections, there
19 shall be imposed for each taxable year which begins after
20 December 31, 1980, on the self-employment income of every
21 individual a tax which is equal to 1 percent of the amount of
22 the self-employment income of such individual for such tax-
23 able year."
24 (2) Such Code is further amended by (A) redesignating
25 section 1403 thereof (relating to miscellaneous provisions) as

1 section 1404, and (B) by adding after section 1402 thereof
2 the following new section:
3 "SEC. 1403. CREDIT AGAINST CATASTROPHIC HEALTH INSUR-
4 ANCE TAX.
5 "(a) ACTUARIAL VALUE OF CATASTROPHIC HEALTH
6 INSURANCE COVERAGE UNDER APPROVED PLANS FOR THE
7 SELF-EMPLOYED.—If, during any part of the taxable year
8 the taxpayer has secured for himself (or for himself and mem-
9 bers of his family) catastrophic health insurance coverage
10 under a plan which is approved by the Secretary of Health,
11 Education, and Welfare under 2122 of the Social Security
12 Act, the taxpayer may, to the extent provided in this subsec-
13 tion and subsection (b), credit against the tax imposed by
14 section 1401(c) for such taxable year an amount equal to the
15 actuarial value of such coverage, as determined under the
16 appropriate Table of Values of Catastrophic Health Insur-
17 ance Coverage certified by such Secretary pursuant to sec-
18 tion 2123(b) of such Act.
19 "(b) LIMIT ON CREDITS.—The total credits allowed a
20 taxpayer under this section shall not exceed 100 percent of
21 the tax against which such credits are allowable.".
22 (3) The table of sections for chapter 2 of subtitle A of
23 such Code is amended by striking out the last item and in-
24 serting in lieu thereof the following:

"Sec. 1403. Credit against catastrophic health insurance tax.
"Sec. 1404. Miscellaneous provisions.".

1 (b)(1) Section 3111 of such Code (relating to rate of
2 social security tax on employers) is amended by adding at the
3 end thereof the following new subsection:
4 "(c) CATASTROPHIC HEALTH INSURANCE.—
5 "(1) In addition to the taxes imposed by the pre-
6 ceding subsections, there is hereby imposed on every
7 employer an excise tax, with respect to having individ-
8 uals in his employ, equal to 1 percent of the wages (as
9 defined in section 3121(a)) paid after December 31,
10 1980, by him with respect to employment (as defined
11 in paragraph (2)).
12 "(2) The term 'employment', as used in paragraph
13 (1), shall have the same meaning as when that term is
14 used for purposes of subsections (a) and (b), except that
15 the provisions of section 3121(b) shall be applied with-
16 out regard to the exclusions specified in paragraphs (5),
17 (6), (8), and (9) thereof.".
18 (2) Such Code is further amended by adding after sec-
19 tion 3113 thereof the following new section:
20 "SEC. 3114. CREDIT AGAINST CATASTROPHIC HEALTH INSUR-
21 ANCE TAX.
22 "(a) ACTUARIAL VALUE OF CATASTROPHIC HEALTH
23 INSURANCE COVERAGE FOR EMPLOYEES UNDER AP-
24 PROVED EMPLOYER PLANS.—If, during any period the tax-
25 payer has secured for any or all of his employees (and for

1 family members of such employees) catastrophic health insur-
2 ance coverage under an employer plan approved by the Sec-
3 retary of Health, Education, and Welfare under section 2122
4 of the Social Security Act, the taxpayer may, to the extent
5 provided in this subsection and subsection (b), credit against
6 the tax imposed by section 3111(c) for such period an amount
7 equal to the actuarial value of such coverage, as determined
8 under the appropriate Table of Values of Catastrophic Health
9 Insurance Coverage certified by such Secretary pursuant to
10 section 2123(b) of such Act.

11 "(b) LIMIT ON CREDITS.—The total credits allowed to
12 a taxpayer under this section shall not exceed 100 percent of
13 the tax against which such credits are allowable.

14 "(c) PAYMENTS BY STATES.—For purposes of this sec-
15 tion, any State which has a State law approved by the Secre-
16 tary of the Treasury under section 2108 of the Social Secu-
17 rity Act shall be deemed to be a taxpayer to which the tax
18 imposed by section 3111(c) applies, and any payments which
19 such State is obligated to make to the Treasury pursuant to
20 such State law shall be deemed to be an obligation to pay
21 such tax.".

22 (3) The table of sections for subchapter B of chapter 21
23 of subtitle C of such Code is amended by adding immediately
24 after the last item the following:

"Sec. 3114. Credit against catastrophic health insurance tax.".

1 (c)(1)(A) Subpart A of part IV of subchapter A of chap-
2 ter 1 of the Internal Revenue Code of 1954 (relating to cred-
3 its allowed) is amended by renumbering section 42 as 43, and
4 by inserting after section 41 the following new section:

5 "SEC. 42. CATASTROPHIC HEALTH INSURANCE TAX.

6 "There shall be allowed to the taxpayer, as a credit
7 against the tax imposed by this chapter for the taxable year,
8 an amount equal to 50 percent of the aggregate of the
9 amounts of the tax, imposed by sections 1401(c) and 3111(c),
10 paid by the taxpayer during the taxable year. For purposes of
11 this section, any credit allowed the taxpayer for the taxable
12 year under section 1403 shall be regarded as an amount of
13 the tax, imposed by section 1401(c), paid by the taxpayer for
14 the taxable year; and any credit allowed the taxpayer for the
15 taxable year under section 3114 shall be regarded as an
16 amount of the tax, imposed by section 3111(c), paid by the
17 taxpayer for the taxable year. Any amounts allowed as a
18 credit under this section shall not be allowed as a deduction
19 under section 164. A State which, for the taxable year, has
20 made contributions pursuant to a State law approved under
21 section 2108 of the Social Security Act shall be regarded as
22 a taxpayer for purposes of this section.".

23 (B) The table of sections for such subpart is amended by
24 striking out the last item and inserting in lieu thereof the
25 following:

"Sec. 42. Catastrophic health insurance tax.
"Sec. 43. Overpayment of tax.".

1 (2) Section 6201(a)(4) of such Code (relating to assess-
2 ment authority) is amended by—
3 (A) inserting "or 42" after "section 39" in the
4 caption of such sections; and
5 (B) striking out "oil," and inserting in lieu thereof
6 "oil) or section 42 (relating to catastrophic health in-
7 surance tax),".
8 (3) Section 6401(b) of such Code (relating to excessive
9 credits) is amended by—
10 (A) inserting after "lubricating oil)" the following:
11 ", and 42 (relating to catastrophic health insurance
12 tax),"; and
13 (B) striking out "sections 31 and 39" and insert-
14 ing in lieu thereof "sections 31, 39, and 42".

15 TITLE II—PRIVATE BASIC HEALTH INSURANCE
16 CERTIFICATION PROGRAM

17 SEC. 201. The Social Security Act is amended by
18 adding after title XIV thereof the following new title:

19 "TITLE XV—PRIVATE BASIC HEALTH
20 INSURANCE CERTIFICATION

21 "PURPOSE

22 "SEC. 1501. It is the purpose of this title to encourage
23 and facilitate the availability to the public of private basic

1 health insurance coverage at a reasonable premium charge
2 by—
3 "(a) establishing a procedure whereby health in-
4 surance policies offered by private insurers may be cer-
5 tified by the Secretary as meeting minimum standards
6 with respect to adequacy of coverage, conditions of
7 payment, opportunity for enrollment, and reasonable-
8 ness of premium charges,
9 "(b) facilitating arrangements whereby basic
10 health insurance policies meeting such standards can
11 be offered through pools of private insurers, and
12 "(c) encouraging States, through their laws and
13 regulations pertaining to the health insurance industry,
14 to facilitate the offering, within the State, of such basic
15 health insurance coverage by carriers doing health in-
16 surance business within the State.
17 "CERTIFICATION OF BASIC PRIVATE HEALTH INSURANCE
18 POLICIES
19 "SEC. 1502. (a) Any insurer which desires to have a
20 health insurance policy certified for use in one or more States
21 specified by the insurer may (in accordance with regulations
22 of the Secretary) provide to the Secretary, for his examina-
23 tion and certification, any health insurance policy.
24 "(b)(1) If the Secretary, after examining any such policy
25 and evaluating any data submitted in connection with such

1 policy, determines that such policy meets the standards pre-
2 scribed in section 1504, he shall certify such policy for use in
3 each State which has in effect a basic health insurance facili-
4 tation program (as defined in section 1510).

5 "(2)(A) The certification by the Secretary of any such
6 policy shall be conditioned upon such policy's continuing to
7 meet the standards prescribed in section 1504; and no policy
8 shall be deemed to have been certified by the Secretary under
9 this title for any period for which it fails to meet such stand-
10 ards.

11 "(B) The Secretary shall establish procedures whereby
12 any insurer having secured the Secretary's certification of
13 any policy offered by such insurer shall from time to time
14 provide to the Secretary (i) relevant data with respect to such
15 policy in order for the Secretary to determine whether such
16 policy continues to meet the standards prescribed in section
17 1504, and (ii) such data and information as the Secretary
18 may require in order to assure proper coordination of the
19 administration of titles XIX and XXI.

20 "(c) Notwithstanding the preceding provisions of this
21 section, the Secretary shall not certify any health insurance
22 policy of any insurer for use in any State unless such insurer
23 furnishes assurances satisfactory to the Secretary that such
24 insurer (whether as a member of a health reinsurance or
25 other residual market arrangement or otherwise) will make

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1 generally available, in each geographic area of the State in
2 which the insurer does health insurance business, to all indi-
3 viduals and family members the following two health insur-
4 ance policies: (i) a policy which meets the standards of sec-
5 tion 1504, and (ii) a policy which, if it were issued in combi-
6 nation with a plan meeting the minimum coverage necessary
7 to meet the requirement imposed by section 2122(a)(1)(B),
8 would, in the aggregate, meet the standards of section 1504.

9 "UTILIZATION OF STATE AGENCIES FOR CERTIFICATION
10 OF POLICIES

11 "SEC. 1503. If any State has in effect a basic health
12 insurance facilitation program (as defined in section 1510),
13 the Secretary shall, if such State is willing to do so, enter
14 into an agreement with such State whereby the agency re-
15 sponsible for the regulation of the health insurance industry
16 within such State will, on behalf of the Secretary, make such
17 determinations regarding whether basic health insurance
18 policies meet the requirements for certification under this
19 title, as may be specified by the Secretary. Such agreement
20 shall provide that the agency will be reimbursed for its rea-
21 sonable expenses incurred in carrying out activities specified
22 in the agreement.

1 "STANDARDS WITH RESPECT TO BASIC HEALTH
2 INSURANCE POLICIES

3 "SEC. 1504. (a) The Secretary shall not certify under
4 this title any insurance policy offered (or to be offered) by an
5 insurer unless he finds that—
6 "(1) such policy provides—
7 "(A) inpatient hospital coverage (without any
8 deductible in excess of $100 or copayment by the
9 insured person) for at least 60 days during any
10 policy year,
11 "(B) medical coverage which shall include
12 home, office, hospital, and other institutional care
13 provided by physicians,
14 "(C) with respect to medical coverage,
15 that—
16 "(i) subject to clauses (ii) and (iii), pay-
17 ment in full shall be made with respect to
18 not less than the first $2,000 of reasonable
19 expenses incurred by any insured person for
20 any policy year for services with respect to
21 which coverage applies,
22 "(ii) the copayment required of any in-
23 sured person with respect to such reasonable
24 expenses shall not exceed 20 per centum
25 thereof, and

1 "(iii) in the case of any deductible appli-
2 cable to the payment of such reasonable ex-
3 penses for any benefit year or benefit period
4 of not less than 12 months duration, such de-
5 ductible shall not exceed $50 for any insured
6 person, and that, for purposes of computing
7 such deductible for any calendar, policy, or
8 other fixed benefit year or period, the insured
9 person shall be given credit for any deduct-
10 ible applied toward such expenses for the
11 last 3 months of the preceding policy year,
12 "(D) in case such policy is a group policy,
13 there will be no exclusion from coverage or limi-
14 tation on payment on account of any medical con-
15 dition (including any preexisting condition) or any
16 waiting period prior to the beginning of coverage
17 with respect to any such condition,
18 "(E) in case such policy is an individual
19 policy (including a policy for an individual and
20 members of his family), there will be no exclusion
21 from coverage on account of any medical condi-
22 tion (including any preexisting condition) other
23 than pregnancy, and there will be no waiting
24 period prior to the beginning of coverage with re-

1 spect to any preexisting condition which is greater
2 than 90 days after the date the policy is issued,
3 "(F) in case such policy covers an individual
4 and members of his family, coverage will be pro-
5 vided for all dependent unmarried children in the
6 family under age 22, and coverage will be auto-
7 matically extended, at birth to any newborn and
8 upon adoption to any newly adopted, child of such
9 individual or his spouse,
10 "(G) in case such policy is a group policy
11 which covers all or a certain category of employ-
12 ees of any employer, that—
13 "(i) coverage will not be terminated
14 with respect to any employee (and members
15 of such employee's family, if such policy
16 covers such members) because of the termi-
17 nation of such employee's employment prior
18 to the expiration of 31 days after the date of
19 such termination,
20 "(ii) the insurer offering such policy will
21 afford to any employee covered by such
22 policy whose employment has been terminat-
23 ed a reasonable opportunity to secure, from
24 such insurer a basic private health insurance

1 policy which has been approved under this
2 title,
3 "(iii) there will be a periodic open en-
4 rollment period of at least 31 days (which
5 shall occur not less often than once during
6 each policy year) in which all eligible em-
7 ployees, who are not covered by such policy
8 because of failure to elect coverage at the
9 time of initial employment or during previous
10 open enrollment periods, can secure coverage
11 thereunder,
12 "(2) the premium charge for such policy is such
13 that there is not an unreasonable ratio of expenses to
14 premiums (as determined under subsection (d)); and
15 "(3) there is established an appropriate (but differ-
16 ent) premium rate for such policy when it is offered to
17 cover (A) a single individual, (B) a married couple, or
18 (C) a family.
19 "(b) The Secretary, in determining whether any com-
20 prehensive prepaid group practice plan is eligible for certifi-
21 cation under this section, shall, in lieu of the standards im-
22 posed by subsection (a), develop and apply criteria which
23 assure that such plan meets requirements which are, on an
24 actuarial and benefit basis, at least equivalent to such stand-
25 ards.

1 "(c) Notwithstanding the provisions of subsections (a)
2 and (b), the Secretary shall not withhold approval under this
3 title of any health insurance policy solely because such policy
4 excludes—
5 "(1) charges for services or supplies in connection
6 with an occupational disease or injury,
7 "(2) items or services for which the insured indi-
8 vidual furnished such items or services has no legal ob-
9 ligation to pay, and which no other person (by reason
10 of such individual's membership in a prepayment plan
11 or otherwise) has a legal obligation to provide or pay
12 for,
13 "(3) any item or service to the extent that pay-
14 ment has been made, or can reasonably be expected to
15 be made (as determined in accordance with regula-
16 tions), with respect to such item or service, under a
17 workmen's compensation law or plan of the United
18 States or a State,
19 "(4) charges for services or supplies with respect
20 to which benefits are provided under title XVIII or
21 title XXI,
22 "(5) items or services which are not reasonable
23 and necessary for the diagnosis or treatment of illness
24 or injury, pregnancy, or to improve the functioning of a
25 malformed body member,

1 "(6) charges for care, treatment, services, or sup-
2 plies, provided to any individual, to the extent that the
3 payment of benefits with respect thereto is prohibited
4 by any applicable law of the jurisdiction in which such
5 individual is residing at the time he receives such care,
6 treatment, services, or supplies,
7 "(7) charges for care, treatment, or supplies pro-
8 vided to any individual, to the extent that they are not
9 reasonably priced (except that, for purposes of this
10 paragraph, the charge for any item or service shall be
11 deemed to be reasonable, if such charge is not in
12 excess of the allowable charge therefor under title
13 XVIII or XXI),
14 "(8) charges in connection with routine physical
15 checkups,
16 "(9) expenses incurred for items or services,
17 where such expenses are for cosmetic surgery or are
18 incurred in connection therewith, except as required for
19 the prompt repair of accidental injury or for improve-
20 ment of the functioning of a malformed body member,
21 "(10) charges made by a hospital for the profes-
22 sional services of any resident physician or intern to
23 the extent that such charges are in excess of the actual
24 cost incurred by the hospital in providing such services,

1 "(11) charges for the professional services of a
2 psychiatrist to the extent that such charges exceed
3 $400 in a policy year, or

4 "(12) amounts which represent deductible and co-
5 insurance provisions and which generally result in ag-
6 gregate benefit coverage which is at least equal to the
7 actuarial equivalent of the benefit coverage resulting
8 from the application of the deductible and coinsurance
9 provisions in section 1504(a)(1).

10 "(d)(1) With respect to policies submitted to the Secre-
11 tary for his certification under this title, the Secretary shall
12 establish (after considering the size of the groups to be cov-
13 ered by any such policy and the nature of the insurer) appro-
14 priate reasonable ratios of expenses to premiums imposed for
15 coverage thereunder. In the case of individual policies such
16 ratios shall be the same as those established by the Secretary
17 for group policies covering the smallest groups. After making
18 an initial determination with respect to any such policy, the
19 Secretary shall periodically thereafter review and make a re-
20 determination of such ratios based on actual expenses there-
21 under and the actual premium charges made for the period
22 with respect to which the review is made, in order to deter-
23 mine whether such policy continues to meet the requirements
24 for certification.

1 "(2) In determining the appropriate reasonable ratio of
2 expenses to premiums imposed with respect to any particular
3 health insurance policy offered by an insurer, the Secretary
4 shall, in his determinations of such ratio, give consideration
5 to the average ratio, with respect to group policies generally
6 underwritten by insurers (classified on the basis of nonprofit
7 or profitmaking) with respect to policies excluding those
8 which are not certified under this title.

9 "APPROVED CARRIER

10 "SEC. 1505. For purposes of sections 1923(b), 1816,
11 and 1842, an 'approved carrier' is an insurer which the Sec-
12 retary has found (1) to offer one or more health insurance
13 policies approved under section 1502 to the general public in
14 each geographic or normal service area in which insurer
15 offers health insurance policies (including any which are not
16 approved under this title) and (2) to employ effective proce-
17 dures and practices designed to assure, through means con-
18 sistent with efficient practices within the insurance industry,
19 appropriate controls of utilization of health care services and
20 the costs and charges imposed therefor with respect to which
21 it will financially participate.

22 "ANTITRUST EXEMPTION

23 "SEC. 1506. (a) It shall not be unlawful under any anti-
24 trust law for any insurer to enter into any contract, combina-
25 tion, or other arrangement with any other insurer or group of

1 insurers for the sole purpose of establishing or participating
2 in an insurance pool, reinsurance, or other residual market,
3 arrangement whereby there will be offered to the public
4 health insurance policies approved under section 1502, if
5 such contract, combination, or other arrangement is approved
6 by the Secretary, as being consistent with the purposes of
7 this title, before any party to the contract, combination, or
8 other arrangement has carried out any activity, or refrained
9 from carrying out any activity, under its terms (other than
10 such activity as may be necessary to negotiate the contract,
11 combination, or other arrangement and to apply for approval
12 of the same under this section). The Secretary shall not ap-
13 prove any contract, combination, or other arrangement under
14 which the parties thereto agree to act in a manner which
15 constitutes a violation of any such law for which no exemp-
16 tion is provided under the preceding sentence or for purposes
17 other than the purposes for which the exemption contained in
18 the preceding sentence is established. Nothing contained in
19 this subsection shall exempt from any antitrust law any pred-
20 atory pricing or practice, or any other conduct in the other-
21 wise exempt activities of two or more such insurers under a
22 contract, combination, or other arrangement approved under
23 this section which would be unlawful under any such law if
24 engaged in by only one such insurer.

1 "(b) For purposes of this section, the term 'antitrust
2 law' means the Federal Trade Commission Act, each statute
3 referred to in section 4 of that Act (15 U.S.C. 44) as an
4 Antitrust Act, any other statute of the United States in pari
5 materia, and any law of any State or political subdivision
6 thereof which prohibits or restrains contracts, combinations,
7 or other arrangements in restraint of trade.

8 "ESTABLISHMENT OF EMBLEM TO INDICATE
9 CERTIFICATION

10 "SEC. 1507. (a) The Secretary shall cause to be de-
11 signed an appropriate emblem which may be used as an indi-
12 cation that certification of an insurance policy under this title
13 has been made by the Secretary; and any insurer which has
14 secured certification of an insurance policy by the Secretary
15 under this title may have printed thereon such emblem, and
16 may, in advertising such policy to potential subscribers, state
17 that such policy has received such a certification.

18 "REPORT TO CONGRESS

19 "SEC. 1508. The Secretary shall, at the earliest practi-
20 cable date (but not later than 60 days) after the expiration of
21 the three-year period which commences on the date of enact-
22 ment of this section, submit to the Congress a report indicat-
23 ing (1) the extent to which basic private health insurance
24 policies certified by the Secretary under this title are actually
25 and generally available to the residents of each State, and (2)

1 the extent to which residents in each State are covered by
2 such policies.

3 "DUTY OF SECRETARY TO MAKE AVAILABLE INDIVIDUAL
4 AND FAMILY HEALTH INSURANCE POLICIES ON A
5 COST BASIS

6 "SEC. 1509. (a) The Secretary shall offer a standard
7 health insurance policy, which meets the applicable criteria
8 prescribed under this title with respect to approved basic
9 health insurance policies, to individuals, married couples, and
10 families living in any State (1) which does not have in effect a
11 basic health insurance facilitation program (as found by the
12 Secretary under section 1510, and (2) in which there is not
13 actually and generally available one or more approved basic
14 health insurance policies approved under this title.

15 "(b) The premiums imposed under any such policy shall
16 be in an amount designed to cover the costs (inclusive of
17 administrative costs and appropriate reserves which will be
18 incurred in furnishing the benefits provided in the policy.

19 "(c) No such policy shall be offered in any area prior to
20 the expiration of the 3-year period which commences on the
21 date of enactment of this title.

22 "(d) Premiums collected by the Secretary for insurance
23 policies offered by him under this section shall be deposited in
24 an Insurance Revolving Fund, and moneys in such fund shall

1 be available, without fiscal year limitation, for the payment of
2 claims under such policies.
3 "(e) For the purpose of providing a contingency reserve
4 for the insurance program established by this section, there is
5 authorized to be appropriated such sums as may be neces-
6 sary; and any sums appropriate for such purpose shall remain
7 available for the purpose of making repayable advances
8 (without interest) to the Insurance Revolving Fund author-
9 ized to be established under subsection (d).
10 "(f) The Secretary, in making payment for services cov-
11 ered under any insurance policy issued pursuant to this sec-
12 tion, shall utilize the payments methodology and administra-
13 tive mechanism employed by him for making payment for
14 services covered under the insurance programs established by
15 title XVIII.
16 "BASIC HEALTH INSURANCE FACILITATION PROGRAM
17 "SEC. 1510. (a) For purposes of this title, a State shall
18 be regarded as having in effect a basic health insurance facili-
19 tation program only if the Secretary, after examining the per-
20 tinent laws and regulations of such State governing the doing
21 of health insurance business within the State by carriers, de-
22 termines that such laws and regulations—
23 "(1) require the establishment of one or more
24 health reinsurance or other residual market arrange-
25 ment to be utilized by such carriers in connection with

1 the offering within the State of basic health insurance
2 policies which meet the standards for certification by
3 the Secretary established by this title,
4 "(2) require all such carriers to be members of a
5 health reinsurance or other residual market arrange-
6 ment and provide that losses, under any such arrange-
7 ment, will be shared by all members thereof on a pro
8 rata basis in proportion to their respective shares of
9 the total health insurance premium earned in the State
10 during the calendar year,
11 "(3) provide that premiums charged for policies
12 issued to individuals or family members under any such
13 health reinsurance or other residual market arrange-
14 ment shall not be less than 125 per centum nor more
15 than 150 per centum of the average group rate for the
16 same coverage under a group policy covering ten lives,
17 and
18 "(4) otherwise encourage and facilitate the offer-
19 ing of such policies within the State by all carriers
20 doing health insurance business therein on a basis
21 which is fair and equitable to each such carrier.
22 "(b) The Secretary is authorized, upon the request of
23 any State, to provide appropriate technical assistance to aid
24 the State in developing a program which meets the condi-
25 tions prescribed in subsection (a).".

1 TITLE III—OTHER AMENDMENTS

2 IMMUNIZATIONS

3 SEC. 301. (a) Section 1861(s) of the Social Security Act
4 is amended—
5 (1) by striking out "and" at the end of paragraph
6 (8),
7 (2) by striking out the period at the end of para-
8 graph (9) and inserting in lieu thereof "; and",
9 (3) by inserting immediately after paragraph (9)
10 the following new paragraph:
11 "(10) such immunizations as the Secretary deter-
12 mines are appropriate, but only if provided on a sched-
13 uled allowance basis (as determined under regulations
14 of the Secretary).", and
15 (4) by redesignating paragraphs (10) through (13)
16 as paragraphs (11) through (14), respectively.
17 (b) Section 1864(a) of such Act is amended by striking
18 out "paragraphs (10) and (11)" and inserting in lieu thereof
19 "paragraphs (12) and (13)".
20 (c) Section 1862(a)(7) of such Act is amended by insert-
21 ing immediately after "(7)" the following: "except as pro-
22 vided in section 1861(s)(10),".
23 (d) The amendments made by this section shall apply
24 only with respect to services furnished on or after the first
25 day of the month following in which this section is enacted.

1 MENTAL HEALTH SERVICES

2 SEC. 302. (a) Section 1833(c) of the Social Security Act
3 is amended—
4 (1) by striking out "$312.50" and inserting in lieu
5 thereof "$500", and
6 (2) by striking out "62½ per centum" and insert-
7 ing in lieu thereof "80 per centum".
8 (b) Section 1812 of such Act is amended—
9 (1) by striking out subsection (c) thereof,
10 (2) in subsection (b) thereof, by striking out "(sub-
11 ject to subsection (c))", and
12 (3) in subsection (e) thereof, by striking out "sub-
13 sections (b), (c), and (d)" and inserting in lieu thereof
14 "subsections (b) and (d)".
15 (c) The amendments made by subsection (a) shall be ef-
16 fective only with respect to services furnished after Decem-
17 ber 31, 1980. The amendments made by subsection (b) shall
18 be effective only with respect to services furnished after De-
19 cember 31, 1981.

20 AMOUNT OF PREMIUMS FOR HOSPITAL INSURANCE
21 COVERAGE

22 SEC. 303. (a)(1) The second sentence of section
23 1818(d)(2) of the Social Security Act is amended by striking
24 out "Such amount shall be equal to $33, multiplied by" and

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1 inserting in lieu thereof "Such amount shall be equal to 50
2 per centum of the product of $33 multiplied by".
3 (2) The amendment made by paragraph (1) shall be ap-
4 plicable in the case of premiums imposed on and after July 1,
5 1979.
6 (b) In addition to other moneys appropriated to the Fed-
7 eral Hospital Insurance Trust Fund, there shall be appropri-
8 ated from time to time, with respect to periods commencing
9 after June 30, 1979, amounts equal to 100 per centum of the
10 amounts deposited in such Fund pursuant to section 1818(f)
11 of the Social Security Act from premiums payable for such
12 period.
13 PAYMENT FOR EXTENDED CARE SERVICES
14 SEC. 304. Section 1861(v)(E) of the Social Security Act
15 is amended to read as follows:
16 "(E)(i) In the case of services furnished by a skilled
17 nursing facility with respect to which payment for services
18 furnished under title XIX is made on a cost-related basis
19 pursuant to the provisions of section 1920(d)(2), such regula-
20 tions may provide for the use of rates which are the same as
21 the rates obtaining for such services under title XIX (except
22 that such rates may be increased by the Secretary on a class
23 or size of institution, or on a geographical basis by a percent-
24 age factor not in excess of 10 per centum to take into ac-
25 count determinable items or services or other requirements

1 under this title not otherwise included in the computation of
2 such rates under title XIX): *Provided,* That no such regula-
3 tions shall become effective prior to the 60th day following
4 the date on which the Secretary submits to the Congress a
5 copy thereof together with a full and complete description of
6 the methodology which would be employed in the determina-
7 tion of rates pursuant thereto, and an evaluation by the Sec-
8 retary and by the Comptroller General of such methodology
9 in terms of the extent to which the employment thereof will
10 promote the efficient and economical administration of this
11 title and equitable treatment to and between skilled nursing
12 facilities furnishing services for which payment may be made
13 hereunder.".

14 EXTENSION OF COVERAGE UNDER RENAL DISEASE
15 PROGRAM

16 SEC. 305. Section 226(e) of the Social Security Act is
17 amended by adding at the end thereof the following: "For
18 purposes of the preceding sentence, any individual, who on or
19 after the date of enactment of this sentence fails to meet the
20 condition imposed by clause (2) of such sentence, shall be
21 deemed to meet such condition. There are authorized to be
22 appropriated, from time to time, to the Federal Hospital In-
23 surance Trust Fund and to the Federal Supplementary Medi-
24 cal Insurance Trust Fund such sums as may be necessary (as
25 based on estimates of the Secretary) to place each such Fund

1 in the same financial condition that it would have occupied
2 had the preceding sentence not been enacted.".

3 ENCOURAGEMENT OF PHILANTHROPIC SUPPORT FOR
4 HEALTH CARE

5 SEC. 306. Title XI of the Social Security Act is amend-
6 ed by inserting after section 1133 (as added by section 29 of
7 this Act) the following new section:

8 "ENCOURAGEMENT OF PHILANTHROPIC SUPPORT FOR
9 HEALTH CARE

10 "SEC. 1134. (a) It is the policy of the Congress that
11 philanthropic support for health care be encouraged and ex-
12 panded, especially in support of experimental and innovative
13 efforts to improve the health care delivery system and access
14 to health care services.

15 "(b)(1) For purposes of determining, under title XVIII
16 or XIX, the reasonable costs of any service furnished by a
17 provider of health services—

18 "(A) except as provided in paragraph (2), unre-
19 stricted grants, gifts, and endowments and income
20 therefrom, shall not be deducted from the operating
21 costs of such provider, and

22 "(B) grants, gifts, and endowments income desig-
23 nated by a donor for paying specific operating costs of
24 such provider shall be deducted from the particular op-
25 erating costs or group of costs involved.

1 "(2) Income from endowments and investments may be
2 used to reduce interest expense, if such income is from an
3 unrestricted gift or grant and is commingled with other funds,
4 except that in no event shall any such interest expense be
5 reduced below zero by any such income.".

96TH CONGRESS
1ST SESSION

S. 748

To protect all Americans from the costs of catastrophic illness through improvements in the medicare program and the creation of private and public catastrophic health insurance programs.

IN THE SENATE OF THE UNITED STATES

MARCH 26 (legislative day, FEBRUARY 22), 1979

Mr. DOLE (for himself, Mr. DANFORTH, and Mr. DOMENICI) introduced the following bill; which was read twice and referred to the Committee on Finance

---

A BILL

To protect all Americans from the costs of catastrophic illness through improvements in the medicare program and the creation of private and public catastrophic health insurance programs.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*
3 SHORT TITLE
4 SECTION 1. This Act may be cited as the "Catastrophic
5 Health Insurance and Medicare Improvements Act of 1979".

II—E

1 PURPOSE

2 SEC. 2. It is the purpose of this Act to provide the
3 opportunity for all americans to be protected against the
4 costs of catastrophic illness by improving the medicare pro-
5 gram established by title XVIII of the Social Security Act,
6 assuring that the majority of the population is protected
7 against catastrophic illness through private insurance, and
8 providing premium subsidies for those who cannot afford such
9 private insurance.

10 TITLE I—MEDICARE IMPROVEMENTS

11 MODIFICATIONS IN SCOPE OF BENEFITS FOR HOSPITAL,
12 EXTENDED CARE, AND HOME HEALTH SERVICES

13 SEC. 101. (a)(1) Section 1811 of the Social Security Act
14 is amended by striking out "post-hospital".

15 (b)(1) Paragraphs (1), (2), and (3) of section 1812(a) of
16 the Social Security Act are amended to read as follows:

17 "(1) inpatient hospital services;

18 "(2) post-hospital extended care services for up to
19 100 days during any spell of illness; and

20 "(3) home health services.".

21 (2) Section 1812(b)(1) of such Act is repealed.

22 (3) Subsections (c) and (d) of section 1812 of such Act
23 are repealed.

24 (4) Section 1812(e) of such Act is amended to read as
25 follows:

1 "(e) For purposes of subsection (b), inpatient psychiatric
2 hospital services shall be taken into account only if payment
3 is or would be, except for this section or the failure to comply
4 with the request or certification requirements of or under sec-
5 tion 1814(a), made with respect to such services under this
6 part.".

7 (c) Section 1814(a)(2)(D) of such Act is amended—

8 (1) by striking out "post-hospital"; and

9 (2) by striking out "for any of the conditions with
10 respect to which he was receiving inpatient hospital
11 services (or services which would constitute inpatient
12 hospital services if the institution met the requirements
13 of paragraphs (6) and (9) of section 1861(e)) or post-
14 hospital extended care services".

15 (d) Section 1814(i) of such Act is amended—

16 (1) by striking out "Posthospital" in the heading
17 thereof; and

18 (2) by striking out "posthospital" in paragraph
19 (1).

20 (e)(1) Section 1832(a)(2)(A) of such Act is amended by
21 striking out "for up to 100 visits during a calendar year".

22 (2) Section 1832(b) of such Act is amended to read as
23 follows:

24 "(b) For definitions of 'medical and other health serv-
25 ices' and other terms used in this part, see section 1861.".

1 (f) Section 1834 of such Act is repealed.

2 (g) Section 1861(i) of such Act is amended by striking
3 out "if he is admitted to the skilled nursing facility—" and
4 all that follows and inserting in lieu thereof the following: "if
5 he is admitted to the skilled nursing facility within 30 days
6 after discharge from such hospital if he is admitted on ac-
7 count of a condition which is directly related to the condition
8 for which he was hospitalized. An individual shall be deemed
9 not to have been discharged from a skilled nursing facility if,
10 within 30 days after discharge therefrom, he is admitted to
11 such facility or any other skilled nursing facility.".

12 (h) Sections 1814(a)(2)(D) and 1835(a)(2)(A) of such Act
13 are each amended—

14 (1) by striking out "was confined to his home"
15 and inserting in lieu thereof in each instance "was sub-
16 stantially confined to his home"; and

17 (2) by inserting ", occupational," after "physical".

18 (i)(1) Section 1861(n) of such Act is repealed.

19 (2) Section 1861(e) of such Act is amended—

20 (A) by striking out "subsections (i) and (n)" in the
21 matter preceding paragraph (1) and inserting in lieu
22 thereof "subsection (i)"; and

23 (B) by striking out "subsections (i) and (n)" in the
24 third sentence and inserting in lieu thereof "subsection
25 (i)".

1 (j) Section 1861(o)(6) of such Act is amended by insert-
2 ing before the semicolon at the end thereof the following: ",
3 which shall include standards developed by the Secretary
4 with respect to health, safety, and the quality and appropri-
5 ateness of services, including the training of home health
6 aides".

7 (k) Section 226(c)(1) of such Act is amended—

8 (1) by striking out "and post-hospital home health
9 services" and inserting in lieu thereof "and home
10 health services"; and

11 (2) by striking out "or post-hospital home health
12 services" in clause (B).

13 (l) Section 7(d)(1) of the Railroad Retirement Act is
14 amended by striking out "posthospital home health services"
15 and inserting in lieu thereof "home health services".

16 MODIFICATION OF COINSURANCE AND DEDUCTIBLES

17 SEC. 102. (a)(1) Section 1813(a)(1) of the Social Secu-
18 rity Act is amended by striking out all after the first sentence
19 thereof.

20 (2) Section 1813(a)(3) of such Act is repealed.

21 (b) Section 1833(c) of such Act is amended by striking
22 out "there shall be considered" and all that follows and in-
23 serting in lieu thereof "there shall not be considered as in-
24 curred expenses for purposes of subsections (a) and (b) any
25 amounts which exceed (in the aggregate) $937.50.".

1 COMMUNITY MENTAL HEALTH CENTERS

2 SEC. 103. (a) Section 1812(a) of the Social Security Act
3 (as amended by section 101 of this Act) is further amended—
4 (1) by striking out "and" at the end of paragraph
5 (2);
6 (2) by striking out the period at the end thereof
7 and inserting in lieu thereof "; and"; and
8 (3) by adding the following new paragraph at the
9 end thereof:
10 "(4) community mental health center services for
11 up to a reasonable number of visits (as defined by the
12 Secretary) during a calendar year.".
13 (b) Section 1812 of such Act is amended by adding the
14 following new subsection at the end thereof:
15 "(g)(1) Payment under this part may be made for com-
16 munity mental health center services furnished an individual
17 for only up to a reasonable number of visits (as defined by the
18 Secretary) during any calendar year.
19 "(2) Services shall be taken into account for purposes of
20 paragraph (1) of this subsection only if payment is or would
21 be, except for this section or the failure to comply with the
22 request and certification requirements of or under section
23 1814(a), made with respect to such services under this
24 part.".
25 (c) Section 1814(a)(2) of such Act is amended—

1 (1) by striking out "or" at the end of subpara-
2 graph (D);
3 (2) by inserting "or" at the end of subparagraph
4 (E); and
5 (3) by adding the following new subparagraph at
6 the end thereof:
7 "(F) in the case of community mental health
8 center services, (i) such services are or were
9 medically necessary, (ii) a plan for furnishing such
10 services has been established by a physician (as
11 defined in section 1861(r)(1)) or other mental
12 health professional (as defined for this purpose in
13 regulations by the Secretary) and is periodically
14 reviewed and approved by a physician, and (iii)
15 such services are or were furnished while the indi-
16 vidual is or was under the care of a physician;".
17 (d) Section 1814(b) of such Act is amended—
18 (1) by striking out "or" at the end of paragraph
19 (1);
20 (2) by striking out the period at the end of para-
21 graph (2) and inserting in lieu thereof "; or"; and
22 (3) by adding the following new paragraph at the
23 end thereof:
24 "(3) with respect to community mental health
25 center services, equal to the costs which are reasonable

1 and related to the cost of providing such services or
2 which are based on such other tests of reasonableness
3 as the Secretary may prescribe in regulations, includ-
4 ing those authorized under section 1861(v)(1)(A).".
5 (e) Section 1861(l) of such Act is amended by inserting
6 "or community mental health center" after "nursing facility"
7 each time it appears therein.
8 (f) Section 1861(u) of such Act is amended by inserting
9 "community mental health center," after "home health
10 agency,".
11 (g) Section 1861(w)(1) of such Act is amended by insert-
12 ing "community mental health center,", after "nursing
13 facility,".
14 (h) Section 1861 of such Act is amended by adding the
15 following new subsection at the end thereof:
16 "Community Mental Health Center Services
17 "(bb)(1) The term 'community mental health center
18 services' means the following items and services furnished to
19 an individual as an outpatient by a community mental health
20 center or (to the extent permitted in regulations by the Sec-
21 retary) by others under arrangements with them made by the
22 center—
23 "(A) active diagnostic and therapeutic services
24 furnished by qualified mental health professionals (as
25 defined by the Secretary in regulations), including psy-

1 chologists and psychiatric social workers and psychiat-
2 ric nurses;
3 "(B) drugs and biologicals which cannot, as deter-
4 mined in accordance with regulations, be self-adminis-
5 tered; and
6 "(C) such items and supplies as are ordinarily fur-
7 nished to outpatients by community mental health cen-
8 ters in connection with an active mental health pro-
9 gram of diagnosis and treatment,
10 excluding, however, any item or service if it would not be
11 included under subsection (b) if furnished to an inpatient of a
12 hospital.
13 "(2) The term 'community mental health center' means
14 a facility which—
15 "(A) meets the definition of a community mental
16 health center under section 201 of the Community
17 Mental Health Centers Act and the regulations pre-
18 scribed thereunder;
19 "(B) is primarily engaged in providing outpatient
20 mental health services;
21 "(C) has a requirement that all mental health
22 services are provided under the case management of a
23 physician;

1 "(D) meets such requirements as the Secretary
2 may prescribe with respect to staffing requirements
3 and qualifications of the staff;
4 "(E) maintains clinical records on all patients;
5 "(F) has in effect a utilization review plan in ac-
6 cordance with regulations prescribed by the Secretary;
7 "(G) has in effect an agreement with a hospital
8 pursuant to subsection (l);
9 "(H) in the case of a community mental health
10 center in any State in which State or applicable local
11 law provides for the licensing of community mental
12 health centers, is licensed pursuant to such law;
13 "(I) has appropriate procedures or arrangements
14 (in compliance with applicable State and Federal law)
15 for storing, administering, and dispensing drugs and
16 biologicals; and
17 "(J) meets such other conditions of participation
18 as the Secretary may find necessary in the interest of
19 the health and safety of individuals who are furnished
20 services by such center.".
21 (i) Section 1832(a)(2)(B)(i) of such Act is amended—
22 (1) by striking out "or" at the end of subclause
23 (I);
24 (2) by striking out "and" at the end of subclause
25 (II) and inserting in lieu thereof "or"; and

1 (3) by adding the following new subclause after
2 subclause (II):
3 "(III) a physician to a patient in a communi-
4 ty mental health center; and".
5 (j) Section 1864(a) of such Act is amended—
6 (1) by inserting ", or whether a facility therein is
7 a community mental health center as defined in section
8 1861(bb)(2)" before the period at the end of the first
9 sentence;
10 (2) by inserting "or a community mental health
11 center" after "home health agency" in the second sen-
12 tence; and
13 (3) by inserting "community mental health
14 center," after "laboratory," each time it appears in the
15 fifth sentence.
16 (k) Section 226(c)(1) of such Act is amended by insert-
17 ing "community mental health center services," after "post-
18 hospital extended care services," the first time it appears
19 therein.
20 (l) Section 7(d)(1) of the Railroad Retirement Act of
21 1974 is amended by inserting "community mental health
22 center services," after "inpatient hospital services,".
23 MEDICARE COVERAGE FOR CATASTROPHIC ILLNESS
24 SEC. 104. (a) Section 1833(a) of the Social Security Act
25 is amended—

1 (1) by striking out "and" at the end of paragraph
2 (2);
3 (2) by striking out the period at the end of para-
4 graph (3) and inserting in lieu thereof ", and"; and
5 (3) by adding at the end thereof the following new
6 paragraph:
7 "(4) in the case of covered services as defined in
8 section 1861(cc), which are rendered during a cata-
9 strophic benefit period (as defined in section 1861(cc)),
10 100 percent of the reasonable charge, reasonable cost,
11 customary charge or other criteria (as the case may be)
12 as those criteria are otherwise determined for such
13 services under this section or section 1861(cc).".
14 (b) Section 1861 of such Act is amended by adding after
15 subsection (bb) (as added by section 103 of this Act) the fol-
16 lowing new subsection:
17 "Benefits During Period of Catastrophic Illness
18 "(cc)(1) Any individual enrolled under part B of this title
19 shall be entitled to catastrophic illness benefits as provided in
20 section 1833(a)(4) during a period of catastrophic illness.
21 "(2)(A) A period of catastrophic illness with respect to
22 any individual shall begin when such individual has either—
23 "(i) had out-of-pocket expenses for coinsurance for
24 services for which payment may be made under part B
25 of this title which exceed, in the aggregate, $1,000 in

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1 any 15-month period consisting of one calendar year
2 plus the last 3 months of the preceding calendar year;
3 or

4 "(ii) incurred expenses for covered services (as de-
5 fined in paragraph (3)) which exceed, in the aggregate,
6 $5,000 in any such 15-month period.

7 "(B) A period of catastrophic illness with respect to any
8 individual shall end on—

9 "(i) the day in such calendar year which follows
10 the first period of 90 consecutive days therein during
11 which the individual incurred expenses for covered
12 services (as defined in paragraph (3)) which aggregate
13 less than $500; or

14 "(ii) the last day of such calendar year, if earlier.

15 "(C) The dollar amounts of incurred expenses which de-
16 termine the beginning or end of a period of catastrophic ill-
17 ness under subparagraph (B) shall be adjusted each year by
18 the Secretary, beginning on September 1 with respect to the
19 following calendar year, by a percentage equal to the per-
20 centage increase or decrease (as the case may be) in the
21 medical care services component of the Consumer Price
22 Index (as determined by the Department of Labor) as adjust-
23 ed to reflect other appropriate economic factors (as deter-
24 mined by the Secretary) during the 12-month period ending
25 on the June 30 last preceding such September 1.

1 "(3) For purposes of this subsection and section
2 1833(a)(4) 'covered services' means—
3 "(A) any services with respect to which benefits
4 are payable to eligible individuals under section 1832;
5 and
6 "(B) eligible drugs (as defined in subsection
7 (t)(2)).".
8 ELIGIBLE DRUGS
9 SEC. 105. (a) Section 1861(t) of the Social Security Act
10 is amended—
11 (1) by inserting "(1)" after "(t)";
12 (2) by inserting before the period at the end there-
13 of the following: ", or as are approved by the Formu-
14 lary Committee established under section 1882"; and
15 (3) by adding at the end thereof the following new
16 paragraph:
17 "(2) The term 'eligible drug' means a drug or biological
18 which (A) can be self-administered, (B) requires a physician's
19 prescription (except for insulin), (C) is prescribed when the
20 individual requiring such drug is not an inpatient in a hospital
21 or extended care facility, during a period of covered care, (D)
22 is included by strength and dosage forms among the drugs
23 and biologicals approved by the Formulary Committee, (E) is
24 dispensed (except as provided by section 1833(i)), by a phar-
25 macist from a participating pharmacy, (F) is dispensed in

1 quantities consistent with proper medical practice and rea-
2 sonable professional discretion, and (G) is a drug which is
3 necessary for treatment of a crippling or life-threatening
4 chronic disease which is common to the population of benefi-
5 ciaries under this title (as determined by the Secretary in
6 regulations).".

7 (b) Section 1861 of such Act is amended by adding after
8 subsection (cc) (as added by section 104 of this Act) the fol-
9 lowing new subsection:

10 "Participating Pharmacy

11 "(dd) The term 'participating pharmacy' means a phar-
12 macy, or other establishment (including the outpatient de-
13 partment of a hospital) providing pharmaceutical services,
14 which—

15 "(1) is licensed as such under the laws of the
16 State (where such State requires such licensure) or is
17 otherwise lawfully providing pharmaceutical services in
18 which such drug is provided or otherwise dispensed in
19 accordance with this title;

20 "(2) has agreed with the Secretary to act as a
21 provider of services in accordance with the require-
22 ments of this section, and complies with such other re-
23 quirements as may be established by the Secretary in
24 regulations to assure the proper, economical, and effi-
25 cient administration of this title;

1 "(3) has agreed to submit, at such frequency and
2 in such form as may be prescribed in regulations, bills
3 for amounts payable under this title for eligible drugs
4 furnished under part A of this title; and
5 "(4) has agreed not to charge beneficiaries under
6 this title any amounts in excess of those allowable
7 under this title with respect to eligible drugs except for
8 so much of the charge for a prescription (in the case of
9 a drug product prescribed by a physician, of a drug
10 entity in a strength and dosage form included in the
11 Formulary where the price at which such product is
12 sold by the supplier thereof exceeds the reasonable al-
13 lowance) as is in excess of the reasonable allowance
14 established for such drug entity in accordance with sec-
15 tion 1884.".
16 (c) Section 1861(u) of such Act (as amended by section
17 103 of this Act) is further amended by inserting "pharmacy,"
18 after "community mental health center,".
19 (d) Section 1833 of such Act is amended by redesignat-
20 ing the second subsection (g) as subsection (h) and by adding
21 at the end thereof the following new subsection:
22 "(i) Payment may be made under this part for eligible
23 drugs only when such drugs are dispensed by a participating
24 pharmacy; except that payment under this part may be made
25 for eligible drugs dispensed by a physician where the Secre-

1 tary determines, in accordance with regulations, that such
2 eligible drugs were required in an emergency or that there
3 was no participating pharmacy available in the community, in
4 which case the physician (under regulations prescribed by the
5 Secretary) shall be regarded as a participating pharmacy for
6 purposes of this part with respect to the dispensing of such
7 eligible drugs.".

8 (e) Part C of title XVIII of such Act is amended by
9 adding at the end thereof the following new sections:

10 "MEDICARE FORMULARY COMMITTEE

11 "SEC. 1882. (a)(1) There is established, within the De-
12 partment of Health, Education, and Welfare, a Medicare
13 Formulary Committee (hereafter in this section referred to as
14 the 'Committee'), a majority of whose members shall be phy-
15 sicians and which shall consist of the Commissioner of Food
16 and Drugs and four individuals (not otherwise in the employ
17 of the Federal Government) who do not have a direct or indi-
18 rect financial interest in the composition of the Formulary
19 established under this section and who are of recognized pro-
20 fessional standing and distinction in the fields of medicine,
21 pharmacology, or pharmacy, to be appointed by the Secre-
22 tary without regard to the provisions of title 5, United States
23 Code, governing appointments in the competitive service.
24 The chairman of the Committee shall be elected annually

1 from the appointed members thereof, by majority vote of the
2 members of the Committee.
3 "(2) Each appointed member of the Committee shall
4 hold office for a term of five years, except that any member
5 appointed to fill a vacancy occurring prior to the expiration of
6 the term for which his predecessor was appointed shall be
7 appointed for the remainder of such term, and except that the
8 terms of office of the members first taking office shall expire,
9 as designated by the Secretary at the time of appointment,
10 one at the end of each of the first five years. A member shall
11 not be eligible to serve continuously for more than two terms.
12 "(b) Appointed members of the Committee, while at-
13 tending meetings or conferences thereof or otherwise serving
14 on business of the Committee, shall be entitled to receive
15 compensation at rates fixed by the Secretary (but not in
16 excess of the daily rate paid under GS-18 of the General
17 Schedule under section 5332 of title 5, United States Code),
18 including traveltime, and while so serving away from their
19 homes or regular places of business they may be allowed
20 travel expenses, as authorized by section 5703 of title 5,
21 United States Code, for persons in the Government service
22 employed intermittently.
23 "(c)(1) The Committee is authorized, with the approval
24 of the Secretary, to engage or contract for such technical
25 assistance as may be required to carry out its functions, and

1 the Secretary shall, in addition, make available to the Com-
2 mittee such secretarial, clerical, and other assistance as the
3 Formulary Committee may require to carry out its functions.
4 "(2) The Secretary shall furnish to the Committee such
5 office space, materials, and equipment as may be necessary
6 for the Formulary Committee to carry out its functions.
7 "(d)(1) The Committee shall compile, publish, and make
8 available a Medicare Formulary (hereafter in this section re-
9 ferred to as the 'Formulary').
10 "(2) The Committee shall periodically update the For-
11 mulary and the listing of drugs.
12 "(e)(1) The Formulary shall contain an alphabetically
13 arranged listing, by established name, of those drug entities
14 within the following therapeutic categories:
15 "Adrenocorticoids
16 "Anti-anginals
17 "Anti-arrhythmics
18 "Anti-coagulants
19 "Anti-convulsants (excluding phenobarbital)
20 "Anti-hypertensives
21 "Anti-neoplastics
22 "Anti-Parkinsonism agents
23 "Anti-rheumatics
24 "Bronchodilators
25 "Cardiotonics

1 "Cholinesterase inhibitors

2 "Diuretics

3 "Gout suppressants

4 "Hypoglycemics

5 "Miotics

6 "Thyroid hormones

7 "Tuberculostatics

8 which the Committee decides are necessary for individuals
9 using such drugs. The Committee shall exclude from the For-
10 mulary any drug entities (or dosage forms and strengths
11 thereof) which the Committee decides are not necessary for
12 proper patient care, taking into account other drug entities
13 (or dosage forms and strengths thereof) which are included in
14 the Formulary.

15 "(2) Such listing shall include the specific dosage forms
16 and strengths of each drug entity (included in the Formulary
17 in accordance with paragraph (1)) which the Committee de-
18 cides are necessary for individuals using such drugs.

19 "(3) Such listing shall include the prices at which the
20 products (in the same dosage form and strength) of such drug
21 entities are generally sold by the suppliers thereof and the
22 limit applicable to such prices under section 1884(b)(1) for
23 purposes of determining the reasonable allowance.

24 "(4) The Committee may also include in the Formulary,
25 either as a separate part (or parts) thereof or as a supplement

1 (or supplements) thereto, any or all of the following informa-
2 tion:
3 "(A) A supplemental list or lists, arranged by di-
4 agnostic, prophylactic, therapeutic, or other classifica-
5 tions, of the drug entities (and dosage forms and
6 strengths thereof) included in the listing referred to in
7 paragraph (1).
8 "(B) The proprietary names under which products
9 of a drug entity listed in the Formulary by established
10 name (and dosage form and strength) are sold and the
11 names of each supplier thereof.
12 "(C) Any other information with respect to eligi-
13 ble drug entities which in the judgment of the Commit-
14 tee would be useful in carrying out the purposes of this
15 title.
16 "(f) In considering whether a particular drug entity (or
17 strength or dosage form thereof) shall be included in or ex-
18 cluded from the Formulary, the Committee is authorized to
19 obtain (upon request therefor) any record pertaining to the
20 characteristics of such drug entity which is available to any
21 other department, agency, or instrumentality of the Federal
22 Government, and to request suppliers or manufacturers of
23 drugs and other knowledgeable persons or organizations to
24 make available to the Committee information relating to such
25 drug. If any such record or information (or any information

1 contained in such record) is of a confidential nature, the Com-
2 mittee shall respect the confidentiality of such record or infor-
3 mation and shall limit its usage thereof to the proper exercise
4 of its authority.
5 "(g)(1) The Committee shall establish such procedures
6 as it determines to be necessary in its evaluation of the ap-
7 propriateness of the inclusion in or exclusion from the For-
8 mulary, of any drug entity (or dosage form or strength there-
9 of). For purposes of inclusion in or exclusion from the Formu-
10 lary the principal factors in the determination of the Commit-
11 tee shall be—
12 "(A) the factor of clinical equivalence in the case
13 of the same dosage forms in the same strengths of the
14 same drug entity; and
15 "(B) the factor of relative therapeutic value in the
16 case of similar or dissimilar drug entities in the same
17 therapeutic category.
18 "(2) The Committee, prior to making a final decision to
19 remove from listing in the Formulary any drug entity (or
20 dosage forms or strengths thereof) which is included therein,
21 shall afford a reasonable opportunity for a formal or informal
22 hearing on the matter to any person engaged in manufactur-
23 ing, preparing, compounding, or processing such drug entity
24 who shows reasonable ground for such a hearing.

1 "(3) Any person engaged in the manufacture, prepara-
2 tion, compounding, or processing of any drug entity (or
3 dosage forms or strengths thereof) not included in the Formu-
4 lary which such person believes to possess the requisite quali-
5 ties to entitle such drug to be included in the Formulary pur-
6 suant to subsection (e), may petition for inclusion of such
7 drug entity and, if such petition is denied by the Formulary
8 Committee, shall, upon request therefor, showing reasonable
9 grounds for a hearing, be afforded a formal or informal hear-
10 ing on the matter in accordance with rules and procedures
11 established by such Committee.

12 "LIMITATIONS ON MEDICARE PAYMENT FOR CHARGES OF
13 PROVIDERS OF SERVICES

14 "SEC. 1883. (a) Any provider of services as defined in
15 section 1861(u), whose services are otherwise reimbursable,
16 under any program under this Act in which there is Federal
17 financial participation on the basis of 'reasonable cost', shall
18 not be entitled to a professional fee or dispensing charge or
19 reasonable billing allowance as determined pursuant to this
20 section.

21 "(b) A fee, charge, or billing allowance shall not be pay-
22 able under this section with respect to any drug entity that
23 (as determined in accordance with regulations) is furnished as
24 an incident to a physician's professional service, and is of a
25 kind commonly furnished in physicians' offices and commonly

1 either rendered without charge or included in the physicians'
2 bills.

3 "REASONABLE ALLOWANCE FOR ELIGIBLE DRUGS

4 "SEC. 1884. (a) For purposes of this title, the term 'rea-
5 sonable allowance' when used in reference to an eligible drug
6 means the following:

7 "(1) When used with respect to a prescription legend
8 drug entity, in a given dosage form and strength, such term
9 means the lesser of—

10 "(A) an amount equal to the customary charge at
11 which the participating pharmacy sells or offers such
12 drug entity, in a given dosage form and strength, to
13 the general public, or

14 "(B) the price determined by the Secretary, in ac-
15 cordance with subsection (b) of this section, plus the
16 professional fee or dispensing charges determined in
17 accordance with subsection (c) of this section.

18 "(2) When used with respect to insulin such term means
19 the charge not in excess of the reasonable customary price at
20 which the participating pharmacy offers or sells the product
21 to the general public, plus a reasonable billing allowance.

22 "(b)(1) For purposes of establishing the reasonable al-
23 lowance in accordance with subsection (a) the price shall be
24 (A) in the case of a drug entity (in any given dosage form and
25 strength) available from and sold by only one supplier, the

1 price at which such drug entity is generally sold (to establish-
2 ments dispensing drugs), and (B) in any case in which a drug
3 entity (in any given dosage form and strength) is available
4 and sold by more than one supplier, only each of the lower
5 prices at which the products of such drug entity are generally
6 sold (and such lower prices shall consist of only those prices
7 of different suppliers sufficient to assure actual and adequate
8 availability of the drug entity, in a given dosage form and
9 strength, at such prices in a region).

10 "(2) If a particular drug entity (in a given dosage form
11 and strength) in the Formulary is available from more than
12 one supplier, and the product of such drug entity as available
13 from one supplier possesses demonstrated distinct therapeutic
14 advantages over other products of such drug entity as deter-
15 mined by the Committee on the basis of its scientific and
16 professional appraisal of information available to it, including
17 information and other evidence furnished to it by the supplier
18 of such drug entity, then the reasonable allowance for such
19 supplier's drug product shall be based upon the price at
20 which it is generally sold to establishments dispensing drugs.

21 "(3) If the prescriber, in his handwritten order, has spe-
22 cifically designated a particular product of a drug entity (and
23 dosage form and strength) included in the Formulary by its
24 established name together with the name of the supplier of
25 the final dosage form thereof, the reasonable allowance for

1 such drug product shall be based upon the price at which it is
2 generally sold to establishments dispensing drugs.

3 "(c)(1) For the purpose of establishing the reasonable
4 allowance (in accordance with subsection (a)) a participating
5 pharmacy, shall, in the form and manner prescribed by the
6 Secretary, file with the Secretary, at such times as he shall
7 specify, a statement of its professional fee or other dispensing
8 charges.

9 "(2) A participating pharmacy, which has agreed with
10 the Secretary to serve as a provider of services under this
11 title, shall, except for subsection (a)(1)(A), be reimbursed, in
12 addition to any price provided for in subsection (b), the
13 amount of the fee or charges filed in paragraph (1), except
14 that no fee or charges shall exceed the highest fee or charges
15 filed by 75 percent of participating pharmacies (with such
16 pharmacies classified on the basis of (A) lesser dollar volume
17 of prescriptions and (B) all others) in a census region which
18 were customarily charged to the general public as of June 1,
19 1978. Such prevailing professional fees or dispensing charges
20 may be modified by the Secretary in accordance with criteria
21 and types of data comparable to those applicable to recogni-
22 tion of increases in reasonable charges for services under sec-
23 tion 1842.

24 "(3) A participating pharmacy shall agree to certify
25 that, whenever such pharmacy is required to submit its usual

1 professional fee or dispensing charge for a prescription, such
2 charge does not exceed its customary charge.".

3 EFFECTIVE DATES

4 SEC. 106. (a) Except as provided in subsection (b), the
5 amendments made by this title shall become effective on Jan-
6 uary 1, 1981, with respect to services rendered and expenses
7 incurred on or after such date.

8 (b) For purposes of section 1861(cc) of the Social Secu-
9 rity Act, the term "covered services" shall include eligible
10 drugs only with respect to expenses incurred and benefits
11 payable for such eligible drugs on or after January 1, 1982.

12 TITLE II—CATASTROPHIC ILLNESS INSURANCE

13 EMPLOYER AND RESIDUAL PLANS

14 SEC. 201. The Social Security Act is amended by
15 adding at the end thereof the following new title:

16 "TITLE XXI—CATASTROPHIC ILLNESS
17 INSURANCE

18 "PURPOSE OF TITLE

19 "SEC. 2101. It is the purpose of this title to make avail-
20 able to all citizens and permanent residents of the United
21 States insurance against high-cost catastrophic illness under
22 an employer plan required under part A of this title or under
23 an individual policy approved under part B of this title.

1 "PART A—EMPLOYER PLANS

2 "PURPOSE

3 "SEC. 2102. It is the purpose of this part to require that
4 each employer make available to each of its employees the
5 option to participate in a group catastrophic health insurance
6 plan which meets the requirements of section 2105.

7 "EMPLOYER DEFINED

8 "SEC. 2103. (a) For purposes of this part the term 'em-
9 ployer' means—

10 "(1) a person engaged in a business affecting com-
11 merce;

12 "(2) the United States; and

13 "(3) the District of Columbia;

14 but such term does not include any State or political subdivi-
15 sion of a State.

16 "(b) For purposes of this part the term 'full-time em-
17 ployee' means any employee who works for any one employ-
18 er at a rate of at least 25 hours per week.

19 "(c) For purposes of this part the term 'State' includes a
20 State of the United States, Puerto Rico, the Virgin Islands,
21 Guam, American Samoa, the Northern Mariana Islands, and
22 the Trust Territory of the Pacific Islands.

23 "EMPLOYER REQUIREMENTS

24 "SEC. 2104. (a) Every employer shall make available to
25 each of his full-time employees who has been such an em-

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1 ployee for more than 30 days, the option to participate in a
2 catastrophic health insurance plan meeting the requirements
3 of section 2105 (hereafter in this part referred to as the
4 'plan') subject to the plans, open enrollment requirements.
5 "(b) No employee may be required by his employer to
6 pay more than 25 percent of the cost of participating in the
7 plan, and the employee shall have the option of paying his
8 share of the cost through a payroll deduction system.

9 "PLAN REQUIREMENTS

10 "SEC. 2105. (a) A group catastrophic health insurance
11 plan must meet the following requirements:
12 "(1) The plan must provide the option to enroll in the
13 plan to all employees and other individuals for whom the
14 employer is required to provide such option under section
15 2104.
16 "(2)(A) The plan must offer an open enrollment period
17 of at least 30 days—
18 "(i) at least once each year with respect to all
19 employees; and
20 "(ii) during the calendar month immediately fol-
21 lowing a change in circumstances with respect to the
22 employee experiencing such change.
23 "(B) For purposes of this paragraph a change of circum-
24 stances means any of the following events with respect to an
25 employee:

1 "(i) The unemployment of a spouse who was cov-
2 ered under a group catastrophic health insurance plan.
3 "(ii) The death of a spouse.
4 "(iii) Marriage or divorce.
5 "(iv) A change in the number of the employee's
6 dependents.
7 "(3) The plan must offer an option to convert to an indi-
8 vidual policy (plus reasonable handling costs) to any individu-
9 al covered by the plan who ceases to be eligible under the
10 plan, without proof of insurability or reference to prior medi-
11 cal condition. Such option must be available up to the time
12 such individual ceases to be eligible, or for 90 days thereafter
13 in the case of an individual who ceases to be eligible on ac-
14 count of age.
15 "(4) The plan must provide coverage for the member
16 employee, his spouse, and for any of his unmarried depend-
17 ents under the age of 26, who are not otherwise covered
18 under a plan, without regard to any pre-existing medical con-
19 dition. For purposes of this title, the term 'dependent' shall
20 have the meaning assigned to it by the Secretary in regula-
21 tions, but such meaning shall include at least those individ-
22 uals who are considered to be dependents of such employee
23 under section 152 of the Internal Revenue Code of 1954.
24 The plan must also continue coverage for any such dependent
25 who became totally disabled prior to age 26, for so long as he

1 remains totally disabled, or until such time as he qualifies for
2 benefits under title XVIII, or a State plan approved under
3 title XIX, of this Act.

4 "(5)(A) The plan must continue coverage for the surviv-
5 ing spouse of a member employee if such spouse was covered
6 by the plan at the time of such employee's death, for a period
7 of at least 3 months, but the plan may discontinue such cov-
8 erage for any such surviving spouse who remarries or be-
9 comes eligible to enroll in a plan as an employee.

10 "(B) The plan must continue coverage for any surviving
11 dependent of a member employee if such dependent was cov-
12 ered by the plan at the time of such employee's death, for a
13 period of at least 3 months, but the plan may discontinue
14 coverage for any such surviving dependent who reaches age
15 26 or becomes eligible to enroll in a plan as an employee or
16 as the spouse of an employee.

17 "(C) The plan must continue coverage under the plan
18 for covered individuals for a period of 3 calendar months after
19 the member employee becomes unemployed or ceases to be a
20 full-time employee. Such coverage must be continued in the
21 same manner and subject to the same conditions as when
22 such member employee was a full-time employee, but the
23 plan may discontinue such coverage if the member employee
24 becomes eligible to enroll in a plan as an employee of another
25 employer or obtains equivalent catastrophic coverage. This

1 subparagraph shall not apply to a member employee who was
2 an employee for a period of less than 3 months.

3 "(D) In the case of an individual who was an employee
4 for less than 3 months, such coverage must be continued for
5 a number of calendar months equal to the number of calendar
6 months or fraction thereof during which the individual was an
7 employee.

8 "(6) The plan must provide for payment, without cost
9 sharing by any individual covered by the plan, for inpatient
10 hospital services (as defined in section 1861(b) of this Act)
11 provided to any individual covered by the plan during any
12 period which is a hospital benefit period with respect to that
13 individual (as determined under section 2106(a)).

14 "(7) The plan must provide for payment, without cost
15 sharing by any individual covered by the plan, for services for
16 which benefits are payable under section 1832 of this Act (to
17 individuals enrolled under part B of title XVIII) provided to
18 any individual covered by the plan during any period which is
19 a medical benefit period with respect to that individual (as
20 determined under section 2106(b)).

21 "BENEFIT PERIODS

22 "SEC. 2106. (a)(1) A hospital benefit period with re-
23 spect to any individual shall begin on the day following the
24 60th day during the 15-month period (consisting of a calen-
25 dar year and the last 3 months of the preceding calendar

1 year) in which that individual, or any other individual who is
2 a member of his family (as defined in subsection (c)), received
3 inpatient hospital services (as defined in section 1861(b) of
4 this Act).

5 "(2) A hospital benefit period with respect to any indi-
6 vidual shall end on—

7 "(A) the day in such calendar year following the
8 first period of 90 consecutive days therein during
9 which neither that individual, nor any member of his
10 family, was receiving inpatient hospital services; or

11 "(B) the last day of such calendar year, if earlier.

12 "(b)(1) A medical benefit period with respect to any in-
13 dividual shall begin when such individual and his family have
14 incurred expenses for services for which benefits are payable
15 under section 1832 of this Act (to individuals enrolled under
16 part B of title XVIII) which aggregate more than $5,000 in
17 the 15-month period (consisting of a calendar year and the
18 last 3 months of the preceding calendar year).

19 "(2)(A) A medical benefit period with respect to any
20 individual shall end on—

21 "(i) the day in such calendar year which precedes
22 the first period of 90 consecutive days therein during
23 which that individual and the members of his family in-
24 curred expenses for such services which aggregate less
25 than $500; or

1 "(ii) the last day of such calendar year, if earlier.
2 "(B) The dollar amounts of incurred expenses which de-
3 termine the beginning or end of a medical benefit period
4 under subparagraph (A) shall be adjusted each year by the
5 Secretary, beginning on September 1 with respect to the fol-
6 lowing calendar year, by a percentage equal to the percent-
7 age increase or decrease (as the case may be) in the medical
8 care services component of the Consumer Price Index (as
9 determined by the Department of Labor) as adjusted to re-
10 flect other appropriate economic factors (as determined by
11 the Secretary) during the 12-month period ending on the
12 June 30 last preceding such September 1.
13 "(c) For purposes of this title the term 'family' means,
14 with respect to an individual, the unit consisting of that indi-
15 vidual and any other person who is—
16 "(1) related to that individual by blood, marriage,
17 or adoption;
18 "(ii) living in a place of residence maintained by
19 that individual or by a person described in clause (i) as
20 his or their own home (and for purposes of this clause
21 a child under age 22 who is absent from home for the
22 purpose of attending an educational institution as a
23 full-time student shall be deemed to be living in such
24 place of residence); and

1 "(ii) is (I) the spouse of that individual, (II) a de-
2 pendent (as determined by the Secretary in regulations)
3 of that individual, (III) the person (or the spouse of the
4 person) of whom such individual is a dependent, or
5 "(iv) a person who is a dependent of the same
6 person of whom such individual is a dependent.

7 "CIVIL PENALTY FOR FAILURE TO COMPLY

8 "SEC. 2107. (a) Any employer who fails to comply with
9 the provisions of this part shall be subject to a civil penalty in
10 an amount up to 100 percent of the amount which the Secre-
11 tary determines would be the additional expense incurred by
12 such employer to comply with this part.

13 "(b)(1) The Secretary shall determine the amount of the
14 penalty on a monthly basis, and the penalty shall continue to
15 be assessed for each month during which such employer fails
16 to comply with this part.

17 "(2) In determining the amount of a civil penalty, the
18 Secretary shall take into account the nature, circumstances,
19 extent, and gravity of the violation or violations and, with
20 respect to the violator, ability to pay, effect on ability to con-
21 tinue to do business, any history of prior such violations, the
22 degree of culpability, and such other matters as justice may
23 require.

24 "(3) The Secretary may compromise, modify, or remit,
25 with or without conditions, any civil penalty which may be

1 imposed under this section. The amount of such penalty,
2 when finally determined, or the amount agreed upon in com-
3 promise, may be deducted from any sums owing by the
4 United States to the employer charged.

5 "(c) A civil penalty for a violation of this part shall be
6 assessed by the Secretary by an order made on the record
7 after opportunity for a hearing in accordance with section
8 554 of title 5, United States Code. Before issuing such an
9 order, the Secretary shall give written notice to the employer
10 to be assessed a civil penalty under such order of the Secre-
11 tary's proposal to issue such order and provide such employer
12 an opportunity to request, within 15 days of the date the
13 notice is received by such employer, such a hearing on the
14 order.

15 "(d) Any employer who requested in accordance with
16 subsection (c) a hearing respecting the assessment of a civil
17 penalty and who is aggrieved by an order assessing a civil
18 penalty may file a petition for judicial review of such order
19 with the United States Court of Appeals for the District of
20 Columbia Circuit or for any other circuit in which such em-
21 ployer resides or transacts business. Such a petition may only
22 be filed within the 30-day period beginning on the date the
23 order making such assessment was issued.

24 "(e) If any employer fails to pay an assessment of a civil
25 penalty—

1 "(1) after the order making the assessment has
2 become a final order and if such employer does not file
3 a petition for judicial review of the order in accordance
4 with subsection (d), or
5 "(2) after a court in an action brought under sub-
6 section (d) has entered a final judgment in favor of the
7 Secretary,
8 the Attorney General shall recover the amount assessed (plus
9 interest at currently prevailing rates from the date of the
10 expiration of the 30-day period referred to in subsection (d)
11 or the date of such final judgment, as the case may be) in an
12 action brought in any appropriate district court of the United
13 States. In such an action, the validity, amount, and appropri-
14 ateness of such penalty shall not be subject to review.

15 "PRIVATE RIGHT OF ACTION

16 "SEC. 2108. (a) Any employee may commence a civil
17 action against his employer if such employer is alleged to be
18 in violation of this part for damages consisting of any ex-
19 penses incurred by such employee or his family on account of
20 the failure of such employer to comply with the provisions of
21 this part.
22 (b) An action brought under this section shall be brought
23 in the United States district court for the district in which the
24 employee resides, in which the employer resides, or in which
25 the employer's principal place of business is located. The

1 United States district courts shall have jurisdiction over any
2 action brought under this section without regard to the
3 amount in controversy or the citizenship of the parties. In
4 any action brought under this section, process may be served
5 on a defendant in any judicial district in which the defendant
6 resides or may be found and subpenas for witnesses may be
7 served in any judicial district.

8 "(c) The court, in issuing any final order in any action
9 brought pursuant to subsection (a), may award costs of suit
10 and reasonable fees for attorneys and expert witnesses if the
11 court determines that such an award is appropriate. Any
12 court, in issuing its decision in an action brought to review
13 such an order, may award costs of suit and reasonable fees
14 for attorneys if the court determines that such an award is
15 appropriate.

16 "(d) Nothing in this section shall restrict any right
17 which any person (or class of persons) may have under any
18 statute or common law to seek enforcement of this Act or
19 any rule or order under this Act or to seek any other relief.

20 "(e) When two or more civil actions brought under sub-
21 section (a) involving the same defendant and the same issues
22 or violations are pending in two or more judicial districts,
23 such pending actions, upon application of such defendant to
24 such actions which is made to a court in which any such
25 action is brought, may, if such court in its discretion so de-

1 cides, be consolidated for trial by order (issued after giving all
2 parties reasonable notice and opportunity to be heard) of such
3 court and tried in—
4 "(1) any district which is selected by such defend-
5 ant and in which one of such actions is pending,
6 "(2) a district which is agreed upon by stipulation
7 between all the parties to such actions and in which
8 one of such actions is pending, or
9 "(3) a district which is selected by the court and
10 in which one of such actions is pending.
11 The court issuing such an order shall give prompt notification
12 of the order to the other courts in which the civil actions
13 consolidated under the order are pending.
14 "PART B—RESIDUAL PLAN
15 "PURPOSE OF PART; APPROPRIATION
16 "SEC. 2150. (a) It is the purpose of this part to provide
17 Federal payments to enable individuals to purchase private
18 catastrophic health insurance policies.
19 (b) For the purpose of carrying out the provisions of this
20 part there are authorized to be appropriated such sums as
21 may be necessary.
22 "ELIGIBLE INDIVIDUALS
23 "SEC. 2151. Any individual who—
24 "(1) is a resident of the United States, and

1 "(2) is a citizen of, or an alien lawfully admitted
2 to, the United States, or an alien otherwise permanent-
3 ly residing in the United States under color of law (in-
4 cluding any alien who is lawfully present in the United
5 States as a result of the application of the provisions of
6 section 203(a)(7) or section 212(d)(5) of the Immigra-
7 tion and Nationality Act),
8 shall be entitled to a premium subsidy under section 2156 if
9 such individual wishes to purchase an approved policy (as
10 defined in section 2154) and such individual is not—
11 "(A) covered under a catastrophic health insur-
12 ance plan which meets the requirements of section
13 2105 of this Act,
14 "(B) entitled to benefits under part A of title
15 XVIII of this Act, or
16 "(C) eligible for services under a State plan ap-
17 proved under title XIX of this Act which are at least
18 substantially equivalent (as determined by the Secre-
19 tary) to the services required to be covered under an
20 approved policy.
21 "AGREEMENTS WITH CARRIERS
22 "SEC. 2153. (a)(1) The Secretary shall enter into agree-
23 ments with private carriers that are willing and able to do so,
24 whereby such carriers shall make available catastrophic
25 health insurance policies which the Secretary determines

1 meet the requirements of this part. The Secretary shall agree
2 to pay a portion or all of the premium cost of such a policy on
3 behalf of any individual who is entitled to such a subsidy
4 payment under section 2156.

5 "(2) Any health maintenance organization qualified pur-
6 suant to title XIII of the Public Health Service Act shall
7 qualify as a carrier under this subsection.

8 "(b) For purposes of this part the term 'carrier' means a
9 voluntary association, corporation, partnership, health main-
10 tenance organization, or other nongovernmental organiza-
11 tion, which is engaged in providing, arranging, paying for, or
12 reimbursing the costs of health insurance policies or con-
13 tracts, medical or hospital service agreements, membership
14 or subscription contracts, or similar arrangements, in consid-
15 eration of premiums or other periodic charges.

16 "(c) The amount of the premium which may be charged
17 by an entity having an agreement under this section for ap-
18 proved policies for which the Secretary may make subsidy
19 payments, may vary by region according to reasonable cost
20 differences, but may not vary according to the health status
21 of the individual (or his family) purchasing the policy (or on
22 whose behalf the policy is purchased).

1 "APPROVED POLICY

2 "SEC. 2154. (a) In order to be an approved policy for
3 purposes of this part, a catastrophic health insurance policy
4 must meet the following requirements:
5 "(1)(A) The policy must offer an open enrollment
6 period of at least 30 days—
7 "(i) at least once each year with respect to
8 all covered individuals; and
9 "(ii) during the calendar month immediately
10 following a change in circumstances with respect
11 to the individual experiencing such change.
12 "(B) For purposes of this paragraph a change of
13 circumstances means any of the following events with
14 respect to a covered individual:
15 "(i) The unemployment of a spouse who was
16 covered under a group catastrophic health insur-
17 ance plan.
18 "(ii) The death of a spouse.
19 "(iii) Marriage or divorce.
20 "(iv) A change in the number of the individ-
21 ual's dependents.
22 "(2) The policy must provide coverage for an indi-
23 vidual, his spouse, and for any of his unmarried de-
24 pendents under the age of 26, who are not otherwise
25 covered under a group plan approved under part A of

1 this title, without regard to any preexisting medical
2 condition. The term 'dependent' shall have the mean-
3 ing assigned to it by the Secretary in regulations, but
4 such meaning shall include at least those individuals
5 who are considered dependents of such individual under
6 section 152 of the Internal Revenue Code of 1954.
7 "(3) The policy must provide for payment, with-
8 out cost sharing by any individual covered by the
9 policy, for inpatient hospital services (as defined in sec-
10 tion 1861(b) of this Act) provided to any individual
11 covered by the policy during any period which is a
12 hospital benefit period with respect to that individual
13 (as determined under section 2155(a)).
14 "(4) The policy must provide for payment, with-
15 out cost sharing by any individual covered by the
16 policy, for services for which benefits are payable
17 under section 1832 of this Act (to individuals enrolled
18 under part B of title XVIII) provided to any individual
19 covered by the policy during any period which is a
20 medical benefit period with respect to that individual
21 (as determined under section 2155(b)).
22 "(5) The policy must provide for payment, with-
23 out cost sharing by any individual covered under the
24 policy, for all services described in paragraphs (3) and
25 (4) provided to any individual covered by the policy

1 during any period which is a total benefit period with
2 respect to that individual (as determined under section
3 2155(c)).

4 "BENEFIT PERIODS

5 "SEC. 2155. (a)(1) A hospital benefit period with re-
6 spect to any individual shall begin on the day following the
7 60th day during the 15-month period (consisting of a calen-
8 dar year and the last 3 months of the preceding calendar
9 year) in which that individual, or any other individual who is
10 a member of his family (as defined in subsection (d)), received
11 inpatient hospital services (as defined in section 1861(b) of
12 this Act).

13 "(2) A hospital benefit period with respect to any indi-
14 vidual shall end—

15 "(A) on the day in such calendar year which fol-
16 lows the first period of 90 consecutive days therein
17 during which neither that individual, nor any member
18 of his family, was receiving inpatient hospital services;
19 or

20 "(B) on the last day of such calendar year, if
21 earlier.

22 "(b)(1) A medical benefit period with respect to any in-
23 dividual shall begin when such individual and the members of
24 his family have incurred expenses for medical services (as
25 defined in subsection (e)) which aggregate more than $5,000

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1 in the 15-month period (consisting of a calendar year and the
2 last 3 months of the preceding calendar year).

3 "(2) A medical benefit period with respect to any indi-
4 vidual shall end—

5 "(A) on the day in such calendar year which fol-
6 lows the first period of 90 consecutive days therein
7 during which that individual and the members of his
8 family incurred expenses for medical services which
9 aggregate less than $500; or

10 "(B) on the last day of such calendar year, if
11 earlier.

12 "(c)(1) A total benefit period with respect to any individ-
13 ual shall begin when such individual and the members of his
14 family have made expenditures for which they are not reim-
15 bursed for inpatient hospital services and medical services
16 which aggregate more than 15 percent (but at least $200) of
17 the income (as determined by the Secretary under subsection
18 (f)) of such family in the 15-month period (consisting of a
19 calendar year and the last 3 months of the preceding calendar
20 year).

21 "(2) A total benefit period with respect to any individual
22 shall end the last day of such calendar year.

23 "(d) For purposes of this part the term 'family' has the
24 same meaning, with respect to any individual, as in section
25 2106(c) of this Act.

1 "(e) For purposes of this section the term 'medical serv-
2 ices' means those services for which benefits are payable
3 under section 1832 of this Act to individuals enrolled under
4 part B of title XVIII.
5 "(f)(1) For purposes of this section, the Secretary shall
6 determine when an individual meets the requirements of sub-
7 section (c) based on income determinations under sections
8 2156 and 2157, and shall notify each insurance company
9 having an agreement with him under this part whenever a
10 policyholder of such company under the agreement meets the
11 income test under such subsection (c).
12 "(2) In carrying out his responsibilities under this sec-
13 tion, the Secretary may contract with appropriate State and
14 local government agencies.
15 "(g) The dollar amounts of incurred expenses which de-
16 termine the beginning or end of a medical benefit period
17 under subsection (b) shall be adjusted each year by the Secre-
18 tary, beginning on September 1 with respect to the following
19 calendar year, by a percentage equal to the percentage in-
20 crease or decrease (as the case may be) in the medical care
21 services component of the Consumer Price Index (as deter-
22 mined by the Department of Labor) as adjusted to reflect
23 other appropriate economic factors (as determined by the
24 Secretary) during the 12 month period ending on the June 30
25 last preceding such September 1.

1 "AMOUNT OF PREMIUM SUBSIDY

2 "SEC. 2156. (a) The amount of the subsidy to be paid to
3 an insurance entity on behalf of any individual shall be deter-
4 mined by the Secretary, based on the standards set forth in
5 subsection (b).

6 "(b)(1) An individual whose family income is equal to or
7 greater than 120 percent of the official nonfarm poverty
8 guideline, published by the Office of Management and Budget
9 and adjusted annually pursuant to section 625 of the Eco-
10 nomic Opportunity Act of 1964, for a family of the same size,
11 shall not be eligible for a subsidy under this part.

12 "(2) An individual with a family income of less than the
13 amount determined under paragraph (1) shall be eligible for a
14 subsidy, determined on a sliding scale basis, which takes into
15 account the following factors:

16 "(A) The amount of the premium.

17 "(B) The family income.

18 "(C) The family size.

19 "(D) Coverage provided by the policy which goes
20 beyond the minimum coverage required of an approved
21 policy.

22 "(c) No more than one member of the same family shall
23 be eligible for a subsidy under this part.

1 "MEANING OF 'INCOME'

2 "SEC. 2157. (a) For purposes of this part, 'income'
3 means (subject to subsection (b)) both earned income and un-
4 earned income; and—
5 "(1) 'earned income' means only—
6 "(A) wages as determined under section
7 203(f)(5)(C) of this Act; and
8 "(B) 'net earnings from self-employment', as
9 defined in section 211 of this Act (without appli-
10 cation of the second and third sentences following
11 subsection (a)(10), and the last paragraph of sub-
12 section (a)), including earnings for services de-
13 scribed in paragraphs (4), (5), and (6) of subsec-
14 tion (c); and
15 "(2) 'unearned income' means all other income,
16 including—
17 "(A) support and maintenance furnished in
18 cash,
19 "(B) any payments received as an annuity,
20 pension, retirement, or disability benefit; including
21 veterans' compensation and pensions; workmen's
22 compensation payments; old-age, survivors, and
23 disability insurance benefits; railroad retirement
24 annuities and pensions; and unemployment insur-
25 ance benefits,

1 "(C) cash gifts, support and alimony pay-
2 ments, and inheritances, and
3 "(D) rents, dividends, interest, and royalties.
4 "(b)(1) In determining, for purposes of this section, the
5 income of any individual or family, for any period of time,
6 there shall be excluded—
7 "(A) the aggregate value of any cash gifts which
8 do not exceed $240, if such period of time is equal to
9 12 months, or, if such period of time is less than 12
10 months, then an amount which bears the same ratio to
11 $240 as such period bears to 12 months, and
12 "(B) any scholarship, grant, fellowship, or loan
13 received for use in paying for tuition, books, and relat-
14 ed fees at any educational (including technical or voca-
15 tional education) institution.
16 "(2) For purposes of paragraph (1) and subsection (a)—
17 "(A) a loan of $240 or more (or aggregate there-
18 of) shall be regarded as a gift if such loan—
19 "(i) is unsecured (or is without adequate se-
20 curity), or
21 "(ii) has no maturity date; and
22 "(B) in the case of a loan which—
23 "(i) bears no interest, or

1 "(ii) bears interest at a rate which is not
2 more than one-half of the prevailing rate of inter-
3 est imposed with respect to similar loans,
4 the recipient of such loan shall be regarded as having
5 received, as a gift, an amount, with respect to any
6 period of time, equal to the excess of—
7 "(iii) the amount of interest which would
8 have been payable by him, with respect to such
9 period, on such loan if such loan bore a rate of
10 interest equal to the prevailing rate of interest im-
11 posed (as of the time such loan was made) with
12 respect to similar loans, over
13 "(iv) the amount of interest (if any) payable
14 by him, with respect to such period, on such loan.
15 "APPROVED POLICIES FOR MEDICAID RECIPIENTS
16 "SEC. 2158. (a) Notwithstanding the provisions of sec-
17 tion 2152(C), any State having a plan for medical assistance
18 approved under title XIX of this Act may purchase approved
19 policies under this part, on behalf of individuals who are
20 qualified to receive assistance under such plan and are not
21 entitled to benefits under part A of title XVIII, or on behalf
22 of any reasonable category thereof.
23 "(b) The amount expended by the State for purchasing
24 such policies shall be considered an amount expended by such

1 State for medical assistance for purposes of section 1903 of
2 this Act.

3 "FEDERAL ACTUARIAL COMMITTEE

4 "SEC. 2159. (a)(1) There is established a Federal Actu-
5 arial Committee which shall consist of 5 members appointed
6 by the President, one of whom shall be designated as the
7 Chairman.

8 "(2) A majority of the members of the committee shall
9 constitute a quorum, but a lesser number may conduct
10 hearings.

11 "(3) A vacancy in the committee shall not affect its
12 powers, but shall be filled in the same mannr as that herein
13 provided for the appointment of the member first appointed to
14 the vacant position.

15 "(4) Each member of the committee shall be entitled to
16 per diem compensation at rates fixed by the Secretary, but
17 not more than the current per diem equivalent of the annual
18 rate of basic pay in effect for grade GS-18 of the General
19 Schedule for each day (including travel time) during which
20 the member is engaged in the actual performance of duties
21 vested in the committee, and all members of the committee
22 shall be allowed, while away from their homes or regular
23 places of business in the performance of service for the com-
24 mittee, travel expenses (including per diem in lieu of subsist-
25 ence) in the same manner as persons employed intermittently

1 in the Government service are allowed expenses under sec-
2 tion 5703 of title 5, United States Code.
3 "(b) The committee shall prepare on an annual basis a
4 table of values of catastrophic health insurance coverage for
5 an individual, to be used as a guideline by which to evaluate
6 the actuarial value of catastrophic health insurance coverage,
7 and the costs of premiums for such coverage, offered through
8 private carriers. The table shall be made available to carriers,
9 health maintenance organizations, and all other interested
10 parties.
11 "(c) The Secretary shall provide such technical, secre-
12 tarial, clerical, and other assistance as the committee may
13 need.
14 "(d) The committee may secure directly from any de-
15 partment or agency of the United States such data and infor-
16 mation as may be necessary to enable it to carry out its
17 duties under this section. Upon request of the chairman of the
18 committee, any such department or agency shall furnish any
19 such data or information to the committee.
20 "(e) There are hereby authorized to be appropriated
21 such sums as may be necessary to carry out this section.
22 "INSURANCE POOLS
23 "SEC. 2160. Notwithstanding any other provision of
24 law, carriers may enter into contracts with any other carrier
25 or group of carriers for the purpose of establishing or partici-

1 pating in an insurance pool to provide catastrophic health
2 insurance coverage under this title.".

3 EFFECTIVE DATES

4 SEC. 202. (a) Except as provided in subsection (b), the
5 provisions of title XXI of the Social Security Act (as added
6 by this title) shall become effective on January 1, 1982.

7 (b) If, at the time that part A of title XXI of the Social
8 Security Act becomes effective, an employer has in effect a
9 group health plan which is an item covered under a collective
10 bargaining agreement, the provisions of such part A shall not
11 apply to such employer until such time as the collective bar-
12 gaining agreement expires, or January 1, 1984, whichever is
13 earlier.

14 MEDICAID REQUIREMENTS

15 SEC. 203. Section 1902(a) of the Social Security Act is
16 amended—

17 (1) by striking out "and" at the end of paragraph
18 (39);

19 (2) by striking out the period at the end of para-
20 graph (40) and inserting in lieu thereof a semicolon;
21 and

22 (3) by adding the following new paragraphs:

23 "(41) beginning January 1, 1982, provide to all
24 individuals otherwise eligible for services under the
25 plan, (A) catastrophic illness services, which must, at a

1 minimum, provide, without cost sharing by the individ-
2 ual or his family, (i) inpatient hospital services during
3 any hospital benefit period (as defined in section
4 2155(a) of this Act) and (ii) those categories of medical
5 services (as defined in section 2155(e)) which were in-
6 cluded under the State plan during January 1979,
7 during any medical benefit period (as defined in section
8 2155(b)), or (B) private insurance protection as pro-
9 vided in section 2158 of this Act; and
10 "(42) provide that no category of individuals who
11 are eligible for assistance under the plan in January
12 1979 may be eliminated from coverage under the
13 plan.".
14 TITLE III—AMENDMENTS TO INTERNAL
15 REVENUE CODE
16 DEDUCTION FOR INDIVIDUAL
17 SEC. 301. (a) Section 213(e)(1)(C) of the Internal Reve-
18 nue Code of 1954 (relating to the definition of medical ex-
19 penses) is amended to read as follows:
20 "(C) for insurance covering medical care referred
21 to in subparagraphs (A) and (B) which meets the re-
22 quirements of paragraph (5).".
23 (b) Section 213(e) of such Code is amended by adding at
24 the end thereof the following new paragraph:

1 "(5) For purposes of paragraph (1)(C) the term
2 'insurance' means—
3 "(A) supplementary medical insurance for
4 the aged under part B of title XVIII of the Social
5 Security Act,
6 "(B) a policy which contains at least the
7 catastrophic health coverage required under part
8 B of title XXI of the Social Security Act, or
9 "(C) in the case of a group health plan pro-
10 vided by an employer, a plan which meets the re-
11 quirements of part A of title XXI of the Social
12 Security Act.".
13 DEDUCTION FOR TRADE OR BUSINESS EXPENSE
14 SEC. 302. Section 162 of the Internal Revenue Code of
15 1954 (relating to trade or business expenses) is amended—
16 (1) by redesignating subsection (h) as subsection
17 (j); and
18 (2) by inserting after subsection (g) the following
19 new subsections:
20 "(h) HEALTH INSURANCE FOR INDIVIDUALS.—No de-
21 duction shall be allowed under subsection (a) for the cost of
22 any health insurance policy purchased by an individual for
23 himself or his family unless such policy meets the require-
24 ments of an approved policy under part B of title XXI of the
25 Social Security Act.

1 "(i) CONTRIBUTIONS BY EMPLOYER TO ACCIDENT
2 AND HEALTH PLANS.—No deduction shall be allowed under
3 subsection (a) for contributions by an employer to accident or
4 health plans for compensation (through insurance or other-
5 wise) to his employees for personal injury or sickness unless
6 such employer complies with the provisions of part A of title
7 XXI of the Social Security Act if so required under that
8 part.".

9 EMPLOYER CREDIT

10 SEC. 303. (a) Subpart A of part IV of subchapter A of
11 chapter 1 of the Internal Revenue Code of 1954 (relating to
12 credits allowable) is amended by adding after section 44C the
13 following new section:

14 "SEC. 44D. CREDIT FOR CERTAIN COSTS OF CATASTROPHIC
15 HEALTH INSURANCE.

16 "(a) GENERAL RULE.—There shall be allowed as a
17 credit against the tax imposed by this subchapter an amount
18 determined under subsection (b) in the case of any taxpayer
19 who is an employer within the meaning of part A of title
20 XXI of the Social Security Act.

21 "(b) AMOUNT OF CREDIT.—The amount of the credit
22 shall be equal to a percentage (determined under subsection
23 (d)) of the amount of excess payroll costs (determined under
24 subsection (c)) experienced by an employer during the taxable
25 year.

1 "(c) EXCESS PAYROLL COSTS.—The amount of an em-
2 ployer's excess payroll costs shall be equal to the amount by
3 which his payroll costs in the taxable year exceed 102 per-
4 cent of what his payroll costs would have been in such tax-
5 able year if such employer had maintained the same level of
6 contribution and the same scope of coverage under the acci-
7 dent or health plans he provided for his employees as he did
8 in his last taxable year which ended prior to the date of the
9 enactment of the Catastrophic Health Insurance and Medi-
10 care Improvements Act of 1979.

11 "(d) PERCENTAGE FOR DETERMINING CREDIT.—

12 "(1) For purposes of subsection (b), the percent-
13 age for the first taxable year beginning on or after the
14 date on which part A of title XXI of the Social Secu-
15 rity Act becomes effective with respect to the employer
16 shall be 50 percent.

17 "(2) For the next four succeeding taxable years
18 such percentage shall be the percentage as in effect in
19 the preceding taxable year, minus 10 percent.".

20 (b) The table of sections for such subpart is amended by
21 inserting after the item relating to section 44C the following
22 new item:

"Sec. 44D. Credit for certain costs of catastrophic health insurance.".

23 (c) Section 6401(b) of such Code (relating to excessive
24 credits treated as overpayments) is amended—

1 (1) by striking out "and 43 (relating to earned
2 income credit)" and inserting in lieu thereof "43 (relat-
3 ing to earned income credit), and 44D (relating to cer-
4 tain costs of catastrophic health insurance)", and
5 (2) by striking out "31, 39, and 43" and inserting
6 in lieu thereof "31, 39, 43, and 44D".

7 EFFECTIVE DATES

8 SEC. 304. (a) The amendments made by this title shall
9 apply to taxable years beginning with the first taxable year
10 beginning after the date on which the requirements of title
11 XXI of the Social Security Act are in effect with respect to
12 the employer (in the case of the taxable year of an employer
13 as defined in such title) or the taxpayer's employer (in the
14 case of the taxable year of an individual who is an employee
15 of an employer as defined in such title).
16 (b) The amendments made by this title shall apply to
17 taxable years beginning on or after January 1, 1982, in the
18 case of a taxpayer who is not an employer, or an employee of
19 an employer, as defined in title XXI of the Social Security
20 Act.

O

96TH CONGRESS
1ST SESSION

S. 760

To amend the Social Security Act by adding thereto a new title XXI which will require employers to provide insurance against the costs of catastrophic illness for their employees and their families; by providing tax credits to assist other persons to purchase such coverage on their own behalf; by replacing the medicaid program with a Federal medical assistance plan for low-income people, and by adding a new title XV thereto which will encourage and facilitate the availability, through private insurance carriers, of basic health insurance at reasonable premium charges, and for other purposes.

IN THE SENATE OF THE UNITED STATES

MARCH 26 (legislative day, FEBRUARY 22), 1979

Mr. LONG introduced the following bill; which was read twice and referred to the Committee on Finance

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A BILL

To amend the Social Security Act by adding thereto a new title XXI which will require employers to provide insurance against the costs of catastrophic illness for their employees and their families; by providing tax credits to assist other persons to purchase such coverage on their own behalf; by replacing the medicaid program with a Federal medical assistance plan for low-income people, and by adding a new title XV thereto which will encourage and facilitate the availability, through private insurance carriers, of basic

health insurance at reasonable premium charges, and for other purposes.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 TITLE I—CATASTROPHIC ILLNESS INSURANCE

4 AMENDMENTS TO SOCIAL SECURITY ACT

5 SEC. 101. The Social Security Act is amended by
6 adding after title XX the following new title:

7 "TITLE XXI—CATASTROPHIC HEALTH
8 INSURANCE PROGRAM

9 "SEC. 2101. (a) Every employer shall, under the terms
10 and conditions hereinafter stated, provide to his employees
11 who are not otherwise protected under an approved employer
12 plan, and to their qualified family members, protection under
13 an approved catastrophic health insurance plan. Employers
14 which have a payroll of $250,000 or less in a year will be
15 eligible for a refundable 50-percent tax credit under section
16 44D of the Internal Revenue Code of 1954 if they choose
17 such a credit in lieu of claiming such premium payments as
18 business expenses.

19 "(b) Individuals who are not covered under an employ-
20 er-sponsored catastrophic health insurance plan may pur-
21 chase coverage under an equivalent individual coverage plan,
22 and be eligible for a similar 50-percent credit or rebaté with
23 respect to their premium payments.

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1 "(c) The term 'employer', as used in this title shall have
2 the same meaning as when that term is used for purposes of
3 section 3121 of the Internal Revenue Code, except that the
4 provisions of section 3121(b) shall be applied without regard
5 to the exclusions specified in paragraphs (5), (6), (8), and (9)
6 of subsection (b) thereof. (See section 44D for treatment of
7 State and local employers and nonprofit organizations as em-
8 ployers for purposes of receiving catastrophic health insur-
9 ance rebates.)

10 "DEFINITIONS

11 "SEC. 2102. For purposes of this part—
12 "(a) The term 'employer plan' means—
13 "(1) an insurance policy, contract, or other ar-
14 rangement entered into between an employer and a
15 carrier under which the carrier, in consideration of pre-
16 miums or other periodic payments, undertakes to pro-
17 vide, pay for, or reimburse the costs of, health services
18 received by those of the employer's employees (and
19 those of the family members of such employees) who
20 are covered by the plan, or
21 "(2) a plan under which the employer, as a self-
22 insured employer (as defined in subsection (d)), under-
23 takes to provide, pay for, or reimburse the costs of,
24 health care services received by those of the employ-

1 er's employees (and those of the family members of
2 such employees) who are covered by the plan.
3 "(b) The term 'individual coverage plan' means an in-
4 surance policy, contract, or other arrangement entered into
5 between a carrier and an individual who is not covered under
6 an employer plan under which such carrier, in consideration
7 of premiums or other periodic payments, undertakes to pro-
8 vide, pay for, or reimburse the costs of, health services re-
9 ceived by such individual (and those of the family members of
10 such individual who are covered by the plan).
11 "(c) The term 'carrier' means a voluntary association,
12 corporation, partnership, or other nongovernmental organiza-
13 tion which is engaged in providing, paying for, or reimburs-
14 ing the costs of, health services under insurance policies or
15 contracts, medical or hospital service agreements, member-
16 ship or subscription contracts, or similar arrangements, in
17 consideration of premiums or other periodic charges payable
18 to the carrier.
19 "(d) The term 'self-insured employer' means an employ-
20 er who (either through outside administrators, including car-
21 riers, or otherwise) engages, without insurance arrangements
22 with a carrier, to provide, pay for, or reimburse the costs of,
23 health services for some or all of his employees.
24 "(e) The term 'employer' includes a State (or political
25 subdivision thereof) and the Federal Government.

1 "APPROVAL OF PLANS

2 "SEC. 2103. (a)(1) In order for an employer plan or an
3 individual coverage plan to be approved by the Secretary
4 under this part—

5 "(A) such plan, in the case of any plan other than
6 an employer plan of a self-insured employer, must be a
7 plan offered by a carrier which is approved by the Sec-
8 retary pursuant to subsection (e);

9 "(B) the coverage provided under such plan must
10 include, but shall not be limited to, the scope of bene-
11 fits prescribed in subsection (b).

12 "(2)(A) Secretary shall offer a catastrophic health insur-
13 ance policy, which meets the criteria prescribed under this
14 title with respect to approved plans to employers or to indi-
15 viduals, in any State in which there is not actually and gen-
16 erally available to employers or to individuals, as the case
17 may be, one or more approved catastrophic health insurance
18 policies approved under this title.

19 "(B) The premiums imposed under any such policy shall
20 be in an amount designed to cover the costs (inclusive of
21 administrative costs and appropriate reserves which will be
22 incurred in furnishing the benefits provided in the policy.

23 "(C) No such policy shall be offered in any area prior to
24 the expiration of the 3-year period which commences on the
25 date of enactment of this title.

1 "(D) Premiums collected by the Secretary for insurance
2 policies offered by him under this section shall be deposited in
3 an Insurance Revolving Fund, and moneys in such fund shall
4 be available, without fiscal year limitation, for the payment of
5 claims under such policies.

6 "(E) For the purpose of providing a contingency reserve
7 for the insurance program established by this section, there is
8 authorized to be appropriated such sums as may be neces-
9 sary; and any sums appropriate for such purpose shall remain
10 available for the purpose of making repayable advances
11 (without interest) to the Insurance Revolving Fund author-
12 ized to be established under subsection (d).

13 "(F) The Secretary, in making payment for services
14 covered under any insurance policy issued pursuant to this
15 section, shall utilize the payments methodology and adminis-
16 trative mechanism employed by him for making payment for
17 services covered under the insurance programs established by
18 title XVIII.

19 "(b)(1) For purposes of subsection (a), the coverage pro-
20 vided under an approved plan must include, but shall not be
21 limited to—

22 "(A) hospital and related services (as defined in
23 paragraph (2)) which are furnished to such individual
24 during a period with respect to which he has met the
25 deductible imposed by paragraph (4)(B), and

1 "(B) medical and other health services (as defined
2 in paragraph (3)) which are furnished to such individual
3 during a period with respect to which he has met the
4 deductible imposed by paragraph (4)(C).
5 "(2) The term 'hospital and related services' means—
6 "(A) inpatient hospital services (as defined in sec-
7 tion 1861(b)),
8 "(B) post-hospital extended care services (as de-
9 fined in section 1861(i)), and
10 "(C) home health services (as defined in section
11 1861(m)).
12 "(3) The term 'medical and other health services'
13 means—
14 "(A) medical and other health services (as defined
15 in section 1861(s)),
16 "(B) home health services (as defined in section
17 1861(m)),
18 "(C) outpatient physical therapy services (as de-
19 fined in section 1861(p)), and
20 "(D) rural health clinic services (as defined in sec-
21 tion 1861(aa)).
22 "Deductible Amount
23 "(4)(A) For purposes of payment of benefits under this
24 part with respect to expenses incurred for health services fur-

1 nished to any insured individual, there shall be taken into
2 account—
3 "(i) in case of expenses incurred for hospital and
4 related services (as defined in paragraph (2)), only so
5 much of such expenses as are incurred for such serv-
6 ices furnished during a period with respect to which
7 the deductible imposed by subparagraph (B) is met, and
8 "(ii) in case of expenses incurred for medical and
9 other health services (as defined in paragraph (3)), only
10 so much of such expenses as are incurred for such
11 services furnished during a period with respect to
12 which the deductible imposed by subparagraph (C) is
13 met.
14 "(B) The deductible imposed by this subsection with re-
15 spect to expenses incurred for hospital and related services
16 (as defined in paragraph (2)) shall be met by an insured
17 individual—
18 "(i) for the period, in the calendar year, which
19 commences on the day following the 60th day, during
20 the calendar year and the last 3 months of the preced-
21 ing calendar year, in which such individual received in-
22 patient hospital services; and
23 "(ii) for the period, in the calendar year, which is
24 prior to the first consecutive 90-day period therein in
25 which such individual is neither an inpatient in a hospi-

1 tal nor an inpatient in a skilled nursing facility, but
2 only if the first day for which such services in the cal-
3 endar year occurs not later than 90 days after the last
4 day with respect to which benefits were payable under
5 this part on account of inpatient hospital services fur-
6 nished to him in the preceding calendar year.
7 "(C) The deductible imposed with respect to expenses
8 incurred for medical and other health services (as defined in
9 paragraph (3)) shall be met by an insured individual—
10 "(i) for the period, in the calendar year, which
11 occurs after such individual has incurred, during such
12 year and the last 3 months of the preceding calendar
13 year, expenses (including expenses deemed under sub-
14 paragraph (D) to be incurred by him, but excluding
15 amounts required to be excluded under paragraph
16 (4)(F) for such services) of $2,000 (or, if higher, the
17 amount determined under subparagraph (G)(2)); and
18 "(ii) for the period, in the calendar year, which
19 occurs prior to the first 90-day period therein during
20 which such individual incurs for such services expenses
21 (including expenses deemed under paragraph (2) to be
22 incurred by him) the aggregate of which is less than
23 $500 (or, if greater, the amount determined under
24 paragraph (5)), but only if (i) during the last 3 months
25 of the preceding calendar year, such individual incurred

1 for such services expenses (including expenses deemed
2 under paragraph (2) to be incurred by the individual) of
3 at least $500 (or, if greater, the amount determined
4 under paragraph (5)), and (ii) such individual had met
5 (by reason of the application of clause (A)) for a period
6 in the preceding calendar year the deductible imposed
7 by this paragraph.

8 "(D) In determining, for purposes of this subsection, the
9 amount of expenses incurred by an individual for medical and
10 other health services furnished during any period, there shall
11 be deemed to have been incurred by such individual any ex-
12 penses incurred for such services furnished during such
13 period to each other member of such individual's family, but
14 only if such other member is (i) the spouse of the individual,
15 (ii) a dependent of such individual, (iii) the person (or the
16 spouse of the person) of whom such individual is a dependent,
17 or (iv) a person who is a dependent of the same person of
18 whom such individual is a dependent.

19 "(E) For purposes of subparagraph (D)—

20 "(i) the term 'dependent' shall have the meaning
21 assigned to it by regulations of the Secretary;

22 "(ii) the term 'family' means two or more individ-
23 uals who are (I) related by blood, marriage or adop-
24 tion, and (II) living in a place of residence maintained
25 by one or more of them as his or their own home (and

1 for purposes of this clause, a child under age 26 who is
2 absent from home for the purpose of attending an edu-
3 cational institution as a full-time student shall be
4 deemed while so absent to be living in such place of
5 residence); and

6 "(iii) the term 'member', when used in reference
7 to a family means an individual described in clause (ii).

8 "(F) In determining, for purposes of this subsection, the
9 amount of expenses incurred (or deemed to be incurred) by an
10 individual for medical and other health services in any calen-
11 dar year, there shall be disregarded all amounts in excess of
12 $500 incurred in connection with the treatment of mental,
13 psychoneurotic, or personality disorders of such individual.

14 "(G) The Secretary shall, between July 1 and October 1
15 of 1981 and of each year thereafter, determine and promul-
16 gate the deductible which shall be applicable for purposes of
17 subparagraph (C)(1) in the succeeding calendar year. Such
18 deductible shall be equal to whichever of the following is the
19 higher:

20 "(i) $2,000, or

21 "(ii) $2,000 multiplied by the ratio of the compo-
22 nent of the Consumer Price Index, prepared by the
23 Department of Labor for June of the year in which
24 such determination is made and promulgated, which
25 represents fees for physician services to such compo-

1 nent of such Consumer Price Index for the month of
2 June 1980, with such product, if not a multiple of
3 $100, being rounded to the nearest multiple of $100.
4 "(H) The Secretary shall between July 1 and October of
5 1981 and of each year thereafter, determine and promulgate
6 the amount which shall be applicable for purposes of subpara-
7 graph (C)(ii) in the succeeding calendar year. Such amount
8 shall be equal to whichever of the following is the higher:
9 "(A) $500, or
10 "(B) $500 multiplied by the ratio of the compo-
11 nent of the Consumer Price Index, prepared by the
12 Department of Labor for June of the year in which
13 such determination is made and promulgated, which
14 represents fees for physician services to such compo-
15 nent of such Consumer Price Index for the month of
16 June 1980, with such product, if not a multiple of $50,
17 being rounded to the nearest multiple of $50.
18 "(5) Payments with respect to expenses incurred in con-
19 nection with the treatment of mental, psychoneurotic, and
20 personality disorders shall not be made unless such treatment
21 consists of 'mental health care services'. As used in this sub-
22 paragraph, the term 'mental health care services' includes
23 only care and services for mental conditions—
24 "(i) which, if provided on an inpatient basis, con-
25 sist of a course of active care and treatment provided

1 in and by an accredited medical institution (as deter-
2 mined by the Secretary),
3 "(ii) which, if provided on a partial hospitalization
4 basis, are provided (i) in and by an accredited medical
5 institution (as determined by the Secretary), or (ii) in
6 and by a qualified community mental health center (as
7 determined in accordance with regulations of the
8 Secretary),
9 "(iii) which, if provided on an outpatient basis, are
10 provided by a qualified community mental health
11 center (as determined in accordance with regulations of
12 the Secretary), or provided by a psychiatrist;
13 except that such term does not include any outpatient serv-
14 ices provided by a psychiatrist, during a 12-month period, for
15 purposes of diagnosis or treatment of acute psychosis in
16 excess of (I) five visits, plus (II) such additional visits as shall
17 have been approved in advance by an appropriate profes-
18 sional review mechanism upon a finding that, in the absence
19 of such additional visits, the patient will require institutional
20 care.
21 "(6) the plan (in the case of an employer plan) (i)
22 must cover all of the employees of such employer
23 (other than employees who perform service for less
24 than 25 hours per week or temporary employees), and

1 (ii) may, at the option of the employer, cover all of the
2 employees of the employer;
3 "(7) the plan must cover the spouse and depend-
4 ent family members (including dependent children until
5 age 26) of any employee (in the case of an employer
6 plan) or individual (in the case of an individual cover-
7 age plan) covered by the plan;
8 "(8) such plan (in the case of an employer plan)
9 must not require or permit any financial participation
10 in the cost of the plan by any individual covered there-
11 under;
12 "(9) such plan (in the case of an employer plan)
13 must provide that coverage (in the case of a new em-
14 ployee, his spouse, and dependent family members) will
15 begin not later than the first day of the first calendar
16 month which commences more than 30 days after the
17 date the employee's employment commences, and that
18 coverage of an employee (and of members of his family
19 who are covered by the plan) will not be terminated by
20 reason of the separation of the employee from his em-
21 ployment by such employer prior to 180 days after the
22 date of such separation, or (if earlier) the first day after
23 the date on which such employee first obtains coverage
24 under another employer plan approved under this part;

1 "(10)(A) such plan, in the case of any employer
2 plan (other than an employer plan of a self-insured em-
3 ployer) must be a plan under which there are available
4 to the employer arrangements for the pooling of risks
5 under the plan by which his employees are covered
6 and under the plans by which employees of other
7 employers are covered so that the premium or other
8 periodic charge payable therefor to the carrier are de-
9 termined on a class basis either (i) without regard to
10 the payments or reimbursements for health services re-
11 ceived by the employer's employees (and family mem-
12 bers of such employees) covered by the plan, or (ii)
13 without regard to the payments or reimbursements for
14 health services received by the employer's employees
15 (and family members of such employees) in excess of a
16 specified amount agreed to between the employer and
17 the carrier of payments or reimbursements as to any
18 one individual or family and under which the premium
19 or other periodic charge made under such arrangement
20 is specifically identified to the purchaser;
21 "(B) the premium or other periodic charge im-
22 posed for the pooling arrangements described in sub-
23 paragraph (A) shall (in case of any plan other than an
24 employer plan of a self-insured employer) be stated, to
25 the employer or self-employed individual subscribing to

1 the plan, in annual (or more frequent) billings or re-
2 newal notices which shall be expressed in such a
3 manner as to facilitate a comparison of such premium
4 or charge with the amount allowable on account of
5 such plan as a tax credit under section 1403 or section
6 3114, as the case may be, of the Internal Revenue
7 Code of 1954.

8 "(C) In any case where, pursuant to one or more collec-
9 tive bargaining agreements, health insurance responsibilities
10 for one or more groups (but not all) of the employees of an
11 employer have been placed with a labor organization, the
12 Secretary may waive the requirement imposed by subsection
13 (b)(6) with respect to such group or groups of the employer's
14 employees for such period as may be necessary to enable the
15 employer and the labor organizations with which he has col-
16 lective bargaining agreements a reasonable opportunity so to
17 arrange health insurance coverage of the employees of the
18 employer as to meet the requirement imposed by subsection
19 (b)(6). The Secretary shall provide technical assistance to,
20 and recommend procedures to be employed by, such em-
21 ployer and such organizations in meeting such requirement.

22 "(c) Approval of the Secretary of any plan (other than
23 an employer plan of a self-insured employer) shall not be
24 denied because such plan is provided under arrangements
25 with carriers involving the plans of two or more employers in

1 the same industry or under a trust or trade association
2 arrangement.
3 "(d)(1) No employer plan or individual coverage plan
4 shall be approved by the Secretary except on the basis of an
5 application for approval submitted by the employer or indi-
6 vidual (or by a carrier on such person's behalf) to the Secre-
7 tary, which application shall be in such form and contain such
8 information and assurances as the Secretary shall by regula-
9 tions require.
10 "(2) Applications for approval may contain provision for
11 recommendations of approval, by the insurance department
12 or similar agency of the State involved; and the Secretary
13 may employ any such recommendations as a basis for expe-
14 diting approval of the application with respect to which such
15 recommendations are made.
16 "(3)(A) The Secretary shall not approve any application
17 of an employer plan by a self-insured employer unless such
18 application contains or is supported by proof and assurances
19 satisfactory to the Secretary that the employer has the finan-
20 cial ability to discharge his obligations under the plan and has
21 the administrative ability effectively to discharge such
22 obligations.
23 "(B) The Secretary may, as a condition of approval of
24 an employer plan by a self-insured employer, require the em-
25 ployer to deposit in a depository designated by the Secretary

1 either an indemnity bond or securities (at the option of the
2 employer) of a kind and in an amount determined by the Sec-
3 retary, and subject to such conditions as the Secretary may
4 prescribe (which shall include authorization to the Secretary
5 in case of default of the employer's obligations to provide
6 benefits under the plan to sell any of such securities sufficient
7 to discharge such obligations or to bring suit upon such bonds
8 to procure the prompt discharge of such obligations).

9 "Approved Carrier

10 "(e)(1) As used in this section—

11 "(A) the term 'catastrophic health insurance'
12 means a health insurance policy or plan which provides
13 the coverage which is required pursuant to subsection
14 (b)(1); and

15 "(B) the term 'carrier' includes any nonprofit hos-
16 pital or medical service corporation.

17 "(2)(A) In order for a carrier to be approved by the
18 Secretary under this subsection, the carrier must—

19 "(i) offer, in each State in which such carrier does
20 health insurance business, catastrophic health insur-
21 ance to all individuals and groups on an annual or
22 shorter contract basis, with the option of the policy-
23 holder to renew at the expiration of the term of the
24 policy, and with provision that the coverage so offered
25 will not be discontinued or denied in the case of any

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1 individual or group except for failure to make timely
2 payment of premium therefor;
3 "(ii) provide claims determination procedures with
4 respect to catastrophic health insurance benefits which
5 (I) comply with the requirements imposed by section
6 503 of the Employee Retirement Income Security Act
7 of 1974 and the regulations issued thereunder by the
8 Secretary of Labor and (II) are consistent with those
9 employed by the carrier in its noncatastrophic health
10 insurance business and which in general are at least as
11 favorable to claimants as those employed under the
12 Federal plan established by part A, and
13 "(iii) operate in accordance with procedures satis-
14 factory to the Secretary for meeting its obligations
15 with respect to policies of catastrophic health insurance
16 and for disposition of unearned premiums on such poli-
17 cies in the event of the discontinuance of such policies
18 or the withdrawal of its status as an approved carrier
19 by the Secretary.
20 "(B) In order to better enable carriers to meet the re-
21 quirements imposed by subparagraph (A)(ii), the Secretary
22 shall provide to carriers, offering approved plans under this
23 part, reasonable access to claim data developed under the
24 Federal plan established by title XVIII.

1 "(d) Approval of a plan by the Secretary under this sec-
2 tion shall not have the effect of causing such plan to be a
3 'governmental plan', as that term is employed in and for pur-
4 poses of title I of the Employee Retirement Income Security
5 Act of 1974, if such plan would, in the absence of such ap-
6 proval, not be a 'governmental plan', as that term is so
7 employed.

8 "(e)(1) It shall not be unlawful, under any antitrust law,
9 for any carrier or group of carriers to enter into or participate
10 in any pool, reinsurance, or other residual market arrange-
11 ment, or for any carrier to carry on any activity which is
12 necessary or appropriate to discharge its functions under any
13 such arrangement, if and to the extent that, such arrange-
14 ment and the activities taken pursuant thereto are confined to
15 the offering and administration of plans approved by the Sec-
16 retary under this section.

17 "(2) As used in paragraph (1), the term 'antitrust law'
18 means the Federal Trade Commission Act, each statute re-
19 ferred to in section 4 of that Act (15 U.S.C. 44) as an Anti-
20 trust Act, any other statute of the United States in pari ma-
21 teria, and any law of any State or political subdivision thereof
22 which prohibits or restrains contracts, combinations, or other
23 arrangements in restraint of trade.

1 "CERTIFICATIONS TO THE SECRETARY OF THE TREASURY
2 "SEC. 2104. (a) Whenever the Secretary approves, or
3 withdraws approval of, any employer plan or individual cov-
4 erage plan under this part, he shall submit a certification of
5 his action to the Secretary of the Treasury.
6 "(b)(1) The Secretary shall, prior to January 1, of each
7 calendar year, certify to the Secretary of the Treasury the
8 Table of Values of Catastrophic Health Insurance Coverage
9 which shall be in effect for such calendar year, together with
10 such additional data as may be needed by the Secretary of
11 the Treasury in connection with the administration of sec-
12 tions 42, 1403, and 3114 of the Internal Revenue Code of
13 1954.
14 "(2) The table of values referred to in paragraph (1)
15 shall be developed, for each calendar year, by the Secretary
16 and shall, except for such adjustments as the Secretary shall
17 deem to be necessary, be the same as the Table of Values of
18 Catastrophic Health Insurance Coverage which is prepared
19 and recommended to the Secretary for such year by the Ac-
20 tuarial Committee established pursuant to section 2105.
21 "(3) Such table of values developed by the Secretary
22 shall be made available to all carriers who offer approved
23 catastrophic health insurance plans and to all other interested
24 persons.

1 "ACTUARIAL COMMITTEE

2 "SEC. 2105. (a)(1) There is hereby established an Actu-
3 arial Committee which shall consist of five individuals, who
4 are not otherwise in the employ of the United States, ap-
5 pointed by the Secretary.

6 "(2)(A) Members of the Committee shall be persons who
7 are qualified to perform the functions and duties of the Com-
8 mittee. No individual shall be a member of the Committee
9 unless he (i) is enrolled, or meets the conditions for enroll-
10 ment (other than those relating to pension experience), as an
11 actuary in the Joint Board for the Enrollment of Actuaries
12 established by section 3041 of the Employee Retirement
13 Income Security Act of 1974, and (ii) has significant actuar-
14 ial experience in the field of health insurance.

15 "(B) At no time shall more than two members of the
16 Committee be in the employ of a carrier (as defined in sub-
17 section (e)) which does health insurance business.

18 "(3) Members of the Committee shall serve for terms of
19 4 years, except that of those first appointed, one shall be
20 appointed for a term of 1 year, one shall be appointed for a
21 term of 2 years, one shall be appointed for a term of 3 years,
22 and two shall be appointed for terms of 4 years. A member
23 may be reappointed, but no member may serve for more than
24 two successive terms. A member appointed to fill a vacancy
25 shall be appointed only for the unexpired term of his prede-

1 cessor. A majority of the members of the Committee shall
2 constitute a quorum thereof and action taken by the Commit-
3 tee shall be by majority vote of those present and voting. The
4 Secretary shall, from time to time, designate a member of the
5 Committee to serve as Chairman thereof.

6 "(4) The Secretary shall furnish to the Committee an
7 executive secretary and such secretarial, clerical, and other
8 services as may be required to enable the Committee to carry
9 out its duties and functions.

10 "(b)(1) Members of the Committee shall each be entitled
11 to receive the daily equivalent of the annual rate of basic pay
12 in effect for grade GS-18 of the General Schedule for each
13 day (including traveltime) during which they are engaged in
14 the actual performance of duties vested in the Committee.

15 "(2) While away from their homes or regular places of
16 business in the performance of services for the Committee,
17 members of the Committee shall be allowed travel expenses,
18 including per diem in lieu of subsistence, in the same manner
19 as persons employed intermittently in the Government are
20 allowed expenses under section 5703(b) of title 5 of the
21 United States Code.

22 "(c) Section 14(a) of the Federal Advisory Committee
23 Act shall not apply to the Actuarial Committee established
24 pursuant to this section.

1 "(d)(1) It shall be the duty and function of the Commit-
2 tee to prepare and recommend to the Secretary, not later
3 than October 1 of each year, a Table of Values of Cata-
4 strophic Health Insurance Coverage which shall be in effect
5 for the calendar year commencing on the following
6 January 1.

7 "(2) Such table of values shall establish, for each State,
8 the actuarial value of one year's catastrophic health insur-
9 ance coverage for one individual, as estimated for the calen-
10 dar year for which such table of values is to be in effect, and
11 shall be designed (with the use of a table of adjustment fac-
12 tors) to enable employers, carriers, and others involved with
13 plans approved under section 2103 to determine the actuarial
14 value of the catastrophic health insurance coverage provided
15 under any such plan.

16 "(3) The value of catastrophic health insurance cover-
17 age shall be established by the Committee according to the
18 best data and information available to it on the basis of the
19 expected costs or charges for health care services, the ex-
20 pected utilization of health care services by all persons
21 having such coverage, the expected administration and claim
22 payment expenses (including an allowance for risk) applicable
23 to plans providing such coverage, and such other information
24 as the Committee determines to be relevant. In establishing
25 such value of coverage in any State, the Committee shall

1 employ appropriate adjustment factors, which shall be ap-
2 plied uniformly within the State, to reflect significant cost
3 differences related to geographic variations and the age and
4 dependency characteristics of individuals covered under plans
5 providing such coverage.

6 "(4) The term 'catastrophic health insurance', as used in
7 this section, means health insurance provided under plans ap-
8 proved under section 2103 which provides that minimum
9 coverage necessary to meet the requirement imposed in sec-
10 tion 2103(b).

11 "(e)(1) The Committee shall have the further duty (A) of
12 reviewing (by random claim or data sample or otherwise) the
13 marketing and rating practices of plans approved under sec-
14 tion 2103 with a view to determining whether such practices
15 unduly or inappropriately restrict, for particular groups, the
16 availability of coverage under plans approved under such sec-
17 tion, and (B) upon request of the Secretary of the Treasury,
18 to assist him in establishing procedures designed to assure
19 the proper administration of sections 42, 1403, and 3114 of
20 the Internal Revenue Code of 1954.

21 "(2) The Committee shall report to the Secretary its
22 findings resulting from its review functions, together with
23 such recommendations as it may have based on such find-
24 ings.".

1 AMENDMENT TO THE INTERNAL REVENUE CODE

2 SEC. 102. (a) Subpart A of part IV of subchapter A of
3 chapter 1 of the Internal Revenue Code of 1954 (relating to
4 credits allowable) is amended by inserting immediately before
5 section 45 the following new section:

6 "SEC. 44D. CREDIT FOR CATASTROPHIC HEALTH INSURANCE
7 PREMIUMS PAID BY CERTAIN TAXPAYERS.

8 "(a) ACTUARIAL VALUE OF CATASTROPHIC HEALTH
9 INSURANCE COVERAGE UNDER APPROVED INDIVIDUAL
10 COVERAGE AND CERTAIN EMPLOYER PLANS.—If, during
11 any part of the taxable year (1) an employer which has a
12 payroll of $250,000 or less during such year, or (2) some
13 other taxpayer who is not an employer, has secured for his
14 employees or for himself, as the case may be, catastrophic
15 health insurance coverage under a plan which is approved by
16 the Secretary of Health, Education, and Welfare under sec-
17 tion 2103 of the Social Security Act, the taxpayer may, in
18 lieu of any deduction and to the extent provided in this sub-
19 section and subsection (b), credit against the taxes otherwise
20 imposed by this chapter for such taxable year an amount
21 equal to one-half the actuarial value of such coverage, as
22 determined under the appropriate Table of Values of Cata-
23 strophic Health Insurance Coverage certified by such Secre-
24 tary pursuant to section 2103 of such Act. Such credits shall

1 be refundable to the taxpayer to the extent they exceed his
2 tax liability.
3 "(b) LIMIT ON CREDITS.—The total credits allowed a
4 taxpayer under this section shall not exceed 100 percent of
5 the premiums against which such credits are allowable.
6 "(c) A State and the local government employees in a
7 State in which all such public employers provide catastrophic
8 health insurance to their employees under the terms and con-
9 ditions prescribed for employers in title XXI of the Social
10 Security Act shall be deemed to be an employer for purposes
11 of subsection (a) regardless of payroll amounts if such State
12 enters into an agreement with the Secretary of the Treasury
13 to comply with the provisions of such title XXI and if the
14 Secretary of Health, Education, and Welfare certifies that
15 such State and each of its subdivisions is in compliance with
16 the provisions of such title. For purposes of subsection (a), a
17 nonprofit organization shall also be deemed to be an employ-
18 er without regard to the amount of its payroll.".
19 EXCISE TAXES
20 (b) Chapter 36 of the Internal Revenue Code of 1954
21 (relating to certain other excise taxes) is amended by adding
22 at the end the following new subchapter:
23 **"Subchapter F—Taxes on Certain Uninsured**
24 **Employers**

"Sec. 4495. Imposition of taxes.

1 "SEC. 4495. IMPOSITION OF TAXES.

2 "(a) TAXES ON UNINSURED EMPLOYERS.—

3 "(1) If an employer has failed to insure his em-
4 ployees under an approved employer catastrophic
5 health insurance plan pursuant to section 2101 of the
6 Social Security Act with respect to any taxable year,
7 there is hereby imposed on the employer a tax equal to
8 150 percent of the amount of premiums that it is esti-
9 mated he would have paid had his employees been so
10 insured.".

11 TITLE II—MEDICAL ASSISTANCE PLAN FOR
12 LOW-INCOME PEOPLE

13 SEC. 201. (a) Effective October 1, 1980, title XIX of
14 the Social Security Act is amended to read as follows:

15 "TITLE XIX—MEDICAL ASSISTANCE PLAN
16 FOR LOW-INCOME PEOPLE

17 "PART A—GENERAL PROVISIONS

18 "PURPOSE

19 "SEC. 1901. It is the purpose of this title to provide, for
20 low-income individuals and members of low-income families,
21 assistance toward the costs of necessary hospital, skilled
22 nursing facility, medical, and other health care services.

23 "FREE CHOICE BY PATIENT GUARANTEED

24 "SEC. 1902. Any individual entitled to benefits under
25 this title may obtain health services provided hereunder from
26 any institution, agency, or person qualified to participate

1 under this title in accordance with reimbursement and service
2 requirements if such institution, agency, or person undertakes
3 to provide him such services. The provisions of the preceding
4 sentence shall not be applicable in the jurisdiction of Puerto
5 Rico, the Virgin Islands, or Guam for any period with re-
6 spect to which there is in effect an election (submitted to the
7 Secretary in such form and manner as he shall by regulations
8 prescribe) by the Governor of such jurisdiction that such pro-
9 visions not be applicable to such jurisdiction.

10 "OPTION OF INDIVIDUALS TO OBTAIN OTHER HEALTH
11 INSURANCE PROTECTION

12 "SEC. 1903. Nothing contained in this title shall be con-
13 strued to preclude any State from providing, or any individu-
14 al from purchasing or securing (through collective bargaining
15 or otherwise), protection against the cost of any health
16 services.

17 "PART B—DESCRIPTION OF MEDICAL ASSISTANCE PLAN

18 "ELIGIBLE INDIVIDUALS

19 "SEC. 1910. (a) Every 'medicaid eligible' (as defined in
20 section 1916(a)) shall be eligible for the health benefits pro-
21 vided under this title in the manner prescribed by section
22 1916. Every individual who—

23 "(1) is (A) a low-income individual, or (B) a
24 member of a low-income family,

1 "(2) is a resident of the United States, and is
2 either (A) a citizen or (B) an alien lawfully admitted
3 for permanent residence or otherwise permanently re-
4 siding in the United States under color of law (includ-
5 ing any alien who is lawfully present in the United
6 States as a result of the application of the provisions of
7 section 203(a)(7) or section 212(d)(5) of the Immigra-
8 tion and Nationality Act), and
9 "(3) has filed (in the case of a low-income individ-
10 ual), or has had filed in his behalf by an appropriate
11 person an application under this title (filed in such form
12 and manner and containing such information as the
13 Secretary shall by regulations prescribe),
14 shall be eligible for the health benefits provided under this
15 title for the benefit period (as determined under subsection
16 (d)(2)) to which such application is applicable; except that no
17 such individual shall be entitled to such benefits on account of
18 services received by him during any period with respect to
19 which he does not meet the condition imposed by paragraph
20 (2) of this subsection.
21 "(b) Whenever the Secretary approves any application
22 (referred to in subsection (a)(3)), he shall issue a health bene-
23 fits card to each individual who, by reason of such applica-
24 tion, is eligible for a benefit period to the health benefits pro-
25 vided by this title. Such health benefits card which shall be

1 used to assist in identifying an eligible individual, shall identi-
2 fy the individual or family member to whom it is issued (by
3 name, sex, age, and social security account number and such
4 criteria as the Secretary shall by regulations prescribe) as
5 being eligible for such benefits for such period.

6 "(c) An application (referred to in subsection (a)(3)) on
7 behalf of the members of a low-income family shall be filed by
8 the head of such family or by such other appropriate person
9 as the Secretary shall by regulations specify.

10 "(d)(1)(A) Any application (referred to in subsection
11 (a)(3)) shall be filed with respect to—

12 "(i) the coverage year in which the application is
13 filed, or

14 "(ii) the coverage year immediately following the
15 coverage year in which the application is filed and
16 which begins not later than 60 days after the date on
17 which such application is filed.

18 "(B) As used in this subsection and section 1911, the
19 term 'coverage year' means the 12-month period beginning
20 April 1 of any year.

21 "(2) The benefit period of any individual resulting from
22 the filing of an application (referred to in subsection (a)(3)),
23 shall commence—

24 "(A) on the first day of the first month in which
25 the application is filed, or

1 "(B) if earlier, the first day of the third month
2 prior to the month in which the application is filed and
3 in which such individual or the family of which he is a
4 member first met the conditions imposed by section
5 1910(a) (1) and (2),
6 and shall end on whichever of the following is earlier—
7 "(C) the close of the coverage year with respect
8 to which such application is filed, or
9 "(D) such date as may be specified in regulations
10 of the Secretary (promulgated in accordance with the
11 provisions of section 1911(d)), if such individual, prior
12 to the date referred to in clause (C), ceases to meet the
13 applicable condition imposed by subsection (a)(1), or
14 fails to submit reports which the Secretary deems to be
15 necessary or useful to enable him to determine whether
16 such individual continues to meet the conditions im-
17 posed by subsection (a) (1) and (2);
18 except that, if on the date that any individual's benefit period
19 would (as determined under the preceding provisions of this
20 paragraph) end, such individual is an inpatient in a health
21 care institution (which is a hospital, skilled nursing facility, or
22 intermediate care facility) participating under title XVIII or
23 this title, such individual's benefit period shall not end until
24 the day following the first day, after such date, that such

1 individual either is no longer an inpatient in or no longer
2 requires care in such an institution.

3 "DETERMINATIONS OF ELIGIBILITY

4 "SEC. 1911. (a) Whenever an application (referred to in
5 section 1910(a)(3)) has been filed by or on behalf of an indi-
6 vidual or on behalf of the members of a family, the determi-
7 nation of whether such individual or such family meets the
8 applicable condition imposed by section 1910(a)(1) (A) or (B)
9 shall be based on the actual income of the individual or family
10 for the 2-month period immediately preceding the date of
11 filing of the application and the prospective income of the
12 individual or family for the 2-month period immediately fol-
13 lowing such date.

14 "(b) An individual shall be deemed, for purposes of sub-
15 section (a), to have no income for the 2-month period immedi-
16 ately preceding the date of the filing of an application (re-
17 ferred to in section 1910(a)(3)) if—

18 "(1) at the time such application is filed by such
19 individual, he is not a member of a family, and

20 "(2) during all of such 2-month period (A) such
21 individual was a member of a family, (B) was not regu-
22 larly employed, and (C) was not the head of such
23 family.

24 "(c) The Secretary, in determining (for purposes of sub-
25 section (a)) the prospective income of any individual or

1 family, may take into account current income (if any) and
2 other relevant factors (including, in appropriate cases, actual
3 income for preceding periods).
4 "(d) An individual (referred to in section 1910(d)(2)(D))
5 shall be deemed not to have ceased to meet the applicable
6 condition imposed by section 1910(a)(1) in a current coverage
7 year because the income of such individual or of the family of
8 which he is a member, as the case may be, has increased, if
9 such income, as so increased, does not exceed 120 per
10 centum of the maximum amount of income which such indi-
11 vidual (or such family) can receive while still being a 'low-
12 income' individual or family (as the case may be). The pre-
13 ceding sentence shall apply also to decreases in family
14 income maximums brought about by a diminution in the
15 number of members thereof, except that a diminution in the
16 number of members of a family of not more than one such
17 member during a benefit period shall not affect the eligibility
18 of the remaining members of such family during the remain-
19 der of such benefit period.

20 "SCOPE OF BENEFITS

21 "SEC. 1912. The benefits provided to an individual eli-
22 gible in any benefit period under this title shall consist of
23 eligibility to have payment made (subject to the provisions of
24 this title) on his behalf for—

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1 "(a) necessary inpatient hospital services;
2 "(b) medical and other health services;
3 "(c) skilled nursing facility services;
4 "(d) home health services;
5 "(e) intermediate care services;
6 "(f) mental health services;
7 "(g) pre-natal and well-baby care;
8 "(h) family planning counseling, services, and
9 supplies;
10 "(i) in the case of eligible children under age 18,
11 early and periodic screening, diagnosis, and treatment;
12 and
13 "(j) payment of any premium imposed under part
14 B of title XVIII for coverage under the insurance pro-
15 gram established by such part;
16 and to have reimbursement made to him in an amount equal
17 to one-half of the amount (i) of the actuarial value, as deter-
18 mined under the appropriate Table of Values of Catastrophic
19 Health Insurance Coverage certified by the Secretary pursu-
20 ant to section 2104(b), of catastrophic health insurance cov-
21 erage for any period for such individual (or such individual
22 and family members) under a self-employed plan approved by
23 the Secretary under section 2122, and (ii) paid by such indi-
24 vidual (and by family members) as premiums for such plan.

1 "COPAYMENT REQUIREMENTS

2 "SEC. 1913. (a)(1) Any individual or family who, for
3 any coverage year, is eligible for the health benefits provided
4 by this title shall be responsible for the first $3 of the cost
5 incurred for a visit for physicians' services (other than as an
6 inpatient) if such visit is not for the purpose of securing ap-
7 propriate well-baby care, family planning services, or serv-
8 ices described in section 1912(i). Such $3 copayment shall be
9 applicable only to each of the first ten visits of any individual
10 or family for physicians' services. In the case of an individual
11 covered under title XVIII, the copayment or deductible re-
12 quirements of this section shall apply to the extent they are
13 less than the copayment required under title XVIII.

14 "(2) In the case of any individual who—
15 "(A) is, for any benefit period, entitled to the
16 health benefits provided under this title,
17 "(B) is not a member of a family or is a member
18 of a family all of whose members meet the require-
19 ments of subparagraph (C),
20 "(C) for a continuous period in excess of 60 days
21 (whether or not in the same benefit period), is an inpa-
22 tient in an institution which is a hospital, skilled nurs-
23 ing facility, or intermediate care facility,
24 there shall be imposed in each month (which begins after
25 such period) in which he is an inpatient in such an institution

1 a special copayment, with respect to health care services in
2 such institution to which he is entitled under this title during
3 each month, equal to the amount by which his cash income
4 for such month exceeds $50.
5 "(b) The amount payable under this title with respect to
6 physicians' services where a copayment is required by sub-
7 section (a)(1) or (a)(2) shall be reduced by an amount (if any)
8 equal to the copayment imposed.
9 "RESIDUAL NATURE OF BENEFITS
10 "SEC. 1914. Amounts otherwise payable under this title
11 with respect to any item or service specified in clauses (a)
12 through (i) of section 1912 provided to an individual during
13 any benefit period shall be reduced by the amount which is
14 paid (or upon claim by the individual, or a person claiming on
15 his behalf, would be payable) under any other public or pri-
16 vate insurance or health care benefits plan by which such
17 individual is covered (including the insurance program estab-
18 lished by title XVIII, the program established by title XXI,
19 and any workmen's compensation law), except that payments
20 under this title shall be primary in the case of a State pro-
21 gram designed to supplement (through higher income tests)
22 the eligibility of this program.
23 "SPECIAL PROVISIONS RELATING TO MEDICAID ELIGIBLES
24 "SEC. 1915. (a) For purposes of this section and the
25 first sentence of section 1910(a), the term 'medicaid eligible'

1 means an individual (whether as a member of a family or
2 otherwise) who, for any month after December 1980 and
3 prior to October 1981, was determined to be eligible for as-
4 sistance under a State plan approved under this XIX (as in
5 effect prior to October 1, 1981).

6 "(b) Notwithstanding any other provision of this title,
7 any individual who is a medicaid eligible shall (subject to
8 subsection (c)) be eligible for the health insurance provided by
9 this title for any period after September 1981 if, for such
10 period, such individual—

11 "(1) meets the requirements imposed (or deemed
12 by Federal law to be imposed) as a condition of eligi-
13 bility for assistance under the State plan under which
14 his status as a medicaid eligible is established, as such
15 plan was in effect for September 1981,

16 "(2) does not meet such requirements but would
17 meet such requirements except for the amount of his
18 income (or the income of the family of which he is a
19 member), if his income (or the income of the family of
20 which he is a member) does not exceed 105 per
21 centum of the maximum applicable income standard
22 imposed as a condition of eligibility under such require-
23 ments as in effect for September 1980, or (if greater)
24 for September 1981,

1 except that no individual shall, by reason of the provisions of
2 this subsection, be deemed to be eligible for health benefits
3 under this title unless such individual meets the requirements
4 of section 1910(a)(2) and there has been filed (in the manner
5 provided by section 1910(a)(3)) by or on behalf of such indi-
6 vidual an application for benefits under this title with respect
7 to such period.

8 "PART C—CONDITIONS AND LIMITATIONS ON PAYMENT,
9 AND ADMINISTRATION

10 "BASIS FOR PAYMENT FOR HEALTH SERVICES

11 "SEC. 1920. (a) Except as is otherwise provided in sub-
12 section (d), covered health care services provided to individ-
13 uals insured under this title shall, in the case such services
14 are provided by a provider of service (as defined in section
15 1861(u)) or an intermediate care facility, be paid for on the
16 basis of the reasonable cost subject to the limitations other-
17 wise provided under title XVIII for such services and, in the
18 case such services are provided by a person (other than a
19 provider of service or an intermediate care facility), be paid
20 on the basis of the reasonable charge (subject to the limita-
21 tions with respect thereto imposed under title XVIII).

22 "(b) In the event that such amounts are not payable due
23 to the failure of the individual or family to enroll in a health
24 insurance plan for which he or such family was otherwise
25 eligible, and to the extent such coverage would have been in

1 effect during the benefits period, and in which his or such
2 family's premium or rate liability was 25 per centum or less
3 (or failure to enroll in part B of title XVIII) amounts other-
4 wise payable under this title shall be reduced by not more
5 than $250 in a benefit period.

6 "(c) As used in subsection (a), the term 'reasonable cost'
7 shall have the same meaning as when such term is employed
8 in title XVIII.

9 "(d)(1) To the extent that the regulations of the Secre-
10 tary promulgated pursuant to paragraph (2) are applicable to
11 a skilled nursing facility or an intermediate care facility, cov-
12 ered services furnished by such facility shall be paid on the
13 cost-related basis established under such regulations rather
14 than on the basis of reasonable cost.

15 "(2) In the interest of the efficient and economical ad-
16 ministration of this title, the Secretary shall promulgate regu-
17 lations under which covered services furnished by all or one
18 or more types or classes of skilled nursing facilities or inter-
19 mediate care facilities in any area (consisting of one or more
20 States) will be paid for on a reasonable cost-related basis, as
21 determined in accordance with methods and standards pre-
22 scribed in such regulations.

1 "CONDITIONS OF AND LIMITATION ON PAYMENT FOR
2 SERVICES

3 "SEC. 1921. (a) Services and the payment therefor
4 under this title are subject to the same conditions and limita-
5 tions as those imposed by sections 1814, 1834, and 1835
6 with respect to services, and the payment therefor, provided
7 under title XVIII.

8 "(b) No payment shall be made under this title to any
9 person on account of any health care service furnished by
10 such person to an individual who is covered under this title
11 for such service unless such person accepts the amount of
12 such payment, together with any copayment required under
13 section 1913 with respect to such service, as payment in full
14 for such service. Whenever payment under this title is made
15 in supplementation of a payment made under any insurance
16 program (whether public or private) for a service, the amount
17 of the payment under this title shall not be in excess of
18 amount which would be paid had such service been provided
19 under this title, and no person accepting such payment as
20 payment for such service shall charge any amount in excess
21 of the amount so paid to the individual receiving such service.

22 "(c) If any eligible individual (as determined under sec-
23 tion 1910) who is a low-income individual or a member of a
24 low-income family (as determined without regard to section
25 1932) is enrolled in—

1 "(1) a health maintenance organization which
2 meets the applicable requirements of section 1876, or
3 "(2) an organization which (A) provides medical
4 and other health services (or arranges for their avail-
5 ability) on a prepayment basis, and (B) receives and
6 prior to September 1, 1973, received, payments under
7 part B of title XVIII under the authority contained in
8 section 1833(a)(1)(A),
9 the Secretary may, in lieu of making payments for health
10 benefits on behalf of such individual as provided in other pro-
11 visions of this title, make payment therefor in the manner
12 authorized by section 1876 for any period, during which he is
13 so enrolled, and for which he is such an eligible individual.
14 "(d) Payments under this title may not be made for
15 services provided by any group practice unit unless such unit
16 meets the applicable requirements of section 1876.
17 "ADMINISTRATION AND QUALITY CONTROL
18 "SEC. 1922. (a) The provisions of this title shall (subject
19 to the provisions of section 702(b)) be administered by the
20 Secretary.
21 "(b) The provisions of title XVIII (and other provisions
22 of law applicable to the health insurance programs estab-
23 lished by such title, including part B of title XI) relating to
24 utilization and professional review and conditions of partici-
25 pation required with respect to persons or providers of health

1 services under title XVIII, shall be applicable to all health
2 services provided under this title.
3 "(c) To the maximum extent practicable, the Secretary,
4 in the administration of this title, shall utilize and otherwise
5 coordinate with the procedures employed in the administra-
6 tion of the health insurance programs established by title
7 XVIII (including the procedures for certification of providers
8 of service), and shall have the same authority (except as
9 otherwise specifically provided) as that conferred upon him
10 with respect to the administration of the insurance programs
11 established by title XVIII.
12 "REQUIREMENTS FOR CARRIERS AND INTERMEDIARIES
13 "SEC. 1923. (a) The Secretary, in the administration of
14 this title, shall, whenever he determines that the interests of
15 quality of service to eligible individuals or program economy,
16 or efficiency of administration would be furthered, require
17 consolidation of activities on the part of carriers (utilized pur-
18 suant to authority contained in section 1842) and agencies or
19 organizations (utilized pursuant to authority contained in sec-
20 tion 1816) in geographic regions with minimum size popula-
21 tions of individuals covered under this title and under the
22 insurance programs established by title XVIII.
23 "(b) No private carrier or other organization shall after
24 the 3-year period which commences on the date of enactment
25 of this section, be utilized in the administration of this title or

1 title XVIII unless such carrier or other organization is an
2 'approved carrier' under section 1505.,

3 "MEDICAL COVERAGE TRUST FUND

4 "SEC. 1924. (a) There is hereby created on the books of
5 the Treasury of the United States a trust fund to be known
6 as the Medical Coverage Trust Fund (hereinafter in this sec-
7 tion referred to as the 'Trust Fund'). The Trust Fund shall
8 consist of such gifts and bequests as may be made as pro-
9 vided in section 201(i)(1), and such amounts as may be de-
10 posited in, or appropriated to, such fund as provided in sec-
11 tions 1925 and 1926.

12 "(b) With respect to the Trust Fund, there is hereby
13 created a body to be known as the Board of Trustees of the
14 Trust Fund (hereinafter in this section referred to as the
15 'Board of Trustees') composed of the Secretary of the Treas-
16 ury, the Secretary of Labor, and the Secretary of Health,
17 Education, and Welfare, all ex officio. The Secretary of the
18 Treasury shall be the Managing Trustee of the Board of
19 Trustees (hereinafter in this section referred to as the 'Man-
20 aging Trustee'). The Commissioner of Social Security shall
21 serve as the Secretary of the Board of Trustees. The Board
22 of Trustees shall meet not less frequently than once each
23 calendar year. It shall be the duty of the Trustee to—

24 "(1) hold the Trust Fund;

1 "(2) report to the Congress not later than the first
2 day of July of each year on the operation and status of
3 the Trust Fund during the preceding fiscal year and on
4 its expected operation and status during the current
5 fiscal year and the next 2 fiscal years;
6 "(3) report immediately to the Congress whenever
7 the Board is of the opinion that the amount of the
8 Trust Fund is unduly small; and
9 "(4) review the general policies followed in man-
10 aging the Trust Fund, and recommend changes in such
11 policies, including necessary changes in the provisions
12 of law which govern the way in which the Trust Fund
13 is to be managed.
14 The report provided for in paragraph (2) shall include a state-
15 ment of the assets of, and the disbursements made from, the
16 Trust Fund during the preceding fiscal year, an estimate of
17 disbursements to be made from the Trust Funds during the
18 current coverage year and each of the next 2 fiscal years.
19 Such report shall be printed as a House document of the
20 session of the Congress to which the report is made.
21 "(c) The Managing Trustee shall pay from time to time
22 from the Trust Fund such amounts as the Secretary of
23 Health, Education, and Welfare certifies are necessary to
24 make the payments of benefits provided for in this title, and

1 the payments with respect to administrative expenses in ac-
2 cordance with section 201(g)(1).

3 "STATE CONTRIBUTIONS TO MEDICAL COVERAGE TRUST
4 FUND, AND TO CATASTROPHIC HEALTH INSURANCE
5 TRUST FUND

6 "SEC. 1925. (a) In order for individuals residing in any
7 State to receive for any period the benefits provided by this
8 title, there must be in effect for such period an agreement
9 between such State and the Secretary entered into under this
10 section.

11 "(b) Any agreement between the Secretary and a State
12 under this section shall provide that the State will (subject to
13 subsection (c)) pay, with respect to each fiscal year for which
14 such agreement is in effect, to the Secretary of the Treasury
15 at such time or times as may be specified in the agreement,
16 an amount equal to—

17 "(1) in case such State is a State which (for the
18 fiscal year ending September 30, 1980, or September
19 30, 1981, had in effect a State plan approved under
20 title XIX, as in effect prior to the effective date of the
21 program established by this title) the sum of the fol-
22 lowing:

23 "(A) an amount equal to (i) the total amount
24 expended from non-Federal funds for the purpose
25 of providing (under such State plan to persons eli-

1 gible under such plan) services of the types for
2 which coverage is provided by this title, for the
3 four-quarter period ending September 30, 1980,
4 or (ii) if greater, the total amount expended from
5 non-Federal funds for such purpose for the four-
6 quarter period ending September 30, 1981, plus
7 "(B) an amount equal to one-half of (i) the
8 total amount expended (as determined by the Sec-
9 retary) from non-Federal public funds for the pur-
10 pose of providing, for individuals not covered
11 under such plan but who are eligible under this
12 title, services of the types for which coverage is
13 provided by this title, for the four-quarter period
14 ending September 30, 1980, or (ii) if greater, the
15 total amount expended (as determined by the Sec-
16 retary) from non-Federal funds for such purpose
17 for the four-quarter period ending September 30,
18 1981; and
19 "(2) in case such State did not, for the fiscal year
20 ending September 30, 1980, or September 30, 1981,
21 have in effect a State plan referred to in paragraph (1),
22 (A) the total amount expended (as determined by the
23 Secretary) from non-Federal funds for the purpose of
24 providing services of the types for which coverage is
25 provided by this title for persons eligible under this

1 title, for the four-quarter period ending September 30,
2 1980, or (B) if greater, the total amount expended (as
3 determined by the Secretary) from non-Federal funds
4 for such purpose for the four-quarter period ending
5 September 30, 1981.
6 "(c) The amount payable by any State under subsection
7 (b) with respect to a coverage year shall be reduced by an
8 amount equal to one-half of the amount expended by such
9 State during such coverage year from non-Federal funds in
10 providing to individuals in such State services of a type—
11 "(1) which is not covered under this title, but
12 "(2) with respect to the cost of which there could
13 have been Federal financial participation under title
14 XIX (as in effect prior to the effective date of the pro-
15 gram established by this title) if such type of service
16 had been included in a State's plan approved under
17 such title XIX.
18 "(d) Amounts paid to the Secretary of the Treasury
19 under this section shall be deposited by him in the Medical
20 Coverage Trust Fund.
21 "APPROPRIATIONS TO MEDICAL COVERAGE TRUST FUND
22 "SEC. 1926. There are authorized to be appropriated
23 for each fiscal year to the Medical Coverage Trust Fund such
24 sums as may be necessary to carry out the program estab-
25 lished by this title.

1 "MINIMUM PAYMENTS

2 "SEC. 1927. If the amount payable to an insured indi-
3 vidual at any particular time as benefits under this title is less
4 than $5, no payment shall be made to him until such time as
5 the payment to which he is entitled as such benefits is $5 or
6 more.

7 "OPTOMETRISTS' SERVICES PROVIDED IN CERTAIN STATES

8 "SEC. 1928. In the case of any State which—
9 "(1) does not provide for the payment of optom-
10 etrists' services furnished to individuals who are eligi-
11 ble for benefits under the medical assistance plan for
12 low-income people established by this title,
13 "(2) during all or some part of the 2-year period
14 ending on the effective date of such medical assistance
15 plan, did provide, under its State plan approved under
16 title XIX (as in effect prior to such effective date),
17 payment of optometrists' services,
18 the term 'physicians' services', as employed in such medical
19 assistance plan established by this title, shall, with respect to
20 individuals residing in such State, be deemed to include any
21 service which is furnished by an optometrist, if—
22 "(3) such service is one which an optometrist is
23 legally authorized to perform,
24 "(4) such service would constitute 'physicians'
25 services', as that term is employed in such medical as-

1 sistance plan established by this title, if it had been
2 performed by a physician.

3 "PART D—DEFINITIONS AND MISCELLANEOUS
4 PROVISIONS

5 "MEANING OF 'LOW-INCOME INDIVIDUAL' AND 'MEMBER
6 OF A LOW-INCOME FAMILY'

7 "SEC. 1930. (a) For purposes of section 1910(a)(1)(A),
8 the term 'low-income individual' means an individual—
9 "(1) who is not a member of a family (as deter-
10 mined under subsection (b)(1)), and
11 "(2) whose income is at a rate of not more than
12 $3,000 for the calendar year 1981 or any calendar
13 year thereafter.
14 "(b) For purposes of section 1910(a)(1)(B)—
15 "(1) the term 'family' means two or more individ-
16 uals who are—
17 "(A) related by blood, marriage, or adoption,
18 and
19 "(B) living in a place of residence maintained
20 by one or more of them as his or their own home;
21 "(2) the term 'member', when used in reference to
22 a family, means an individual described in paragraph
23 (1), and
24 "(3) the term 'low-income', when used in refer-
25 ence to a family, means a family, the aggregate income

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1 of all the members of which is at a rate of not more
2 than—
3 "(A) in case there are only two members of
4 such family, $4,200, or
5 "(B) in case there are only three members of
6 such family, $4,800, or
7 "(C) in case there are only four members of
8 such family, $5,400, or
9 "(D) in case there are more than four mem-
10 bers of such family, an amount equal to $5,400
11 plus $400 for each member of such family in
12 excess of four.
13 "(c) The Secretary may prescribe the circumstances
14 under which, consistent with the purposes of this title and in
15 the same manner as authorized in section 1611(d), the gross
16 income of an individual or family from a trade or business
17 (including farming) will be considered sufficiently large to
18 cause such individual or family not to be regarded as a 'low-
19 income individual', or a 'low-income family', even though
20 such individual's or family's income does not exceed the ap-
21 plicable dollar amount prescribed in subsection (a)(2) or (b)(3).
22 "(d) In the case of jurisdictions of the Commonwealth of
23 Puerto Rico, the Virgin Islands, and Guam, the amounts set
24 forth in subsection (b)(3) (A), (B), (C), and (D) shall each be
25 deemed to be reduced to such amount as the Secretary deter-

1 mines to be appropriate to assure that the ratio of individuals
2 and families in any such jurisdiction who meet the criteria for
3 low income (for purposes of this title) to the total population
4 of such jurisdiction is not greater than the ratio of individuals
5 in that State of the United States which has the highest such
6 ratio of individuals who meet such criteria to the total popu-
7 lation of such State.

8 "MEANING OF 'INCOME'

9 "SEC. 1931. (a) For purposes of this title, 'income'
10 means (subject to subsection (b)) both earned income and un-
11 earned income; and—

12 "(1) 'earned income' means only—

13 "(A) wages as determined under section
14 203(f)(5)(C); and

15 "(B) 'net earnings from self-employment', as
16 defined in section 211 (without application of the
17 second and third sentences following subsection
18 (a)(10), and the last paragraph of subsection (a)),
19 including earnings for services described in para-
20 graphs (4), (5), and (6) of subsection (c); and

21 "(2) 'unearned income' means all other income,
22 including—

23 "(A) support and maintenance furnished in
24 cash,

1 "(B) any payments received as an annuity,
2 pension, retirement, or disability benefit; including
3 veterans' compensation and pensions; workmen's
4 compensation payments; old-age, survivors, and
5 disability insurance benefits; railroad retirement
6 annuities and pensions; and unemployment insur-
7 ance benefits,
8 "(C) cash gifts, support and alimony pay-
9 ments, and inheritances, and
10 "(D) rents, dividends, interest, and royalties.
11 "(b)(1) In determining, for purposes of this section, the
12 income of any individual or family, for any period of time,
13 there shall be excluded—
14 "(A) the aggregate value of any cash gifts which
15 do not exceed $240, if such period of time is equal to
16 12 months, or, if such period of time is less than 12
17 months, then an amount which bears the same ratio to
18 $240 as such period bears to 12 months, and
19 "(B) any scholarship, grant, fellowship, or loan
20 received for use in paying for tuition, books, and
21 related fees at any educational (including technical or
22 vocational education) institution.
23 "(2) For purposes of paragraph (1) and subsection (a)—
24 "(A) a loan of $240 or more (or aggregate there-
25 of) shall be regarded as a gift if such loan—

1 "(i) is unsecured (or is without adequate se-
2 curity), or
3 "(ii) has no maturity date; and
4 "(B) in the case of a loan which—
5 "(i) bears no interest, or
6 "(ii) bears interest at a rate which is not
7 more than one-half of the prevailing rate of inter-
8 est imposed with respect to similar loans,
9 the recipient of such loan shall be regarded as having
10 received, as a gift, an amount, with respect to any
11 period of time, equal to the excess of—
12 "(iii) the amount of interest which would
13 have been payable by him, with respect to such
14 period, on such loan if such loan bore a rate of
15 interest equal to the prevailing rate of interest im-
16 posed (as of the time such loan was made) with
17 respect to similar loans, over
18 "(iv) the amount of interest (if any) payable
19 by him, with respect to such period, on such loan.
20 "SPEND-DOWN REQUIREMENT
21 "SEC. 1932. (a) For purposes of determining eligibility,
22 the amount of the income of any individual or family (as de-
23 termined under section 1931) shall be reduced by an amount
24 equal to such individual's or family's incurred health care ex-
25 penses to the extent such expenses constitute a legal obliga-

1 tion and are not payable by any other third party payor
2 (whether public or private) (as determined under subsection
3 (b)) for the benefit period with respect to which such individ-
4 ual's or family's income is determined.
5 "(b)(1) The term 'health care expenses', when applied to
6 any individual or family, means (subject to paragraphs (2)
7 and (3)) reasonable expenditures by or on behalf of such indi-
8 vidual or the members of such family (as the case may be) for
9 any of the following:
10 "(A) inpatient hospital services (including services
11 in an institution for tuberculosis or mental diseases),
12 "(B) outpatient hospital services,
13 "(C) other laboratory and X-ray services,
14 "(D) skilled nursing facility services,
15 "(E) physicians' services furnished by a physician
16 (as defined in section 1861(r)(1)), whether furnished in
17 the office, the patient's home, a hospital, or a skilled
18 nursing facility, or elsewhere,
19 "(F) optometrists' and podiatrists' services,
20 "(G) home health services,
21 "(H) private duty nursing services,
22 "(I) clinic services,
23 "(J) dental services,
24 "(K) physical therapy, speech, pathology, and au-
25 diology services,

1 "(L) prescribed drugs, dentures, durable medical
2 equipment and related supplies, and prosthetic devices,
3 and eyeglasses prescribed by a physician skilled in dis-
4 eases of the eye or by an optometrist,
5 "(M) other rehabilitation services,
6 "(N) intermediate care facility services,
7 "(O) inpatient psychiatric hospital services,
8 "(P) health insurance premiums, or
9 "(Q) ambulance service.
10 "(2) For purposes of paragraph (1), the expenditure for
11 any item or service specified therein means—
12 "(A) in case payment for such item or service has
13 been made prior to the time the determination of
14 health care expenses (which includes such item or
15 service) is made, the amount actually paid for such
16 item or service,
17 "(B) in case payment for such item or service has
18 not been made at such time and such item or service is
19 of a type which is covered under the health coverage
20 plan established by this title, whichever of the follow-
21 ing is the lesser:
22 "(i) the actual charge for such item or serv-
23 ice, or
24 "(ii) the reasonable charge or reasonable cost
25 (as the case may be) for such item or service as

1 determined under this title when such item or
2 service is provided as an item or service covered
3 under such health plan.

4 "(3) The term 'health care expenses' also includes an
5 amount equal to one-half of the amount (A) of insurance pre-
6 miums paid by or on behalf of an individual for catastrophic
7 health insurance coverage for such individual (or for such in-
8 dividual and family members) under a self-employed plan ap-
9 proved by the Secretary under section 2103.

10 "(c) The health care expenses (as determined under the
11 preceding provisions of this section) may, in the case of any
12 individual, be determined on a prospective basis for any
13 future period for which such individual's income (or the
14 income of the family of which an individual is a member) is
15 determined, but only if such individual is determined (in ac-
16 cordance with regulations of the Secretary) to be an individ-
17 ual who, on the basis of his recent past medical history, can
18 be expected, for such future period to require inpatient insti-
19 tutional care for all or a substantial part of such future
20 period.

21 "INPATIENT HOSPITAL SERVICES

22 "SEC. 1933. For purposes of this title, the term 'inpa-
23 tient hospital services' shall have the meaning assigned to
24 such term by section 1861(b).

1 "HOSPITAL

2 "SEC. 1934. For purposes of this title, the term 'hospi-
3 tal' means an institution which meets the requirements set
4 forth in clauses (1) through (9) of section 1861(c).

5 "MEDICAL AND OTHER HEALTH SERVICES

6 "SEC. 1935. For purposes of this title, the term 'medi-
7 cal and other health services' shall have the meaning as-
8 signed to such term in so much of section 1861(s) as precedes
9 the last sentence thereof; except that such term shall include
10 (1) such physician's and other services, diagnostic X-ray
11 tests, diagnostic laboratory tests, and other diagnostic tests
12 as are involved in providing appropriate well-baby care (as
13 determined in accordance with regulations of the Secretary)
14 and (2) outpatient rehabilitation services.

15 "SKILLED NURSING FACILITY SERVICES

16 "SEC. 1936. For purposes of this title, the term 'skilled
17 nursing facility services' means the items and services which
18 (1) are described in clauses (1) through (7) of section 1861(h),
19 and (2) are furnished by a skilled nursing facility; excluding,
20 however, any item of service if it would not be included
21 under section 1861(b), if furnished to an inpatient of a
22 hospital.

23 "SKILLED NURSING FACILITY

24 "SEC. 1937. For purposes of this title, the term 'skilled
25 nursing facility' means an institution (or a distinct part of an

1 institution) which meets the criteria set forth in section
2 1861(j).

3 "HOME HEALTH SERVICES

4 "SEC. 1938. For purposes of this title, the term 'home
5 health services' shall have the meaning assigned to such term
6 in section 1861(m); except that the term 'skilled nursing fa-
7 cility', as used in clause (7) of such section, shall be deemed
8 to include a skilled nursing facility (as defined in section
9 1937); except that such term shall not include any term or
10 service if it would not be included under section 1932 if fur-
11 nished to an inpatient of a hospital.

12 "HOME HEALTH AGENCY

13 "SEC. 1939. For purposes of this title, the term 'home
14 health agency' shall have the meaning assigned to such term
15 in section 1861(o).

16 "PHYSICIANS' SERVICES

17 "SEC. 1940. For purposes of this title, the term 'physi-
18 cians' services' means professional services performed by
19 physicians, including surgery, consultation, and home, office,
20 and institutional calls (but not including services which are
21 included within the definition of inpatient hospital services).

22 "PHYSICIAN

23 "SEC. 1941. For purposes of this title, the term 'physi-
24 cian' shall have the meaning assigned to such term in section
25 1861(r)(1).

1 "MEANING OF CERTAIN OTHER TERMS

2 "SEC. 1942. For purposes of this title, any term
3 which—

4 "(1) is defined in section 1861;

5 "(2) is employed in provisions which, by refer-
6 ence, are used in defining any of the terms defined in
7 sections 1932 through 1940; and

8 "(3) is not otherwise defined in this section;

9 shall, insofar as such term is applicable to the provisions of
10 this title and except as the Secretary (in order to carry out
11 the purposes of this title) shall otherwise by regulations pro-
12 vide, have the meaning assigned to it in section 1861.

13 "INTERMEDIATE CARE FACILITY

14 "SEC. 1943. (a) For purposes of this title, the term 'in-
15 termediate care facility' means an institution which (1) is li-
16 censed under State law to provide, on a regular basis, health-
17 related care and services to individuals who do not require
18 the degree of care and treatment which a hospital or skilled
19 nursing facility is designed to provide, but who because of
20 their mental or physical condition require care and services
21 (above the level of room and board) which can be made avail-
22 able to them only through institutional facilities, (2) meets
23 such standards prescribed by the Secretary as he finds appro-
24 priate for the proper provision of such care, and (3) meets
25 such standards of safety and sanitation as are established

1 under regulations of the Secretary in addition to those appli-
2 cable to nursing facilities under State law.
3 "(b) The term 'intermediate care facility' also in-
4 cludes—
5 "(1) any skilled nursing facility or hospital which
6 meets the requirements of subsection (a);
7 "(2) a Christian Science sanatorium operated, or
8 listed and certified, by the First Church of Christ, Sci-
9 entist, Boston, Massachusetts, but only with respect to
10 institutional services deemed appropriate by the
11 Secretary;
12 "(3) any institution which is located on an Indian
13 reservation, if such institution is certified by the Secre-
14 tary as meeting the requirements of clauses (2) and (3)
15 of subsection (a) and providing the care and services
16 required under clause (1) of such subsection; and
17 "(4) with respect to intermediate care services de-
18 scribed in section 1944(b), the public institution (or dis-
19 tinct part thereof) providing such services.
20 "INTERMEDIATE CARE SERVICES
21 "SEC. 1944. (a) For purposes of this title, the term 'in-
22 termediate care services' means services provided by an in-
23 termediate care facility to an inpatient thereof, but only if (1)
24 such individual meets the conditions referred to in section

1 1943(a), and (2) such services are required to meet the needs
2 of such individual because of such condition.
3 "(b) The term 'intermediate care services' also includes
4 services in a public institution (or distinct part thereof) for the
5 mentally retarded or persons with related conditions, but only
6 if—
7 "(1) the primary purpose of such institution (or
8 distinct part thereof) is to provide health or rehabilita-
9 tive services for mentally retarded individuals and
10 which meet such standards as may be prescribed by
11 the Secretary; and
12 "(2) the mentally retarded individual with respect
13 to whom a request for payment under this title is made
14 is receiving active treatment under a program of active
15 treatment designed to meet the needs of such
16 individual.
17 "MENTAL HEALTH CARE SERVICES
18 "SEC. 1945. (a) The term 'mental health care services'
19 includes only care and services for mental conditions—
20 "(1) which, if provided on an inpatient basis, con-
21 sist of a course of active care and treatment provided
22 in and by an accredited medical institution (as deter-
23 mined by the Secretary),
24 "(2) which, if provided on a partial hospitalization
25 basis, are provided (A) in and by an accredited medical

1 institution (as determined by the Secretary), or (B) in
2 and by a qualified community mental health center (as
3 determined in accordance with regulations of the Sec-
4 retary), or
5 "(3) which, if provided on an outpatient basis,
6 are—
7 "(A) provided by a qualified community
8 mental health center (as determined in accordance
9 with regulations of the Secretary), or
10 "(B) provided by a pyschiatrist;
11 except that such terms shall not include any outpatient serv-
12 ices provided by a psychiatrist, during any 12-month period,
13 for purposes of diagnosis or treatment of acute psychosis in
14 excess of (i) five visits, plus (ii) such additional visits as shall
15 have been approved in advance by an appropriate profession-
16 al review mechanism upon a finding that, in the absence of
17 such additional visits, the patient will require institutional
18 care.
19 "(b)(1) The term 'mental health services', in the case of
20 services provided on an outpatient basis by a qualified mental
21 health center (as determined in accordance with regulations
22 of the Secretary) or by a psychiatrist, includes any drug
23 which is prescribed for a patient by the physician under
24 whose direction such patient is receiving such services, but
25 only if—

1 "(A) such drug is included on the list (referred to
2 in paragraph (2)) and is prescribed in accordance with
3 the criteria indicated in such list, and
4 "(B) such physician determines that unless such
5 patient receives such drug, such patient can reasonably
6 be expected to require institutional care.
7 "(2) The Secretary is authorized (after consultation with
8 appropriate professional individuals and organizations) to
9 compile and publish (and from time to time revise) a list of
10 drugs which he has determined to be effective in the treat-
11 ment of various mental conditions. Such list shall indicate,
12 with respect to each drug included therein, the particular
13 mental conditions with respect to which such drug is effec-
14 tive, and the appropriate dosage (in terms of quantity and
15 intervals at which such drug shall be administered) of such
16 drug.
17 "OUTPATIENT REHABILITATION SERVICES
18 "SEC. 1946. (a) For purposes of this title, the term 'out-
19 patient rehabilitation services' means physical therapy,
20 speech pathology, occupational therapy, and medical-social
21 services furnished by a provider of services, a clinic, rehabili-
22 tation agency (including a single service rehabilitation
23 agency), or a public health agency, or by others under an
24 arrangement with, and under the supervision of, such provid-

1 er, clinic, rehabilitation agency, or public health agency, to
2 an individual as an outpatient—
3 "(1) who is under the care of a physician, and
4 "(2) with respect to whom a plan prescribing the
5 type, amount, and duration of such services that are to
6 be furnished to such individual has been established,
7 and is periodically reviewed by a physician;
8 excluding, however—
9 "(3) any item of service if it would not be includ-
10 ed under 'inpatient hospital services' if furnished to an
11 inpatient in a hospital; and
12 "(4) any such service—
13 "(A) if furnished by a clinic or rehabilitation
14 agency, or by others under arrangements with
15 such clinic or agency, unless such clinic or reha-
16 bilitation agency—
17 "(i) provides an adequate program of
18 such services for outpatients and has the
19 facilities and personnel required for such pro-
20 gram or required for the supervision of such
21 a program, in accordance with such require-
22 ments as the Secretary may specify,
23 "(ii) has policies, established by a group
24 of professional personnel, including one or
25 more physicians (associated with the clinic or

1 rehabilitation agency) and one or more quali-
2 fied physical therapists or speech patholo-
3 gists (as may be appropriate) to govern the
4 services (referred to in clause (i)) it provides,
5 "(iii) maintains clinical records on all
6 patients,
7 "(iv) if such clinic or agency is situated
8 in a State in which State or applicable local
9 law provides for the licensing of institutions
10 of this nature, (I) is licensed pursuant to
11 such law, or (II) is approved by the agency
12 of such State or locality responsible for li-
13 censing institutions of this nature, as meeting
14 the standards established for such licensing;
15 and
16 "(v) meets such other conditions relat-
17 ing to the health and safety of individuals
18 who are furnished services by such clinic or
19 agency on an outpatient basis, as the Secre-
20 tary may find necessary, or
21 "(B) if furnished by a public health agency,
22 unless such agency meets such other conditions
23 relating to health and safety of individuals who
24 are furnished services by such agency on an out-
25 patient basis, as the Secretary may find neces-

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1 sary. The term 'outpatient rehabilitative services'
2 also includes rehabilitation services furnished an
3 individual by a physical therapist or speech pa-
4 thologist (in his office or in such individual's
5 home) who meets licensing and other standards
6 prescribed by the Secretary in regulations, other-
7 wise than under an arrangement with and under
8 the supervision of a provider of services, clinic,
9 rehabilitation agency, or public health agency, if
10 the furnishing of such services meets such condi-
11 tions relating to health and safety as the Secre-
12 tary may find necessary.

13 "PROHIBITION AGAINST EXCLUSION BY EMPLOYERS OF
14 CERTAIN EMPLOYEES FROM COVERAGE UNDER
15 GROUP HEALTH INSURANCE PLANS

16 "SEC. 1947. (a) If any employer provided for some or
17 all of his employees coverage under a group health insurance
18 plan, it shall be unlawful for such employer to exclude from
19 coverage under such plan any employee of such employer
20 if—

21 "(1) such employee belongs to a category of em-
22 ployees who would ordinarily be eligibile for coverage
23 under such plan, and

1 "(2) such employee is excluded from coverage
2 under such plan because of the coverage provided
3 under this title.
4 "(b) Any person violating the provisions of subsection
5 (a) shall be fined not more than $10,000 and imprisoned for
6 not more than 1 year.".
7 (b)(1) Section 201(i)(1) of the Social Security Act is
8 amended by striking out "and the Federal Supplementary
9 Medical Insurance Trust Fund" and inserting in lieu thereof
10 "the Federal Supplementary Medical Insurance Trust Fund,
11 and the Medical Coverage Trust Fund".
12 (2) Section 201(g)(1)(A) of such Act is amended—
13 (A) by inserting "the Medical Coverage Trust
14 Fund, and" immediately after "shall include also", and
15 (B) by inserting "title XIX," immediately after
16 "title XVI," wherever it appears therein.
17 TITLE III—PRIVATE HEALTH INSURANCE
18 CERTIFICATION PROGRAM
19 SEC. 301. The Social Security Act is amended by
20 adding after title XIV thereof the following new title:
21 "TITLE XV—PRIVATE HEALTH INSURANCE
22 CERTIFICATION
23 "PURPOSE
24 "SEC. 1501. It is the purpose of this title to encourage
25 and facilitate the availability to the public of private basic

1 health insurance coverage at a reasonable premium charge
2 by—
3 "(a) establishing a procedure whereby basic health
4 insurance policies offered by private insurers may be
5 certified by the Secretary as meeting minimum stand-
6 ards with respect to adequacy of coverage, conditions
7 of payment, opportunity for enrollment, and reason-
8 ableness of premium charges,
9 "(b) facilitating arrangements whereby basic
10 health insurance policies meeting such standards can
11 be offered through pools of private insurers, and
12 "(c) encouraging States, through their laws and
13 regulations pertaining to the health insurance industry,
14 to facilitate the offering, within the State, of such basic
15 health insurance coverage by carriers doing health in-
16 surance business within the State.
17 "CERTIFICATION OF BASIC PRIVATE HEALTH INSURANCE
18 POLICIES
19 "SEC. 1502. (a) Any insurer which desires to have a
20 health insurance policy certified for use in one or more States
21 specified by the insurer may (in accordance with regulations
22 of the Secretary) provide to the Secretary, for his examina-
23 tion and certification, any health insurance policy.
24 "(b)(1) If the Secretary, after examining any such policy
25 and evaluating any data submitted in connection with such

1 policy, determines that such policy meets the standards pre-
2 scribed in section 1504, he shall certify such policy for use in
3 each State which has in effect a basic health insurance facili-
4 tation program (as defined in section 1510).

5 "(2)(A) The certification by the Secretary of any such
6 policy shall be conditioned upon such policy's continuing to
7 meet the standards prescribed in section 1504; and no policy
8 shall be deemed to have been certified by the Secretary under
9 this title for any period for which it fails to meet such
10 standards.

11 "(B) The Secretary shall establish procedures whereby
12 any insurer having secured the Secretary's certification of
13 any policy offered by such insurer shall from time to time
14 provide to the Secretary (i) relevant data with respect to such
15 policy in order for the Secretary to determine whether such
16 policy continues to meet the standards prescribed in section
17 1504, and (ii) such data and information as the Secretary
18 may require in order to assure proper coordination of the
19 administration of titles XIX and XXI.

20 "(c) Notwithstanding the preceding provisions of this
21 section, the Secretary shall not certify any health insurance
22 policy of any insurer for use in any State unless such insurer
23 furnishes assurances satisfactory to the Secretary that such
24 insurer (whether as a member of a health reinsurance or
25 other residual market arrangement or otherwise) will make

1 generally available, in each geographic area of the State in
2 which the insurer does health insurance business, to all indi-
3 viduals and family members the following two health insur-
4 ance policies: (i) a policy which meets the standards of sec-
5 tion 1504, and (ii) a policy which, if it were issued in combi-
6 nation with a plan meeting the minimum coverage necessary
7 to meet the requirement imposed by section 2122(a)(1)(B),
8 would, in the aggregate, meet the standards of section 1504.

9 "UTILIZATION OF STATE AGENCIES FOR CERTIFICATION
10 OF POLICIES

11 "SEC. 1503. If any State has in effect a basic health
12 insurance facilitation program (as defined in section 1510),
13 the Secretary shall, if such State is willing to do so, enter
14 into an agreement with such State whereby the agency re-
15 sponsible for the regulation of the health insurance industry
16 within such State will, on behalf of the Secretary, make such
17 determinations regarding whether basic health insurance
18 policies meet the requirements for certification under this
19 title, as may be specified by the Secretary. Such agreement
20 shall provide that the agency will be reimbursed for its rea-
21 sonable expenses incurred in carrying out activities specified
22 in the agreement.

1 "STANDARDS WITH RESPECT TO BASIC HEALTH
2 INSURANCE POLICIES

3 "SEC. 1504. (a) The Secretary shall not certify under
4 this title any insurance policy offered (or to be offered) by an
5 insurer unless he finds that—
6 "(1) such policy provides—
7 "(A) inpatient hospital coverage (without any
8 deductible in excess of $100 or copayment by the
9 insured person) for at least 60 days during any
10 policy year,
11 "(B) medical coverage which shall include
12 home, office, hospital, and other institutional care
13 provided by physicians,
14 "(C) with respect to medical coverage,
15 that—
16 "(i) subject to clauses (ii) and (iii), pay-
17 ment in full shall be made with respect to
18 not less than the first $2,000 of reasonable
19 expenses incurred by any insured person for
20 any policy year for services with respect to
21 which coverage applies,
22 "(ii) the copayment required of any in-
23 sured person with respect to such reasonable
24 expenses shall not exceed 20 per centum
25 thereof, and

1 "(iii) in the case of any deductible appli-
2 cable to the payment of such reasonable ex-
3 penses for any benefit year or benefit period
4 of not less than 12-months duration, such de-
5 ductible shall not exceed $50 for any insured
6 person, and that, for purposes of computing
7 such deductible for any calendar, policy, or
8 other fixed benefit year or period, the insured
9 person shall be given credit for any deduct-
10 ible applied toward such expenses for the
11 last 3 months of the preceding policy year,
12 "(D) in case such policy is a group policy,
13 there will be no exclusion from coverage or limi-
14 tation on payment on account of any medical con-
15 dition (including any preexisting condition) or any
16 waiting period prior to the beginning of coverage
17 with respect to any such condition,
18 "(E) in case such policy is an individual
19 policy (including a policy for an individual and
20 members of his family), there will be no exclusion
21 from coverage on account of any medical condi-
22 tion (including any preexisting condition) other
23 than pregnancy, and there will be no waiting
24 period prior to the beginning of coverage with re-

1 spect to any preexisting condition which is greater
2 than 90 days after the date the policy is issued,
3 "(F) in case such policy covers an individual
4 and members of his family, coverage will be pro-
5 vided for all dependent unmarried children in the
6 family under age 22, and coverage will be auto-
7 matically extended at birth to any newborn, and
8 upon adoption to any newly adopted, child of such
9 individual or his spouse,
10 "(G) in case such policy is a group policy
11 which covers all or a certain category of employ-
12 ees of any employer, that—
13 "(i) coverage will not be terminated
14 with respect to any employee (and members
15 of such employee's family, if such policy
16 covers such members) because of the termi-
17 nation of such employee's employment prior
18 to the expiration of 31 days after the date of
19 such termination,
20 "(ii) the insurer offering such policy will
21 afford to any employee covered by such
22 policy whose employment has been termi-
23 nated a reasonable opportunity to secure,
24 from such insurer a basic private health in-

1 surance policy which has been approved
2 under this title,
3 "(iii) there will be a periodic open en-
4 rollment period of at least 31 days (which
5 shall occur not less often than once during
6 each policy year) in which all eligible em-
7 ployees, who are not covered by such policy
8 because of failure to elect coverage at the
9 time of initial employment or during previous
10 open enrollment periods, can secure coverage
11 thereunder,
12 "(2) the premium charge for such policy is such
13 that there is not an unreasonable ratio of expenses to
14 premiums (as determined under subsection (d)); and
15 "(3) there is established an appropriate (but differ-
16 ent) premium rate for such policy when it is offered to
17 cover (A) a single individual, (B) a married couple, or
18 (C) a family.
19 "(b) The Secretary, in determining whether any com-
20 prehensive prepaid group practice plan is eligible for certifi-
21 cation under this section, shall, in lieu of the standards im-
22 posed by subsection (a), develop and apply criteria which
23 assure that such plan meets requirements which are, on an
24 actuarial and benefit basis, at least equivalent to such
25 standards.

1 "(c) Notwithstanding the provisions of subsections (a)
2 and (b), the Secretary shall not withhold approval under this
3 title of any health insurance policy solely because such policy
4 excludes—

5 "(1) charges for services or supplies in connection
6 with an occupational disease or injury,

7 "(2) items or services for which the insured indi-
8 vidual furnished such items or services has no legal ob-
9 ligation to pay, and which no other person (by reason
10 of such individual's membership in a prepayment plan
11 or otherwise) has a legal obligation to provide or pay
12 for,

13 "(3) any item or service to the extent that pay-
14 ment has been made, or can reasonably be expected to
15 be made (as determined in accordance with regula-
16 tions), with respect to such item or service, under a
17 workmen's compensation law or plan of the United
18 States or a State,

19 "(4) charges for services or supplies with respect
20 to which benefits are provided under title XVIII or
21 title XXI,

22 "(5) items or services which are not reasonable
23 and necessary for the diagnosis or treatment of illness
24 or injury, pregnancy, or to improve the functioning of a
25 malformed body member,

1 "(6) charges for care, treatment, services, or sup-
2 plies, provided to any individual, to the extent that the
3 payment of benefits with respect thereto is prohibited
4 by any applicable law of the jurisdiction in which such
5 individual is residing at the time he receives such care,
6 treatment, services, or supplies,
7 "(7) charges for care, treatment, or supplies pro-
8 vided to any individual, to the extent that they are not
9 reasonably priced (except that, for purposes of this
10 paragraph, the charge for any item or service shall be
11 deemed to be reasonable, if such charge is not in
12 excess of the allowable charge therefor under title
13 XVIII or XXI),
14 "(8) charges in connection with routine physical
15 checkups,
16 "(9) expenses incurred for items or services,
17 where such expenses are for cosmetic surgery or are
18 incurred in connection therewith, except as required for
19 the prompt repair of accidental injury or for improve-
20 ment of the functioning of a malformed body member,
21 "(10) charges made by a hospital for the profes-
22 sional services of any resident physician or intern to
23 the extent that such charges are in excess of the actual
24 cost incurred by the hospital in providing such services,

1 "(11) charges for the professional services of a
2 psychiatrist to the extent that such charges exceed
3 $400 in a policy year, or

4 "(12) amounts which represent deductible and co-
5 insurance provisions and which generally result in ag-
6 gregate benefit coverage which is at least equal to the
7 actuarial equivalent of the benefit coverage resulting
8 from the application of the deductible and coinsurance
9 provisions in section 1504(a)(1).

10 "(d)(1) With respect to policies submitted to the Secre-
11 tary for his certification under this title, the Secretary shall
12 establish (after considering the size of the groups to be cov-
13 ered by any such policy and the nature of the insurer) appro-
14 priate reasonable ratios of expenses to premiums imposed for
15 coverage thereunder. In the case of individual policies such
16 ratios shall be the same as those established by the Secretary
17 for group policies covering the smallest groups. After making
18 an initial determination with respect to any such policy, the
19 Secretary shall periodically thereafter review and make a re-
20 determination of such ratios based on actual expenses there-
21 under and the actual premium charges made for the period
22 with respect to which the review is made, in order to deter-
23 mine whether such policy continues to meet the requirements
24 for certification.

1 "(2) In determining the appropriate reasonable ratio of
2 expenses to premiums imposed with respect to any particular
3 health insurance policy offered by an insurer, the Secretary
4 shall, in his determinations of such ratio, give consideration
5 to the average ratio, with respect to group policies generally
6 underwritten by insurers (classified on the basis of nonprofit
7 or profitmaking) with respect to policies excluding those
8 which are not certified under this title.

9 "APPROVED CARRIER

10 "SEC. 1505. For purposes of sections 1923(b), 1816,
11 and 1842, an 'approved carrier' is an insurer which the Sec-
12 retary has found (1) to offer one or more health insurance
13 policies approved under section 1502 to the general public in
14 each geographic or normal service area in which such insurer
15 offers health insurance policies (including any which are not
16 approved under this title) and (2) to employ effective proce-
17 dures and practices designed to assure, through means con-
18 sistent with efficient practices within the insurance industry,
19 appropriate controls of utilization of health care services and
20 the costs and charges imposed therefor with respect to which
21 it will financially participate.

22 "ANTITRUST EXEMPTION

23 "SEC. 1506. (a) It shall not be unlawful under any anti-
24 trust law for any insurer to enter into any contract, combina-
25 tion, or other arrangement with any other insurer or group of

1 insurers for the sole purpose of establishing or participating
2 in an insurance pool, reinsurance, or other residual market,
3 arrangement whereby there will be offered to the public
4 health insurance policies approved under section 1502, if
5 such contract, combination, or other arrangement is approved
6 by the Secretary, as being consistent with the purposes of
7 this title, before any party to the contract, combination, or
8 other arrangement has carried out any activity, or refrained
9 from carrying out any activity, under its terms (other than
10 such activity as may be necessary to negotiate the contract,
11 combination, or other arrangement and to apply for approval
12 of the same under this section). The Secretary shall not ap-
13 prove any contract, combination, or other arrangement under
14 which the parties thereto agree to act in a manner which
15 constitutes a violation of any such law for which no exemp-
16 tion is provided under the preceding sentence or for purposes
17 other than the purposes for which the exemption contained in
18 the preceding sentence is established. Nothing contained in
19 this subsection shall exempt from any antitrust law any pred-
20 atory pricing or practice, or any other conduct in the other-
21 wise exempt activities of two or more such insurers under a
22 contract, combination, or other arrangement approved under
23 this section which would be unlawful under any such law if
24 engaged in by only one such insurer.

1 "(b) For purposes of this section, the term 'antitrust
2 law' means the Federal Trade Commission Act, each statute
3 referred to in section 4 of that Act (15 U.S.C. 44) as an
4 Antitrust Act, any other statute of the United States in pari
5 materia, and any law of any State or political subdivision
6 thereof which prohibits or restrains contracts, combinations,
7 or other arrangements in restraint of trade.

8 "ESTABLISHMENT OF EMBLEM TO INDICATE
9 CERTIFICATION

10 "SEC. 1507. (a) The Secretary shall cause to be de-
11 signed an appropriate emblem which may be used as an indi-
12 cation that certification of an insurance policy under this title
13 has been made by the Secretary; and any insurer which has
14 secured certification of an insurance policy by the Secretary
15 under this title may have printed thereon such emblem, and
16 may, in advertising such policy to potential subscribers, state
17 that such policy has received such a certification.

18 "REPORT TO CONGRESS

19 "SEC. 1508. The Secretary shall, at the earliest practi-
20 cable date (but not later than 60 days) after the expiration of
21 the three-year period which commences on the date of enact-
22 ment of this section, submit to the Congress a report indicat-
23 ing (1) the extent to which basic private health insurance
24 policies certified by the Secretary under this title are actually
25 and generally available to the residents of each State, and (2)

1 the extent to which residents in each State are covered by
2 such policies.

3 "DUTY OF SECRETARY TO MAKE AVAILABLE INDIVIDUAL
4 AND FAMILY HEALTH INSURANCE POLICIES ON A
5 COST BASIS

6 "SEC. 1509. (a) The Secretary shall offer a standard
7 health insurance policy, which meets the applicable criteria
8 prescribed under this title with respect to approved basic or
9 catastrophic health insurance policies, to individuals, married
10 couples, and families living in any State (1) which does not
11 have in effect a basic health insurance facilitation program
12 (as found by the Secretary under section 1510), and (2) in
13 which there is not actually and generally available one or
14 more approved basic health insurance policies approved
15 under this title.

16 "(b) The premiums imposed under any such policy shall
17 be in an amount designed to cover the costs (inclusive of
18 administrative costs and appropriate reserves) which will be
19 incurred in furnishing the benefits provided in the policy.

20 "(c) No such policy shall be offered in any area prior to
21 the expiration of the 3-year period which commences on the
22 date of enactment of this title.

23 "(d) Premiums collected by the Secretary for insurance
24 policies offered by him under this section shall be deposited in
25 an Insurance Revolving Fund, and moneys in such fund shall

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1 be available, without fiscal year limitation, for the payment of
2 claims under such policies.
3 "(e) For the purpose of providing a contingency reserve
4 for the insurance program established by this section, there is
5 authorized to be appropriated such sums as may be neces-
6 sary; and any sums appropriate for such purpose shall remain
7 available for the purpose of making repayable advances
8 (without interest) to the Insurance Revolving Fund author-
9 ized to be established under subsection (d).
10 "(f) The Secretary, in making payment for services cov-
11 ered under any insurance policy issued pursuant to this sec-
12 tion, shall utilize the payments methodology and administra-
13 tive mechanism employed by him for making payment for
14 services covered under the insurance programs established by
15 title XVIII.
16 "BASIC HEALTH INSURANCE FACILITATION PROGRAM
17 "SEC. 1510. (a) For purposes of this title, a State shall
18 be regarded as having in effect a basic health insurance facili-
19 tation program only if the Secretary, after examining the per-
20 tinent laws and regulations of such State governing the doing
21 of health insurance business within the State by carriers, de-
22 termines that such laws and regulations—
23 "(1) require the establishment of one or more
24 health reinsurance or other residual market arrange-
25 ment to be utilized by such carriers in connection with

1 the offering within the State of basic health insurance
2 policies which meet the standards for certification by
3 the Secretary established by this title,
4 "(2) require all such carriers to be members of a
5 health reinsurance or other residual market arrange-
6 ment and provide that losses, under any such arrange-
7 ment, will be shared by all members thereof on a pro
8 rata basis in proportion to their respective shares of
9 the total health insurance premium earned in the State
10 during the calendar year,
11 "(3) provide that premiums charged for policies
12 issued to individuals or family members under any such
13 health reinsurance or other residual market arrange-
14 ment shall not be less than 125 per centum nor more
15 than 150 per centum of the average group rate for the
16 same coverage under a group policy covering ten lives,
17 and
18 "(4) otherwise encourage and facilitate the offer-
19 ing of such policies within the State by all carriers
20 doing health insurance business therein on a basis
21 which is fair and equitable to each such carrier.
22 "(b) The Secretary is authorized, upon the request of
23 any State, to provide appropriate technical assistance to aid
24 the State in developing a program which meets the condi-
25 tions prescribed in subsection (a).".

1 TITLE IV—OTHER AMENDMENTS

2 PROGRAM IMMUNIZATIONS

3 SEC. 401. (a) Section 1861(s) of the Social Security Act
4 is amended—
5 (1) by striking out "and" at the end of paragraph
6 (8),
7 (2) by striking out the period at the end of para-
8 graph (9) and inserting in lieu thereof "; and",
9 (3) by inserting immediately after paragraph (9)
10 the following new paragraph:
11 "(10) such immunizations as the Secretary deter-
12 mines are appropriate, but only if provided on a sched-
13 uled allowance basis (as determined under regulations
14 of the Secretary).", and
15 (4) by redesignating paragraphs (10) through (13)
16 as paragraphs (11) through (14), respectively.
17 (b) Section 1864(a) of such Act is amended by striking
18 out "paragraphs (10) and (11)" and inserting in lieu thereof
19 "paragraphs (12) and (13)".
20 (c) Section 1862(a)(7) of such Act is amended by insert-
21 ing immediately after "(7)" the following: "except as pro-
22 vided in section 1861(s)(10),".
23 (d) The amendments made by this section shall apply
24 only with respect to services furnished on or after the first

1 day of the month following the month in which this section is
2 enacted.

3 MENTAL HEALTH SERVICES

4 SEC. 402. (a) Section 1833(c) of the Social Security Act
5 is amended—
6 (1) by striking out "$312.50" and inserting in lieu
7 thereof "$500", and
8 (2) by striking out "62½ per centum" and insert-
9 ing in lieu thereof "80 per centum".
10 (b) Section 1812 of such Act is amended—
11 (1) by striking out subsection (c) thereof,
12 (2) in subsection (b) thereof, by striking out "(sub-
13 ject to subsection (c))", and
14 (3) in subsection (e) thereof, by striking out "sub-
15 sections (b), (c), and (d)" and inserting in lieu thereof
16 "subsections (b) and (d)".
17 (c) The amendments made by subsection (a) shall be ef-
18 fective only with respect to services furnished after Decem-
19 ber 31, 1980. The amendments made by subsection (b) shall
20 be effective only with respect to services furnished after De-
21 cember 31, 1981.

22 AMOUNT OF PREMIUMS FOR HOSPITAL INSURANCE
23 COVERAGE

24 SEC. 403. (a)(1) The second sentence of section
25 1818(d)(2) of the Social Security Act is amended by striking

1 out "Such amount shall be equal to $33, multiplied by" and
2 inserting in lieu thereof "Such amount shall be equal to 50
3 per centum of the product of $33 multiplied by".
4 (2) The amendment made by paragraph (1) shall be ap-
5 plicable in the case of premiums imposed on and after July 1,
6 1979.
7 (b) In addition to other moneys appropriated to the Fed-
8 eral Hospital Insurance Trust Fund, there shall be appropri-
9 ated from time to time, with respect to periods commencing
10 after June 30, 1979, amounts equal to 100 per centum of the
11 amounts deposited in such Fund pursuant to section 1818(f)
12 of the Social Security Act from premiums payable for such
13 period.
14 PAYMENT FOR EXTENDED CARE SERVICES
15 SEC. 404. Section 1861(v)(E) of the Social Security Act
16 is amended to read as follows:
17 "(E)(i) In the case of services furnished by a skilled
18 nursing facility with respect to which payment for services
19 furnished under title XIX is made on a cost-related basis
20 pursuant to the provisions of section 1920(d)(2), such regula-
21 tions may provide for the use of rates which are the same as
22 the rates obtaining for such services under title XIX (except
23 that such rates may be increased by the Secretary on a class
24 or size of institution, or on a geographical basis by a percent-
25 age factor not in excess of 10 per centum to take into ac-

1 count determinable items or services or other requirements
2 under this title not otherwise included in the computation of
3 such rates under title XIX): *Provided*, That no such regula-
4 tions shall become effective prior to the 60th day following
5 the date on which the Secretary submits to the Congress a
6 copy thereof together with a full and complete description of
7 the methodology which would be employed in the determina-
8 tion of rates pursuant thereto, and an evaluation by the Sec-
9 retary and by the Comptroller General of such methodology
10 in terms of the extent to which the employment thereof will
11 promote the efficient and economical administration of this
12 title and equitable treatment to and between skilled nursing
13 facilities furnishing services for which payment may be made
14 hereunder.".

15 EXTENSION OF COVERAGE UNDER RENAL DISEASE
16 PROGRAM

17 SEC. 405. Section 226(e) of the Social Security Act is
18 amended by adding at the end thereof the following: "For
19 purposes of the preceding sentence, any individual, who on or
20 after the date of enactment of this sentence fails to meet the
21 condition imposed by clause (2) of such sentence, shall be
22 deemed to meet such condition. There are authorized to be
23 appropriated, from time to time, to the Federal Hospital In-
24 surance Trust Fund and to the Federal Supplementary Medi-
25 cal Insurance Trust Fund such sums as may be necessary (as

1 based on estimates of the Secretary) to place each such Fund
2 in the same financial condition that it would have occupied
3 had the preceding sentence not been enacted.".

4 ENCOURAGEMENT OF PHILANTHROPIC SUPPORT FOR
5 HEALTH CARE

6 SEC. 406. Part A of title XI of the Social Security Act
7 is amended by adding after section 1131 the following new
8 section:

9 "ENCOURAGEMENT OF PHILANTHROPIC SUPPORT FOR
10 HEALTH CARE

11 "SEC. 1134. (a) It is the policy of the Congress that
12 philanthropic support for health care be encouraged and ex-
13 panded, especially in support of experimental and innovative
14 efforts to improve the health care delivery system and access
15 to health care services.

16 "(b)(1) For purposes of determining, under title XVIII
17 or XIX, the reasonable costs of any service furnished by a
18 provider of health services—

19 "(A) except as provided in paragraph (2), unre-
20 stricted grants, gifts, and endowments and income
21 therefrom, shall not be deducted from the operating
22 costs of such provider, and

23 "(B) grants, gifts, and endowment income desig-
24 nated by a donor for paying specific operating costs of

1 such provider shall be deducted from the particular op-
2 erating costs or group of costs involved.
3 "(2) Income from endowments and investments may be
4 used to reduce interest expense, if such income is from an
5 unrestricted gift or grant and is commingled with other funds,
6 except that in no event shall any such interest expense be
7 reduced below zero by any such income.".

The CHAIRMAN. This hearing will come to order.

This morning we will hear testimony on various catastrophic health insurance and medical assistance reform proposals.

For nearly a decade, Senator Ribicoff and I, along with Senator Talmadge and others, have sought to provide coverage for all Americans against the bankrupting effects of catastrophic illness or injury.

I am proud to see that the President has also decided to move in that direction.

For too long, catastrophic health insurance and medical assistance reform have been hamstrung by those who would rather do nothing than to support a realistic and achievable national health insurance. They impede this progress in the hope of eventually forcing us to take a single step into the type of system prevalent in the United Kingdom.

The President and I may disagree on an ultimate plan for complete national health insurance. However, we certainly can reach agreement on this important step.

I continue to believe strongly that we need to build on the strength of our existing health care system while working on ways to eliminate its weaknesses.

Whether or not critics choose to call my efforts on behalf of catastrophic coverage piecemeal I, for one, intend to push for the earliest possible implementation of this most crucial element of health care. Catastrophic health insurance is no more piecemeal than medicare.

For my own part—and I am sure that I speak for a growing bipartisan group of sponsors—we will look kindly and objectively at any good ideas in the President's proposal. As it turns out, much of what is clearly and indisputably good about the first stage of his plan is already contained in our bills.

So, if there is to be compromise on these measures, I expect it will be between our bills and Senator Dole's bill and the parallel course the President has chosen—rather than between the President and those who are now belittling and attacking his plan as being totally unacceptable because it is not a total Federal takeover of health care.

The President has indicated that he is willing to spend $10 billion to $15 billion on his proposal. That amount is somewhere between the cost of our catastrophic-only proposal, S. 351, and the catastrophic plus medical assistance reform, S. 350, both of which I join in sponsoring.

I would certainly be willing to work with the President to figure out how much we can afford to do beyond catastrophic health insurance—such as improved coverage for our low-income population—that would keep us within the $10 billion to $15 billion for the total package.

I would also like to work with the President in assuring that we have in place proper controls in the area of technology assessment, professional oversight, and approval of capital expenditures.

One of my own disagreements with the President's plan is not one of substance but of timing. I understand that the President's plan would allow no new Federal spending before 1983, but I see no reason to hold back on the catastrophic health insurance or at

least that part of it. Illness and injury just does not wait until convenient times.

I do not see why we should not be able to bring some help in this area to the American people by January 1981, at the latest, and I believe that the hearings will demonstrate that some vital parts of the program—particularly the extension of catastrophic insurance—could even be in place by January 1980.

If Congress enacts the program early this year, the necessary organizational and implementing steps can be taken to deliver new protection to most people by that time.

I am hopeful that our hearings will serve as a basis for making the necessary decisions.

I believe some others may care to make statements.

Senator Dole?

Senator DOLE. I thank you, Mr. Chairman. I certainly share the views just expressed by the chairman and, as I indicated, it may be, in an oversimplified way, that some may have the headlines but I think we may have the votes. That is the bottom line in the Congress of the United States.

It seems to some of us that it is time to address this one area of catastrophic coverage. I would hope that we could work out a compromise, and from what I have been able to glean from the Secretary's statement, also public statements, there is no doubt about it, that there is some support for the concept.

We may have different approaches. We may not all agree on how we finance even the cost of catastrophic coverage, but at least there is a great deal of interest, as the chairman has indicated, on both sides of the aisle.

Yesterday, Senators Danforth, Domenici, and myself introduced, for lack of a better name, a Republican proposal. I am not suggesting that all Republicans will support it. Some may have other ideas; some may not have any idea at all.

But, in any event, it was a recognition of the problem that we believe should be addressed.

I would hope, as we look at S. 350 and 351 and S. 748, introduced yesterday, that we can work out some agreement with the administration.

I also share the view expressed by the chairman that this is not a piecemeal approach. The proposal that we introduced yesterday, S. 748, really has three key parts. First, those eligible for medicare will be protected by expansion of their present benefits. I think that is something the administration, at least, has addressed.

Second, the large majority of the employees will be assured of the availability of adequate private insurance protection.

Third, those who are part of the residual marketplace, not already covered, may choose to have the Federal Government serve as a facilitator and, in some instances, financial backup, contracting with private insurance companies for catastrophic coverage.

We all have the figures. There are some 83 million Americans, at least estimated 83 million Americans, who have inadequate insurance.

As far as the gaps in the coverage, certainly catastrophic illness can destroy the financial security of even the upper middle income families. Last year alone, according to figures, we had an estimated

7 million families with out-of-pocket medical expenses exceeding 15 percent of their incomes.

There have been some who have suggested in this time of great budget restraint that we more or less fuel the fire escalating governmental spending, that we should underwrite the cost of a comprehensive plan. It is much like the Mideast peace settlement; everybody would like a comprehensive plan, but you just could not get a comprehensive plan, so we kind of got sort of a catastrophic plan between Israel and Egypt.

I think we could use that same analogy in health care. We would all like a comprehensive plan where everybody would be covered. We do not have the money, plus there are other impediments to that approach that bother some of us, but we can address the real problem; the catastrophic area. That is what we are doing along with Senator Long and others.

So many ask, why only catastrophic? It has been suggested, editorially and otherwise, that covering only catastrophic expenses will lead to an increase in unnecessary use of expensive, high-technology care and divert money away from other important areas of health care spending.

I believe these questions can, and should, be answered. Catastrophic health insurance does not address the issues of prevention of disease or upfront coverage for the day-to-day medical problems, yet we cannot overlook those 7 million people each year who are forced to spend 15 percent or more of their income on medical care.

We cannot solve all the problems facing us in the context of a single bill, but I believe that the protection for catastrophic loss is a realistic goal that we can accomplish now. Major questions concerning the program cost, how it is to be financed, how the benefits are to be defined, need to be answered. But, we need to address these important questions in a bipartisan manner.

Mr. Chairman, I appreciate this opportunity. Apparently we all have a common goal, to help the American people. Perhaps we can build a consensus in this committee with the help of our distinguished first witness and pass something in this session of the Congress.

The CHAIRMAN. Thank you.

Mr. Secretary, we will be delighted to hear your statement. We are very pleased to have you before us.

I believe, by the way, if the Senators will permit me to do so, I would like to start a committee procedure of hearing Cabinet officers first and then our colleagues in the Senate can come along thereafter. The President's Cabinet officers are busy people, too.

All right, Mr. Secretary. Would you please proceed?

STATEMENT OF HON. JOSEPH A. CALIFANO, JR., SECRETARY, HEALTH, EDUCATION, AND WELFARE

Secretary CALIFANO. Mr. Chairman, thank you. I would like to submit my entire statement for the record and just read certain portions of it.

Mr. Chairman, I appreciate the opportunity this morning to discuss with this distinguished committee an issue of major importance to our citizens, a national health plan.

It is appropriate that I appear before you since this committee has historically provided leadership in health care finance.

We believe that this hearing marks an important turning point in the development of national health policy.

President Carter hopes that the 96th Congress can take a significant step toward a comprehensive national health program. In the coming weeks, the administration will propose a phase I bill—a bill that, contrary to some reports, does not just provide protection against the costs of catastrophic illness.

Indeed, we oppose a catastrophic only approach. Instead, we will seek to improve coverage for all segments of the population—the aged, the poor, the employed and others—and will seek to put in place new structures which will require only future expansion for the realization of President Carter's goal of a universal, comprehensive plan.

Few ideas have been the subject of more national debate and less congressional action than national health insurance. Not only have Presidents since Harry Truman sought passage of a national health insurance plan, but in the last decade a number of proposals have been introduced in the Congress.

Yet only one of these bills has emerged from a full committee of the Senate—the Committee on Finance. None has been reported out by a full committee of the House. And neither house of the Congress has approved a national health insurance proposal.

It is imperative, therefore, that we in the administration and you in the Congress who are deeply concerned about the state of health care in the United States work together to devise a strong piece of legislation—but a piece of legislation that, unlike past proposals in this area, can be enacted into law.

THE PRESIDENT'S DECISION

Last July, the President directed me to develop a tentative national health plan to assure that all Americans have comprehensive health care coverage. He also directed me to develop several alternative methods for phasing in the plan over time.

He asked for a plan that would not only increase health insurance coverage but that would seek to bring skyrocketing health costs under control, to increase the efficiency and fairness of our health care system, to make quality health care more widely available and to devote more health resources to disease prevention and health promotion.

We developed that tentative plan and some phasing alternatives. In January, the President asked me to consult widely so that he could determine the best course of action for introducing a bill in the 96th Congress.

Since January, my colleagues and I have consulted Members of Congress, including committee and subcommittee chairmen, and health industry experts.

With few exceptions, the consensus among legislators is that the 96th Congress cannot and will not digest a complete national health plan in one bite. The overwhelming number of those who favor eventual adoption of a national health plan urged me to bring this message back to the President: Ask the President to

limit his legislative recommendation to the first phase of a national health plan and to describe his vision of a total plan so we can put that phase in context.

There were, of course, many specific suggestions, but that was the general consensus, with a strong sense of the need to contain costs, to reform the system and to focus more attention on prevention.

Based on those consultations and on important budgetary, economic and administrative considerations, the President last week made a broad decision that has two main features:

First, the President has decided to send to the Congress a message outlining a universal, comprehensive national health plan. As noted, the President remains committed to the goal of providing every American with coverage for basic health services.

Second, the President will at the same time send to the Congress specific legislation that will embody the first phase of a universal, comprehensive plan. This bill, which would have no significant budgetary impact until fiscal 1983, will constitute a significant step toward instituting basic reforms in our health system and insuring that all Americans have adequate protection against the cost of medical care.

The phase I legislation will, when fully in place, represent an additional $10 billion to $15 billion investment, in today's dollars, in health care for Americans—an investment which can be substantially offset by effective cost containment and health system reforms.

In the coming weeks, we will develop this final phase I bill and the final description of the comprehensive, universal plan in consultation with key congressional and other leaders.

The President's phase I bill will build upon the strengths not only of the administration's work, but also the work done in this area by Members of the Congress. I hope that the proposal will attract a broad base of support, both from those who think that phase I is all that we should do and from those who wish to do more.

It is rarely possible to solve every problem in an important sphere of our national life in a single bill. But, by proceeding step by step, we can nonetheless make advances of extraordinary significance. Lyndon Johnson recognized that medicare and medicaid would not meet the health needs of all Americans, but he also knew it would help millions of our citizens.

President Carter recognized that the child health assurance program would not meet the health needs of every low income citizen—but he also knew when he proposed it 2 years a go, just as he knows when the bill is reintroduced this year, that it will help more than 2 million low income mothers and children. And President Carter recognizes that our phase I bill will not solve every health problem in this Nation—but he also knows that, if enacted, it will represent a giant stride forward in providing equitable, adequate and cost-conscious health protection to all Americans.

Let us not be mesmerized—or immobilized—by our desire to achieve a universal and comprehensive plan. Let us instead bend every effort in the 96th Congress to make an important part of that noble dream reality.

Let me emphasize one other point: Enactment of a phase I bill must be based on passage of effective hospital cost containment legislation. Only when we contain unnecessary costs in the health care system can we responsibly seek to implement necessary new health benefits.

As we open the national health plan debate in the 96th Congress, we all recognize that we will be dealing with a highly complex subject—with significant implications for our health care system, for the fiscal and budgetary policy of the Federal Government and for the state of our Nation's economy.

Health care in the United States is not just men and women dressed in white coats carrying little black bags ministering to the infirm. It is also, as this subcommittee knows well, big business.

Health is the third biggest business in our country today, yet both the administration and the members of this committee share a strong belief that it is imperative to make some basic changes in the health care industry. Our present health care system is fundamentally flawed—with nearly $87 billion in Federal and State health spending for fiscal 1979, and with Federal, State and local government paying nearly 55 percent of all hospital bills, we already have part of a national health plan. But this plan does not meet the primary objective of our nation's health policy—providing quality care to all Americans at an affordable price.

To be sure, there is a good deal that is right with the health system in the United States today. Health status has been gradually improving, and health insurance protection through public and private programs has been growing.

But there is also a good deal wrong with the health system in the United States today. We believe that there are three sets of problems facing our health care system today which can only be effectively addressed through a national health program.

First, millions of Americans lack coverage for basic health services and lack protection from extraordinary medical expenses.

Moreover, the very common exclusions and limitations which are present in current coverage severely limit health coverage for the average American family.

In sum, Mr. Chairman, the problem of inadequate insurance coverage is pervasive. I believe that it can only be dealt with in the context of a broadly structured national health program which includes not only protection against the cost of major illness, but also provisions which begin to address other serious failures of present health insurance coverage.

Second, the costs of health care are sharply increasing, adding to inflation and threatening the stability of governmental budgets.

The rise in health costs can be partly explained by increasing demand for health care with the passage of medicare and medicaid and by advances in medical technology. But sharply escalating health care costs are primarily the result of other factors, the most salient being the failure of the traditional competitive forces of the marketplace to operate in the health care industry.

More than 90 percent of all hospital bills are paid by third parties—insurance companies, medicaid, or medicare. Thus, neither the consumer, the patient, nor the provider, the doctor and the hospital, directly feel the pinch of rising costs.

The third parties customarily pay for services rendered to these beneficiaries on an inefficient and inflationary cost-plus basis.

Customary interactions between buyers and sellers do not take place in the hospital industry. Most decisions in the health care marketplace are made by the provider, not the consumer. Physicians control 70 percent of all health care decisions. As a result, the normal mechanisms of the marketplace, like competition, have not worked to bring down costs. Physicians often know little about the cost of the services they order—and they have little incentive to find out.

Mr. Chairman, the pervasiveness of these problems also leads us to the conclusion that the only way to deal with escalating health costs is in the context of a broadly based national health plan, including fundamental changes in our reimbursement mechanisms.

Third, systematic reforms are needed to increase access to health services, to provide more appropriate types of services and to eliminate the inefficiency and lack of competition in the health care industry.

Mr. Chairman, these are the fundamental problems that demand solution if our health care system is truly to serve the American people.

I have been deliberately referring to the administration's concern in establishing a national health program not a national health insurance program. I choose these words carefully. From the outset, the President has instructed us to put together a program which dealt not only with the lack of insurance coverage in the health care industry, but with the broad range of problems which exist in our health care system today.

The existence of this broad and varied set of defects in our present health system again has led us to the conclusion that we must deal with these interrelated problems, to the greatest extent possible, in the context of a broadly conceived national health plan.

The phase I bill should, in other words, be constructed so that it can evolve easily toward a completed national health plan.

Although, as noted, we are in the process of developing our phase I bill, I can sketch in broadly this morning some of its major elements.

GENERAL STRUCTURE

The overall structure of phase I will have three major components:

First, coverage of full time employed individuals and their families will be predicated upon mandated employer coverage that will effectively require most, and possibly all, employers to provide private insurance that has a core level of protection and that meets other basic standards. To the extent possible, this coverage should provide incentives for less extensive preventive and outpatient services over more expensive services within a hospital.

We believe that to minimize Federal involvement and efficiently deploy available resources it makes sense to build on the foundation of existing private insurance coverage.

Second, publicly financed health care programs will provide coverage for the aged and the poor.

To the greatest extent possible, we will seek to integrate, to make uniform and to make efficient program administration and reimbursement systems in these public programs. For example, serious administrative difficulties exist in medicaid because we have 53 different programs—in all States except Arizona and in the territories—not a single program.

Third, for those not protected by employer coverage or by the public programs for the poor and the aged, the Federal Government will guarantee the opportunity to buy health insurance at a reasonable rate. In the phase I bill, this Federal guarantee will provide the opportunity to purchase more affordable quality protection against the costs of major illness. At present, such an opportunity for coverage does not exist for millions of nonpoor, nonaged, nonemployed Americans.

THE AGED AND DISABLED

The phase I bill will obviously continue to provide the benefits offered under the current medicare program and will also include additional protection for our elderly and disabled citizens. We must especially insure that our elderly citizens are not devastated by the cost of major illnesses. We will also consider making more accessible to the elderly methods of therapy that could reduce the need for extended hospitalization.

THE POOR

The phase I bill would significantly expand the number of America's poor who would be covered fully for their medical expenses. The plan would expand coverage, in part, by setting eligibility for millions of our poor at uniform income levels nationwide, thus remedying the striking interstate inequities that exist in the present medicaid program.

THE EMPLOYED

As indicated above, the phase I bill will establish mandatory standards for private insurance coverage provided by employers. These standards could include: Quality requirements; a core benefit package that includes hospital and physician services, X-rays and laboratory tests and that, to the extent possible, encourages preventive services and outpatient care; and, extension of coverage for a certain period beyond termination of employment.

The phase I bill will mandate that qualified employer plans protect families against major expenses by limiting their financial obligation to a reasonable ceiling in a given year. This financial protection could be expanded in subsequent years.

In addition, the plan may mandate that employers maintain their current financial contributions per employee for health insurance coverage.

We will look carefully at the impact these requirements have on business, especially on small and low-wage firms.

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ALL OTHERS

For all those who are not employed and who are not otherwise covered through the provisions for the aged and the poor or through other private insurance, the phase I bill would, as noted, seek to make quality coverage against major illness more affordable.

Thus, health coverage that puts a ceiling on the direct health costs that must be borne in any year will be universally available.

COST CONTAINMENT AND OTHER HEALTH SYSTEM REFORMS

Finally, and of critical importance, the plan would include a series of cost containment and delivery system reform provisions.

The hospital provisions will build upon the President's hospital cost containment bill which was introduced earlier this month and which is currently before this committee. We will also be considering provisions to reform our current open-ended mechanisms of physician reimbursement.

The system reform provisions will, as noted, also build on a number of important ongoing administration efforts such as encouragement of health maintenance organizations, limitations on capital expenditures, and provisions aimed at assessing the appropriateness of new technological advances in the health care area.

In a few weeks, we will be proposing legislation that will encourage many more medicare beneficiaries to join cost-effective HMO's by allowing them to benefit directly if they choose this health delivery system.

Moreover, the legislation we will submit later this year seeking reauthorization of the health manpower laws will also be linked to resource planning for our phase I bill.

COST SHARING

The phase I bill will involve cost sharing for all but the poor. As noted, a reasonable ceiling will, however, be placed on the amount any family or individual would be required to pay for direct medical expenses in any year.

FEDERAL FINANCING

There will be no payroll tax increases required by President Carter's phase I bill. Additional Federal expenditures will be financed by general revenues.

In sum, our proposal for the first phase of a national health program will contain provisions aimed at improving coverage from the outset for all groups in the population and putting in place necessary cost control and system reform provisions. I must emphasize the importance of laying a firm foundation for eventual expansion of the program to deal with problems beyond the reach of our current resources.

THE PROPOSALS BEFORE THE COMMITTEE

Mr. Chairman, let me now briefly summarize the two health insurance measures currently before this committee as we understand them.

We have not had an opportunity to analyze in depth your proposal or that of either Senator Dole, Senator Danforth, and Senator Domenici—S. 760 and S. 748—both introduced yesterday.

S. 351 consists of two parts:

The first title of the bill is a catastrophic health insurance program which provides protection for all residents. It operates primarily through a federally administered public plan for the unemployed, welfare recipients, the aged, and the persons who do not opt for private insurance coverage. The program would be financed through a 1-percent tax on the payroll of employers, tax credits, and an offset for private insurance premiums. Employers and the self-employed could buy a private catastrophic insurance plan and the premium costs would be subtracted from the payroll tax obligation.

Benefits would be similar to those offered currently under medicare, but would be subject to two deductibles—$2,000 of medical expense and hospital stays of 60 days. With the cost of a hospital day averaging $215, this could mean that a hospitalized person, without any other hospital insurance, would have to pay $12,900 in hospital expenses before he or she would receive financial protection.

The second title of the bill consists of a voluntary Federal certification program for basic private health insurance designed to encourage private insurers to make such coverage available in all parts of the country.

The second bill—S. 350—contains the features just described plus a third title which would replace medicaid with a uniform, national program of medical benefits for low-income persons. The plan would be administered like the medicare program and would be financed by Federal general revenues and a maintenance-of-effort level by State governments.

We are concerned about both of these proposals, Mr. Chairman, because of the nature of the catastrophic component and because they do not contain enough structural reforms to control costs and to make the health care system more efficient and effective.

We share important common ground, however. Similarities between the key elements of your broader proposal S. 350 and our thinking on the first phase of a national health program include the following:

Both would move toward an improved and more uniform program for the aged, poor, and disabled, and a program that we could administer more effectively.

Both would seek protection for the employed population.

Both would involve establishing standards for private insurance coverage, although the voluntary standards in S. 350 and S. 351 will not do the job.

Both would make protection against the cost of major illness universally available although I would underscore our commitment to cost containment and to insuring that only necessary costs are covered by these provisions.

Yesterday in the legislation introduced by you and introduced by the three Republican Senators the concept of mandating employer coverage was included. I understand both pieces of legislation are

consistent with our concepts of mandating employer coverage in our legislation.

Mr. Chairman, perhaps our most important concern about the measures before this committee involves the danger of enacting a proposal that deals only with the problems created by the high costs of major illness. We realize the political appeal of and the real need for catastrophic health insurance protection. Our citizens want universal coverage of catastrophic health expenses because they feel it is wrong that Americans continue to face the possibility of being destroyed financially by a major illness or accident.

While we recognize this appeal and affirm this as a real need, we would oppose enactment of a catastrophic health insurance proposal alone because such a proposal poses significant dangers.

First, we are deeply concerned because a catastrophic proposal, standing alone, could, and I believe would, lead to an escalation of unnecessary expenditures for high cost, high technology care—unless it were to be combined with adequate reimbursement, utilization, and technology controls.

Although catastrophic coverage will meet real needs and will thus involve necessary costs, it will, without proper structural changes, be an open invitation to profligacy, especially in the hospital sector. With the present cost-plus hospital reimbursement system, increasing coverage for high cost hospital care will, without adequate accompanying reforms, especially reimbursement reforms, lead to additional waste of scarce public funds.

We must thus take great care to insure that a phase I bill will not unnecessarily increase expensive inpatient care. And we must, as noted, base a phase I bill on passage of hospital cost containment legislation.

Second, we are deeply concerned because passage of only a catastrophic bill would not be equitable. Although we all agree that some scarce Federal resources should be allocated to protect Americans from major medical costs, we must use scarce dollars fairly and this means seeking to provide basic health benefits—coverage for regular services, not just those that entail high expense—to those aged and poor who desperately need adequate health care.

Indeed, unless a catastrophic program were combined with more adequate arrangements for basic coverage for the low-income population, it would be a cruel illusion for those citizens. Millions of low-income families would be driven to financial despair before qualifying for assistance under the catastrophic program.

Thus, fairness demands that we take a more balanced approach in order to meet other fundamental health care needs, not just the need for protection against the expense of major illnesses.

Third, we are concerned because enactment of a catastrophic only bill will not establish a framework for realizing our ultimate goal—universal, comprehensive health protection that provides all Americans with basic health coverage, for preventive and primary care services, not just protection against the costs of major illness.

Mr. Chairman, catastrophic coverage alone while politically responsive may be economically and socially irresponsible, whereas coverage against the costs of major illness in concert with appropriate structural reforms that lead to a universal, comprehensive plan

can be both responsive and responsible as a first step toward a more complete national health program.

Mr. Chairman, let me now briefly describe in a bit more detail some of the problems that we have with S. 350 and S. 351.

Our additional concerns with the catastrophic proposal include the following: The catastrophic approach in S. 351 is based on a payroll tax. It would, as noted, impose an additional 1-percent tax on taxpayers. By contrast, we favor using employer coverage. The President does not want to increase the payroll tax for health insurance.

This approach eliminates any additional increases in the payroll tax and is more compatible with our eventual goal of using private insurance to mandate greater coverage for our employed citizens. It is, Mr. Chairman, consistent with the legislation that you introduced yesterday in that regard.

DEDUCTIBLES

The approach in S. 351 has split deductibles, one for physician services and one for hospital services. In addition, the deductibles are unbalanced in the sense that many more families would trigger the $2,000 medical deductible than would trigger the 60 day hospital deductible. For example, an individual requiring intensive care for an accidental injury might easily run up physician bills of $3,000 and hospital bills of another $10,000.

Yet if he were hospitalized for 45 days and had no other insurance, the S. 351 would only help him with $1,000 in doctors' bills and do nothing to help offset the much greater hospital costs of $10,000.

A single method of cost-sharing, with less financial exposure for individuals, would be more equitable in its applicato medical and hospital expenses and would also be easier to administer.

This is a point of great significance, Mr. Chairman. As presently designed, the deductible in S. 351 could be so large that they would cause some American families great hardship. Our phase I bill would provide significantly more financial protection.

INCENTIVES AND CONTROLS

The approach in S. 351 is based on continuing present medicare reimbursement and utilization controls. As noted, we favor reimbursement controls based on our hospital cost containment legislation. We also favor strengthened controls on capital expenditures and health care technology. We feel that the strengthened controls are essential for a catastrophic program and that our current medicare controls are not enough.

There are many similarities between the "Standards" title in S. 351 and our own thoughts on setting out standards for private insurance as part of a first phase of a national health program. Our key difference in this area is that the standards under the S. 350 and S. 351 are only applied in a voluntary fashion to the insurance industry. In other words, if an insurance company offers a policy meeting the standards that policy can receive a Good Housekeeping seal.

To make any standards effective, the incentive probably should go beyond the mere receipt of a Government seal. For example, the provisions of the tax code could be changed so that a policy which did not meet standards would not be eligible for a tax deduction. Further, we could mandate that policies offered by employers must meet the standards established in the phase I bill.

Finally, there are many similarities between our approach to the problems of improving coverage for the low-income population and the approach embodied in S. 350. However, both S. 350 and our phase I bill will, to the extent possible, have to deal with two major problems.

THE NEAR POOR

In designing subsidies for those near poor who are not fully covered under the low-income public plan, we must seek to reduce heavy financial burdens and provide work incentives to the greatest extent possible.

STATE FINANCING

S. 351 essentially limits present State financing for medicaid acute care services and would require States to maintain that level of financing. This kind of provision would tend to penalize the states which had done the most under medicaid and would reward those States which had done the least. An equitable approach to States roles under a phase I bill is one of the key problems that our bill will seek to address.

Mr. Chairman, we have described our differences and problems. But, in closing, I would emphasize our desire to build upon important areas of agreement between the administration and your commitment to improve health benefits for millions of Americans in a fiscally responsible way. The broader bill, S. 350, sponsored by you and Senator Ribicoff, is a constructive starting point for our discussions.

The Finance Committee, the other committees in both the Senate and the House with health jurisdiction, and the Members of the Congress as a whole have an historic opportunity. Together, we can make significant, structurally sound improvements in our Nation's health care system—improvements that would expand coverage to meet critical needs, that would help contain escalating health costs, that would increase the quality, efficiency, and fairness of America's health care system and that, most importantly, would lay the groundwork for the universal and comprehensive health plan that is President Carter's ultimate goal.

In the coming weeks, as we present our legislative proposals to you, I hope that we can find substantial common ground in our mutual quest for a health care system that responds to our citizens' health care needs and reforms the structure of our delivery system to contain costs, increase efficiency and make quality care more widely available.

Thank you Mr. Chairman.

The CHAIRMAN. Thank you for your statement, Mr. Secretary. I find myself thinking back to the testimony that Paul Hall once gave before the Commerce Committee, I believe it was the Mari-

time Subcommittee. He referred to the kind of person that the unions referred to as a management fink. I asked him, "What do you mean by that?" He said:

He is really the kind of fellow who does not have labor's interest at heart and keeps us from getting together on something. For example, if the fellows feel they ought to get a pay raise, he says, "Hell no. That's not our problem. Our problem is the lousy food" and so on. Everytime you try to get the people to agree on something that they ought to have as an objective, he would have something to confuse the issue.

It seems to me if we do business in this Congress the way we do business on this committee, we will pass a bill that will do a great deal for the American people. To avoid a lot of wasted effort and confusion I oftentimes ask for a show of hands.

I would say, just a minute, fellows, before we go anything further, anybody who thinks we ought to do something about this, raise your hand. Now, those who do not think we ought to do anything about this, raise your hand.

At that point, we can see whether a majority want to do anything. Then we go forward to see just how much the committee would like to do. We can then bring out a bill which represents the consensus, or majority.

It seems to me that the American people have been denied the progress we should have been making because some are holding out for something that goes all the way, like the British system.

Many of those same people came to me, and others, urging us to support medicare. Their argument at that time was that they were not getting anywhere with their proposal for a comprehensive federalized program. They urged us to go for medicare, and we did that.

Now, I would like to ask you, Mr. Secretary, if this is not true. The more we build on what is already in place, the least it will cost either in taxes or in a burden on the economy.

I am told that about 90 percent of the population has some protection toward some or all of the cost of the benefits that go into place before you get to the catastrophic part of the coverage.

Secretary CALIFANO. Mr. Chairman, let me say we do believe we should build on what is in place that is good. One of the things in our legislation that will do that, and in the bill that you introduced yesterday that does that, is the mandating of some coverage by employers of employees which helps avoid the necessity for additional taxes and which takes advantage of the fact that we have a private insurance industry and almost 100 million of the Americans who are insured, to some degree or other, are insured through their employer-employee arrangement already.

In that sense; yes. We do want to build in what we have. However, there are things that have to be changed which the members of this committee are as conscious of as anyone.

Senator Talmadge has been talking about hospital cost containment for years, and some of the reimbursement methods of hospital-based physicians. We think those changes should be made as a prelude to any national health plan or any major step in a new phase, and that it is important to do that.

The Chairman. The mandated approach has a lot of appeal. You say you have not analyzed my proposal. I have had enough chance

to analyze what you have been saying and I put that bill in because it seemed to me that it may be the best approach to take; that is, simply mandate the coverage.

The question is, How are you going to mandate it? That approach simply says, rather than try to put the employer in jail for not providing the coverage he would owe a tax of about 150 percent of what it would take to provide the coverage. How does that appeal to you?

Secretary CALIFANO. I think it is worth looking at. I am delighted there is an analogy, Mr. Chairman, that would indicate you would be willing to support that provision in our hospital cost containment legislation that talks about those hospitals that go over the goal, in effect, paying a tax of 150 percent.

The CHAIRMAN. Maybe that is where the idea came from. Somewhere back in the computer of my memory, there was an idea about 150 percent would be an appropriate level of tax for someone who failed to provide the insurance.

Secretary CALIFANO. Mr. Chairman, I am accompanied, I should have said at the beginning of my testimony, by Dr. James Mongan, the deputy assistant secretary for health policy and special assistant to the secretary for national health insurance. Dr. Mongan was a distinguished staff member of this committee. We appreciate the fact that you let him come and work with us.

The CHAIRMAN. I think that employing Dr. Mongan shows that you are making great progress in your studies down there, and apparently you have found somebody who can add a little commonsense.

My time is expired. I would suggest that we limit ourselves to a 5-minute rule the first round of questions so everybody can have a chance to get in his 2 cents worth and we are going by the early bird rule. Since I was the first one here, I asked the first question.

Mr. Danforth was the next in the room. You are recognized.

Senator DANFORTH. Mr. Secretary, one of the questions that is going to be asked is how do we pay for whatever program we enact. It is my understanding that the cost to the Treasury of phase I of the administration's program is about $10 billion to $15 billion a year when it is fully implemented, the cost to the Treasury of Senator Long's proposal is somewhere in the neighborhood of $5 billion to $7 billion and the cost to the Treasury of the bill that was introduced by Senator Dole and Senator Domenici and myself yesterday is about $1 billion to $3 billion a year.

Thinking about how to raise all or part of that bill led me to the following, and I would like your comments on it. In 1951, Congress imposed a tax on cigarettes in the amount of 8 cents a pack. Because of inflation, 8 cents in 1951 would amount to somewhere in the neighborhood of 20 cents today.

In 1951, the combined Federal and State tax on cigarettes amounted to about 50 percent of the cost of a pack of cigarettes. Today, the average—depending on the State—the average State and Federal tax on a package of cigarettes amounts to about one-third of the cost of a pack of cigarettes.

Since the 8 cents tax was imposed in 1951, in addition to inflation, two other things have happened. First of all, the Surgeon General has made a very convincing case that there is a relation-

ship between cigarette smoking and poor health; and second, with the advent of medicare and medicaid and increasingly so with whatever we do with this bill, the Federal Government, the taxpayer, John Q. Public, has gotten into the business of picking up the tab for poor health.

I am told that if we increase the cigarette tax by 10 cents a pack, we would pick up about $3 billion, which would be the outer limit of the projected cost of the Dole-Danforth-Domenici bill. It would be approximately half the cost of the Long bill, and maybe one-third to 20 percent the cost of the administration's bill. I would like your thoughts as to whether it would make sense—when we are trying to do two things: Provide for the health of the American people and still prevent, or still keep some kind of a brake on runaway inflation and the huge deficit of the Federal budget—whether it would make some sense for us to attempt to pick a part of the revenue for this by increasing the Federal excise tax on ciagrettes and earmarking the amount that would be produced by that to pay for whichever of these plans, or whatever kind of compromise, we can come up with.

Secretary CALIFANO. Senator, I cannot speak for the administration on that proposal, because we have not made a decision on the revenue-raising methods in connection with this plan. Personally, I would have no objection to any such tax.

We have done studies at HEW that indicate that a 15 percent increase in the price of cigarettes has an impact in reducing sales. This is particularly true with respect to the extent it reduces sales among young people, which is the target of the cigarette companies; 75 percent of the adults who smoke in this country are hooked before they are 21 years of age. To the extent that it would have an impact on their not buying cigarettes, it would make a significant contribution to health care as well.

The CHAIRMAN. Senator Packwood?

Senator PACKWOOD. Mr. Secretary, on page 34 of your statement, you say:

> Third, we are concerned because enactment of a catastrophic-only bill would not establish a framework for realizing our ultimate goal, universal comprehensive health protection that provides all Americans with basic health coverage for preventive and primary care services, not just protection against the cost of major illness.

On page 30 of the report prepared by the Budget Committee in March of this year, you say that 90 percent of those have some kind of coverage, maybe not adequate, but some kind of coverage.

Are you possibly concerned that if we pass mandated catastrophic coverage by employers so everyone who works has catastrophic coverage and almost everyone who works has some kind of additional coverage that there simply will not be any constituency for national health insurance?

Secretary CALIFANO. No; that is not the point that that is designed to make, and as I have indicated repeatedly, I think we have to come about this problem step by step and in phases. I think that the major success we have had in getting health legislation on the books such as medicare and medicaid under Lyndon Johnson, has been in effect by pieces. We indeed proposed a new major piece with the child health assurance program which would bring 2 million more poor children.

The problem is, the system is very skewed to the hospital part, which is the most expensive end of it. It is not simply that the Federal programs are skewed that way, which they are under both medicare and medicaid. There are tests that, if they are done in the hospital, we pay for; if they are not done in the hospital, we do not pay for.

There are thousands of cancer patients in hospitals who do not have to be there, but their doctors put them there because we will pay for the expensive cancer drugs under medicare if they are in the hospital. The whole insurance industry is skewed that way as well. They are very much inclined to pay for hospital kinds of things and not pay for something less than hospital care, and that is what we are worried about.

The place at which I announced the first parts of our plan last week, the New York University Medical Center, is, we think, an ingenious and effective way to reduce hospital costs. It is basically a center that will take the patient as soon as they do not need the full array of hospital care, 2 or 3 days after the operation, and move them into a setting which would be 40-percent less expensive, and provide health education for them so they learn how to take care of themselves.

We had to make an exemption under medicare and medicaid to make that a demonstration; otherwise, we could not reimburse for that kind of care. That does not make sense.

We worry about catastrophic only insurance further skewing us in the wrong direction, the most expensive direction.

Senator PACKWOOD. Mr. Secretary, most of us running for elective office are a litmus test on what people are thinking by the kinds of questions they ask. You go through a factory, you get questions on gun registration and probably on taxes. You never get questions about national health insurance. On occasion, why do we have to go to the hospital to be paid? You covered that.

Some are concerned about health care for their parents, especially reimbursement for home health care. Never any questions about national health insurance. A nagging fear in the back of their mind about catastrophic costs because they know somebody in the factory who broke their back and ran out of insurance and was severely strapped.

But I think the answer would be, if we passed catastrophic coverage, if there is some kind of home health care provision for both elderly and others, just those two facts will insure that there will never be a British type of national health service in this country; there will never be a Kennedy kind of health insurance in the sense of his old bill. His new bill is amazingly changed from what he has been advocating for the last 15 years. But just with those two provisions, there will never be national health insurance and a good many people who want national health insurance sense that, and they do not want catastrophic coverage because it removes the hook by which they are trying to bring in the rest of the system into national health insurance.

Secretary CALIFANO. We have never proposed a British type of system. I do not think that makes any sense in this country. The kind of plan we are talking about would very much utilize what we

think is the best of our system, try to put competition in places where we can put some competition.

But I think our concern goes both to the equity issue of what you do with the scarce dollars where there are poor people who need basic care, and second to the fact that we think this would skew the system toward the most expensive end, and we really should be trying to invest more money at the other end of the system, prevention, ambulatory care, what have you.

Senator TALMADGE. Senator Dole?

Senator DOLE. First of all, Mr. Secretary, I appreciate your statement. I find many of the comments helpful—I do not suggest that they are an endorsement of S. 748, which you have not had time to analyze, but at least we seem to be thinking along the same track.

You indicate that catastrophic is not enough, but ours is limited to that. I hope you will have a chance to analyze the Danforth-Domenici-Dole proposal and submit your comments so that we can include them in the record.

Secretary CALIFANO. Senator, we will and we will also analyze it. I should also note Senator Danforth used some numbers relating to cost. We have great difficulty running costs on these bills. Our health care estimate is not what our welfare income maintenance estimating is. We will ultimately cost out all of this legislation out once we can get the numbers.

Senator DOLE. When we talk about the cost, we are talking about the cost to the Treasury. There will be additional costs to the employer. There will be other costs which probably are not indicated in our statement. I assume that may be also true in your proposal, because if you are going to mandate the coverage, mandate the employer to provide it, I suggest that will be an additional cost.

Do you assume that the employee will bear some of that burden?

Secretary CALIFANO. In what we have looked at, Senator, we have assumed that the employee might be subjected to a proportion of that burden, maybe 25 percent of it, with the employer carrying 75 percent, but that the employee would have the right and ability to negotiate out that 25 percent.

Also, one has to be careful. For some employers, there will not be an additional cost, as you know. For the larger companies and the bigger unions, they will already have a basic package of coverage. For smaller employees, you have to be very careful. This can be a significant burden on the small businessman, small employer, to provide perhaps where necessary some kind of subsidy or some kind of relief.

Senator DOLE. We discuss that in S. 748. Again, I will not address that if you have not had a chance to look at it.

You indicate that unless we have some kind of cost containment that there will not be any health initiatives from the administration. Does that include the child health initiative.

Secretary CALIFANO. I would think, Senator, that regarding the child health initiative, this committee that acted on it last year could pass it out very fast. That bill, as you know, and as you are pointing out, is directed very much toward the preventive end of the spectrum. It is to go after poor children, to assess them. The

current program is very difficult to operate and I think the child health assessment program will have a substantial impact.

It passed the House committee, too. I would hope that we could get that early in the session.

Hospital cost containment is critical in terms of pumping more money into hospitals. We really have to get those costs under control. I noticed yesterday in the House hearings, that it was pointed out, and 1978 again confirms what the 1977 figures confirm, namely that to the extent there has been a reduction in the rate of increase of hospital costs, it is largely attributable to the nine States with mandatory programs which have had percentages of increase far below the percentage increase of hospitals in States which do not have those programs.

We think we need that program. Every day we do not have it, we in effect impose a tax on the American people that they should not have to pay.

Senator DOLE. You indicate in your testimony as you did in your cost containment testimony that 70 percent of all health care decisions are made by physicians, and this is one of the roots of our problem. I am wondering what the administration initiatives may be in this area.

Secretary CALIFANO. One, there has to be more physician education on the cost of what they are ordering up. When I spoke to the Association of Medical School Deans in the great city of New Orleans, I asked the medical schools to provide more education in that area. I think that the professional standards review organizations, which we are learning more about, which can work effectively to look at what the doctors are doing.

Some hospitals are printing on the same charts, they print the results of the tests and the costs of the tests. I think Mass. General does that now and it seems to have an impact on slowing down the doctor in ordering tests and some kind of continuing education program for the doctors who are out there in terms of the tests that they order up.

Finally, I suppose one has to look. One cannot ignore the malpractice problem and the extent to which defensive medicine may be practiced by doctors in fear of malpractice.

The CHAIRMAN. The Senator's time has expired. Senator Heinz?

Senator HEINZ. Thank you, Mr. Chairman.

Mr. Secretary, on page 33 of your statement, you say that you are very deeply concerned that the passage of the catastrophic bill would be inequitable. You make the case that passage of such a measure without the kinds of things that you describe in the administration proposal would be inherently unfair to the aged or poor.

Could you assess for the committee the extent to which poor people now have some kind of access to the equivalent of catastrophic care and, having assessed that, then explain why a program that would appear to be fair to the poor, to the aged, to middle income, is inherently unfair?

Secretary CALIFANO. Basically, the only poor people who are covered by medicaid are those that fit into the AFDC category or the SSI category, by and large children in single-parent families, the aged, the blind, and the disabled. There are millions—we can

give you the precise number—millions of poor people who do not receive medicaid, who are not eligible for it, singles, childless couples, women who are pregnant for the first time. There are millions of people who do not meet that standard.

I think that funds in a time of scarce resources should be allocated to those people to achieve basic health care for them.

Second, a relatively small expenditure by someone making $5,000 a year or $4,000 a year can cause chaos with them as compared with these higher expenditures for people who are in the middle, or upper middle, level of the spectrum. I think, indeed, one of the bills that Chairman Long has introduced recognizes that problem because it would essentially eliminate the categorization of poor individuals covered by medicaid. It would cover people up to an income of $5,400 for a family of four.

We might argue about the income level, but I think, by and large, we would like to see some elimination of that categorization, that relationship to categorization, that kind of coverage.

Those are two examples.

The number of poor with no coverage at all is 5.4 million. The number of near-poor—that is, within 10 percent of the poverty line—with no coverage is 3.1 million people.

Senator HEINZ. That is without coverage even by medicaid?

Secretary CALIFANO. That is right.

Senator HEINZ. Would you care to go on and just address the second part of the question? If, in fact, both the near-poor, the poor, the lower-income people, middle-income people and so forth were covered by catastrophic, why that is, besides your first point, inherently wrong?

Secretary CALIFANO. What we are saying, in our first phase, we will have a significant catastrophic component. We believe you have to do some other things as well, and part of that is to provide some kind of coverage for the poor people I indicated. Another part is to provide systems reform at the same time.

Otherwise, if we are working in a system that is wasting billions of dollars a year just with excess beds, pumping money into that system does not make sense.

Senator Danforth can correct me, but even the narrowest catastrophic bill, so to speak, with the highest deductible, which is $5,000, even in that bill there is some recognition of the problems. I think you eliminate the premium on medicare in your legislation.

Senator DANFORTH. No.

Secretary CALIFANO. Senator Long does that then, I think. We are saying that, if there is a pot of money and we are willing to make the next significant investment in the health care of our citizens, we ought to distribute that pot equitably and in a way that does not skew the system to the most inefficient end of the spectrum alone.

The CHAIRMAN. Senator Boren?

Senator BOREN. Mr. Secretary, let me return to the question of costs again. I was puzzled by your statement. I believe that there would be no specific impact until 1983 under phase I. I wonder if you could explain that, what is meant by significant and what will be the impact?

Then, if you could break down by category for me the costs as you see them, how much of the estimated pricetag is due to increasing eligibility for basic health care benefits, how much is due to extending the coverage to catastrophic. How would you break that down? What would be the employers' part of picking up the additional insurance? What would be the cost of covering the aged to the Government, and what do you estimate the cost to be in terms of some kind of subsidy and making available health insurance for those who are not employed and who are not otherwise covered by health insurance programs?

I realize that it is difficult to come up with specific figures, because we are still dealing with a general proposal, but just to give me a ballpark idea of what you are talking about in terms of distribution of the costs.

Secretary CALIFANO. The overall cost is $10 billion to $15 billion more. That is the limit, in effect, the President has placed on phase I.

Senator BOREN. Does that include costs to the employer?

Secretary CALIFANO. No, it does not include costs to the employer. How it will be allocated among increasing expansion of coverage of catastrophic care I cannot answer now. I will have that information when we have specific legislation, which will take several weeks to put together.

Why can I not give you an answer now? Because there are so many things on which it depends, what kind of reimbursement reform we have for hospitals, for example; what kind of reimbursement reform you have for physicians; the extent to which you skew the program toward preventive care, ambulatory care versus hospital care. We will have that when we come forward.

With respect to—what was the first part of your question?

Senator BOREN. You said there would be no specific impact until 1983.

Secretary CALIFANO. That was included in the President's principles. We are not as optimistic as the chairman is that Congress can report a bill out in the next few months. If you assume legislation passes in the 96th Congress late in the second session, and recognizing that fiscal year 1983 begins October 1, 1982, that gives us about 18 to 20 months to prepare for a major new thrust and I believe we need that time to do that intelligently.

I think there are a lot of problems inherent in medicaid. One of the reasons medicare was, from day one, better administered was that there were a couple of years of planning that came into that. Medicaid came just like Topsy and we were forced to put it in place very fast.

For example, if you take Senator Long's extended bill which would, in effect, federalize medicaid, create uniform standards, keep the States at a maintenance-of-effort level, that kind of dramatic change in the current program takes awhile to put into place. That is why we say fiscal year 1983. That is October 1, 1982.

Senator BOREN. Thank you.

The CHAIRMAN. Senator Byrd?

Senator BYRD. Thank you, Mr. Chairman.

Mr. Secretary, on page 27, you say additional Federal expenditures will be financed by general revenues. What is the figure in that regard?

Secretary CALIFANO. We do not know, Senator. Let me give you an example. If the hospital cost containment bill were as effective as we think it will be and if the Congress thought that we had sent up exactly the right bill and passed the bill we sent up, we would be saving by that time $8 billion a year, so you would offset more than the $15 billion. If the bill were only $10 billion, the cost of it in the first year would set off all but $2 billion of it.

If it were that small of an amount, general revenues could easily handle it, even with a balanced budget.

Senator BYRD. If you leave out the offset for cost containment, what would the cost be?

Secretary CALIFANO. $10 billion to $15 billion, Senator.

Senator BYRD. On that same page, you say phase I will involve cost sharing for all but the poor. Would you amplify the cost-sharing aspect of it?

Secretary CALIFANO. For example, in the employer-mandated program, we would probably have some arrangement whereby the employer would be required to pay 75 percent of the premium and the employee 25 percent. The employee would be permitted to negotiate away that 25 percent. We would have that kind of cost sharing.

Senator BYRD. What do you mean, negotiate away?

Secretary CALIFANO. If the employer wanted to pay that 25 percent in collective bargaining, that would be fine.

Senator BYRD. As I understand it, referring to one of Senator Boren's questions, you envision that the legislation would not become effective until fiscal year 1983. Is that correct?

Secretary CALIFANO. No significant expense until October 1, 1982, that is correct.

Senator BYRD. By that, you mean that the new legislation, as a practical matter, would not be effective until fiscal year 1983?

Secretary CALIFANO. That is correct, Senator. The kind of significant steps we would like to take in the first phase, I think in all candor will take time to get them in place, and to administer them well. If this Congress passed them at the end of the next session, late 1980, it would take us 18 months to get ready to put them in place intelligently, to plan them out and do it right, and that is why we set that date.

Senator BYRD. I think it is wise to give adequate time, because, as you pointed out, some of the other programs, medicaid—probably medicare, too—were enacted so quickly that many of the pitfalls were not visualized and many of the costs were not adequately estimated.

I have just one other question. Did I understand you to say in your testimony that 100 million Americans are now covered by health insurance?

Secretary CALIFANO. What I said, Senator, was that one of the reasons we liked the idea of mandating coverage by employer and employee as a part of a package, is because almost 100 million Americans now get their health insurance through that system. It

seems to us we should take advantage of what is in place, of what is good.

Senator BYRD. If 100 million Americans are now covered, plus their dependents, that would take care of the bulk of the American population, would it not?

Secretary CALIFANO. No, that is not plus their dependents. That is 100 million individuals. That is the worker and his family.

Senator BYRD. Including his dependents?

Secretary CALIFANO. That is correct.

Senator BYRD. Thank you, Mr. Secretary.

Thank you, Mr. Chairman.

Secretary CALIFANO. That is basically 100 million out of the 230 million people in the United States.

The CHAIRMAN. Senator Bentsen?

Senator BENTSEN. Thank you very much, Mr. Chairman.

Mr. Secretary, I am concerned by what I deem to be some arbitrariness in the statement as to what happens to people if we just have the catastrophic coverage. As I understand it, over 90 percent of the people covered to some degree now, with varying degrees of coverage. They are covered by various forms of public and private insurance, including medicare.

So most people have coverage up to the 60 days. That takes many of these people up to substantial levels of coverage before they reach the deductible of catastrophic coverage proposed by the chairman.

There are 150 million people today who have some kind of supplementary catastrophic coverage. If that is the case, where are these dire results that you predict? If catastrophic insurance causes all of these kinds of serious problems you suggest, why would not the insurance companies be making a very major change in the kinds of policies that are presented today in catastrophic insurance?

I just do not see the world coming to an end if you have catastrophic insurance coverage. We have a lot of that now. I do think there is now a great inequity involved for the person of moderate income who incurs extraordinary medical bills and has no private or public catastrophic coverage.

I have been watching a situation now for 6 months. I know of two children, about 2 years of age, who are getting intensive health care. One of them is a charity patient, and thank God that child has that coverage. The other is a person of average means. But those health care expenses cannot be handled by that person of average means for a long period of time, and catastrophic insurance would take care of that, so there is a grave inequity that has to be corrected.

I do not agree with your predictions that this bill would result in immeasurable harm. I do not see it, because the bill's effect is moderated substantially by the fact that 92 percent of the people have basic coverage and the fact that supplementary catastrophic coverage is not a new thing. It is very much in evidence and we have had some experience where it has been quite helpful.

Secretary CALIFANO. Senator, I am not talking about irreparable harm. The points I tried to make are the following ones: One, that first of all, if you have catastrophic coverage only, you further

skew the system towards the most expensive end. The most wasteful, profligate part of the health care system is the hospital industry—130,000 excess beds that cost the American people $4 billion a year.

We have equipment that is utterly unnecessary in hospitals. In Senator Danforth's State, in Kansas City, we have more CAT scanners than the whole country of Sweden has. We have enough CAT scanners in southern California for the rest of the United States.

If you put your money there, that will just be a signal to go, go, go, and that, without hospital cost containment, hospital controls, will say to the American people, we do not give a damn about the $50 billion that we will waste over the next 5 years. We will waste billions more.

I am saying that if you go with catastrophic as part of something else, we have to go with controls on the hospitals before we do that.

Second, if the resources are limited and we have only *x* billion, whatever it is, you have a certain amount you may want to invest in health care, that simple equity requires that we recognize that there are now over 9 million, almost 10 million people, that have absolutely nothing; 8 million Americans have no health insurance; 10 million Americans are flat-out poor and near-poor and have no coverage. We ought to provide something for them, because a $100 bill for them can be as devastating as a $5,000 bill for the person you are talking about.

We are not opposed to catastrophic coverage. We think we should change the reimbursement systems for hospitals and do other things at the time you put it in, however, and we should not do it alone.

Senator BENTSEN. Mr. Chairman, I would like to put something into the record. I heard the Secretary dismiss out of hand Senator Packwood's concern about having a federally controlled health system imposed here. I am very much concerned about it, but I seem to recall a rather laudatory statement the Secretary made last year after his visit to England, and I would like to put that in the record.

The CHAIRMAN. Yes.

[The material referred to follows:]

An Associated Press report came from London to the effect that after examining the British National Health Service, HEW Secretary Joseph C. Califano said he was very impressed.

The biggest obstacle to a similar system in the U.S. is money, the secretary opined. U.S. hospitals are incredibly obese and profligate, he was quoted as saying.

Secretary CALIFANO. Senator, what I said last year was that they were providing health care on a more broadly based scale than we were, which is true.

Senator BENTSEN. Substantially more than that, Mr. Secretary.

Secretary CALIFANO. But I do not think their system is the right system for this country. That is why we are proposing the kinds of things that we are proposing here.

The CHAIRMAN. Senator Chafee?

Senator CHAFEE. Mr. Secretary, you and I discussed a good deal in the Human Resources Committee preventive medicine and in your comments here on page 34, you talk about the need for preventive and primary care services, for which I applaud you. But

I just wonder. I do not want to be harsh, but it seems as though people are tipping their hat constantly to preventive medicine. It is a good issue these days.

I am wondering what exactly you are doing in the field of preventive medicine. What we are spending is peanuts.

You say you are going to do something in this area. You have been very active on the cigarette, antismoking issue although the President has not shown the same enthusiasm you have. He went down to North Carolina and cheered on the growers, as I read his comments.

Secretary CALIFANO. Somebody has to go to North Carolina. I cannot get into that State anymore.

Senator CHAFEE. I do not think you will be his representative down there in the next campaign.

Nevertheless, there is no question that the link between cigarette smoking and consequential poor effects on health and every statistic that any serious person examines shows this. There is no questions about it, and so it says on every single package. So I just wonder, what are you going to do? You have not come forward with any specifics yet.

We all know that under Blue Cross-Blue Shield plan will not cover a nutritionist. Could you outline to me what some of your thoughts are in preventive medicine? Are you going to come forward with a plan?

Secretary CALIFANO. There are some already in place. The child immunization program for which we are pressing very hard. I believe we will have 90 percent of the children immunized against childhood diseases. We also have flu immunization program for high-risk individuals with chronic respiratory diseases. Third, you mentioned the cigarette program. It is a part of a broader health education program. We will also be moving aggressively in the area of alcoholism next month. We have been working for over a year now to try to put a program together in that area.

I think our legislation will contain requests that the reimbursement mechanisms be changed for HMO's, which we consider to be a very effective preventive health organization which have much less hospitalization, much less surgery than for patients with fee-for-service doctors.

We have requested additional funds for fluoridation.

Senator CHAFEE. Let me ask specifically about nutrition. You might consider—I notice the other day you came out pretty strongly against cosmetic-type surgery, yet nutrition, it seems to me and control of weight is probably as significant a step as anyone can take in preventive medicine.

What would you say to reimbursement for people going to Weight Watchers?

Secretary CALIFANO. I personally would have no problem with a program like that. Let me note what we did with respect to cosmetic surgery. It was simply to say that Public Health Service hospitals should not provide discretionary cosmetic surgery, mostly facelifts for wives of military personnel.

Senator CHAFEE. I do not argue with that decision, but some might say that going to Weight Watchers is cosmetic. I do not think so.

Secretary CALIFANO. I agree with you, and on nutrition I agree with you. In my medical school speech, I have asked them to teach their doctors more about nutrition so that they, in turn, teach their patients more about nutrition. More about nutrition should be taught in the schools.

Senator CHAFEE. Everybody says this to them, and they pay no attention. That must have been a good speech in New Orleans. But that particular chapter——

Secretary CALIFANO. I gave it after having dinner with the Chairman.

Senator CHAFEE. You dined well and spoke well, I am sure. But the medical schools pay no attention to you on the subject of nutrition.

Secretary CALIFANO. I think they are paying more attention to these preventive areas than they were in the past. I only made this speech in December. I think they are starting to look at the critical——

Senator CHAFEE. I personally will look very carefully at what you do come forward with when you do come forward with your plan in preventive medicine. I cheer you on, and hope that you will realize, as I am sure you do, the importance of it and that it does not have great broad, immediate appeal. It is not half as dramatic, as we well know, as some new surgical technique.

But if we are interested in saving lives—and for saving lives, it seems to me it is as important as anything else. I have had heard some crass people say. "We don't want to go too far with this. We will wreck our pension system."

I take it you are not worried over that?

Secretary CALIFANO. Not at all.

Senator CHAFEE. I hope not.

Thank you, Mr. Chairman.

The CHAIRMAN. I would suggest that we not have a 10-minute limitation on questions. That will give everybody a chance to have another round to explore what they want to explore.

Mr. Secretary, I find it rather strange that you speak for the administration, however, you come up here and take the view that you have been taking for some time—taking the view of those people who say you have to have everything or have nothing. On balance, this view has been a burden on the move toward better health care, because we could have done so much.

Yet you come here and you say, "Unless we pass your cost containment bill, you cannot support anything else."

It seems to me as though you are making the same argument that others have made.

I can recall very well when medicare was passed. I was the floor manager as well as the committee chairman when it passed the Senate and became law. As I recall, at that time I had been making speeches predicting that there was no doubt whatsoever that the costs were going to go up.

For one thing, doctors had been doing all sorts of free work for the poor and their relatives and friends and I believed that they were going to start charging medicare and medicaid for that care.

That obviously was apparent on the face of it. In addition, with the Government paying for care, people would stay in hospitals longer. That was the experience in Louisiana.

Even though these programs would run up the costs and they did, it did not cause us to discontinue the programs. The first year experience was 50 percent above the cost estimate for medicare and a great deal more than that under medicaid. We took the view, sure, it cost more than we anticipated, but look at all the good it is doing for people.

Are you here to testify that if we do not pass the kind of hospital cost containment bill you are recommending that you are going to withdraw your proposal for additional medical protection?

Secretary CALIFANO. No. What I am saying, Mr. Chairman, it would be profligate in our view, and it would waste a lot of the taxpayers' money to put in place a program that would funnel more money in hospitals without imposing some kind of restraints on hospitals.

The Senate spoke last year on the subject of hospital cost containment and I think this committee is recognizing the importance of that subject by scheduling markups so promptly on it.

The CHAIRMAN. Mr. Secretary, you have shown an interest in trying to contain costs, and I applaud you for that But I am going to tell you that your views are not unanimously shared in your Department. I think you have some people down there who are experts at wasting money, and many of them were there 20 years before you ever arrived on the scene.

If you were just to put, for example, a work requirement, as a condition of getting welfare money, you would probably save enough money to pay for expanded health coverage.

But I am not here trying to do that. All I am saying is that we have a lot of poor, sick people who are dying and we ought to be taking care of those people in the catastrophic area as rapidly as we can. The man who made me think we should have catastrophic was Senator Paul H. Douglas. He used to serve on this committee, one of the greatest liberals who ever served in my time in the Senate.

He used to stand up and quote that beautiful old hymn, "Lead Kindly, Light." "I ask not to see the distant shore, one step enough for me."

Here is a statistic provided by your Department. They say in 1976 we had 164 million people who were insured for hospital care. And that does not include medicare and medicaid. You add that to it, and you get over 200 million people who would be protected in some fashion already.

That would only leave you about 18 million not protected.

All we really would have to do is say that in insuring people, dependents up to age 26 must be included. I suggested that in that bill I introduced yesterday. That inspiration came from the Connecticut Insurers. And if you say that, in addition, employers must insure the unemployed for 6 months after the employment was terminated by the employer, and if you included coverage for aged people and relatives living in the homes of workers, you would have, by that point, probably about 97 or 98 percent coverage of the people who need coverage.

You would still need a little more money to reach the rest of them.

To me, I cannot see any sense in saying that you would not provide coverage for catastrophic, people who are dying every day, without having adequate coverage just because you cannot provide some additional insurance in certain other areas.

For example, right now, the Blue Cross and Blue Shield people provide first dollar type insurers, and most companies do not think that makes sense, and frankly, most economists do not think it makes sense. If you are going to pay for the first dollar, then the patient has very little interest in holding down the cost.

The toughest thing about raising those expenses ordinarily is to have to look that patient in the eye and ask that poor soul to pay a big bill. In my view, if you have a deductible and a co-pay feature, it has to hold down the cost. A patient ought to pay for some of the costs that are within his means. In this way dollars can be saved to take care of the costs the patient cannot afford to pay.

What is wrong with that philosophy?

Secretary CALIFANO. Mr. Chairman, under that legislation that you are talking about, an individual would have to lay out more than $12,000 for those first 60 days.

The CHAIRMAN. Let's make it $3,000. It is easy enough under the approach I introduced yesterday to get it to $3,000 by the mandated insurance approach.

Secretary CALIFANO. I think I am delighted to hear that suggestion. I do not think that we are objecting to having catastrophic insurance as a part of a larger phase; we are not objecting to that in any way, but we think there has to be other things included.

There are also millions of poor people who die, not because they do not have catastrophic coverage but because they do not have any coverage at all, because they are out of the system completely.

Your second bill has the title that covers that as well. We would like you to lean much more heavily toward that piece of legislation and add some systems reforms, some of the kinds of reforms that would build on the hospital cost containment bill, some of the reforms discussed in this committee on frequent occasions.

The CHAIRMAN. Mr. Secretary, just in terms of priority, and speaking as chairman of the tax-writing committee, we should be taking care of poor people, or people who are not poor but have been made poor by the catastrophic illnesses, before we vote for a general tax cut for everybody in this country. Yet we voted a big tax cut bill last year and will be voting for tax cuts again, putting the need for a tax cut for everybody ahead of care for people who are dying because they cannot afford medical care.

In terms of priorities, you are sitting there as Secretary of HEW. How can you put the need of a tax cut beyond the need of taking care of people who are dying for lack of medical care?

Secretary CALIFANO. Mr. Chairman, I do not. I agree with you 100 percent on that. I do not know if it would be supported in the Senate or the administration, but I am willing to try for it.

The CHAIRMAN. Thank you very much.

Mr. Danforth?

Senator DANFORTH. Mr. Secretary, unlike you, I have not been undertaking some crusade against the tobacco companies or

against smoking. I have ashtrays in my office. People are free to use them, and the like. But it seems to me that it is such a natural to finance particularly catastr phic health insurance from a cigarette tax that it is almost impossible to overlook it. Therefore, I wanted to bring it up again on the theory that the first time it may have gone by too quickly.

Secretary CALIFANO. Senator, it did not go by too quickly.

Senator DANFORTH. Now, I think that it is the case that people who smoke cigarettes are much more likely to get sick than people who do not smoke cigarettes. I think that has been shown, and particularly when we talk about catastrophic illness, when we talk about people who have heart disease, people who have lung cancer, the kind of diseases that require long periods of hospitalization. And so it would seem to me that if we are looking for some way to finance a program that is going to be expensive, where are we going to look?

Are we going to look to the ordinary taxpayer? Are we going to increase taxes for everybody? Or are we simply going to increase the rate of inflation for everybody by increasing the deficit?

We do not have any money in the Treasury now to finance these programs, so why not—not from the standpoint of trying to stop people from smoking, but just to finance the program—put the program on that segment of society which is increasing the burden of health costs for the rest of society?

I think that it is true that there have been projections as to the economic costs of cigarette smoking. I think that it is true that there have been projections as to the hospital costs and medical costs of treating people because of cigarette smoking.

Would the administration be willing to take a look at a proposal to finance at least a part of this catastrophic care out of an increased cigarette tax?

Supposing it went up a dime a pack. I do not think people are going to be marching on Washington, saying if we smoke a pack a day, it will cost a dime a day. They put that in the parking meter. In Washington, you cannot even park your car for a dime.

If you raise $3 billion by increasing the price of a package of cigarettes a dime, would that not be worth doing?

Secretary CALIFANO. Senator, the administration will look at this, I assure you of that, but I cannot give you this morning an administration point of view. I gave you my personal point of view, which it is a logical and obvious action you are talking about.

The health care cost of cigarette smoking is somewhere between $5 billion and $7 billion a year in this country. The loss of work, the economic cost, is somewhere between $12 billion and $18 billion.

Of the $15 billion we pay in disability payments $1 billion is attributable to disability caused by cigarettes, lung cancer, heart attacks, stroke, emphysema, chronic respiratory diseases.

Senator DANFORTH. The public in general is paying for that, right?

Secretary CALIFANO. That is right.

Senator DANFORTH. Nonsmokers as well as smokers are paying for that?

Secretary CALIFANO. That is correct.

Senator DANFORTH. It is also true that cigarette smoking is likely to lead to long term health care problems, is that not right?

Secretary CALIFANO. That is correct.

I have no problem with what you are suggesting, but I cannot give you an administration position on that subject. We will look at it.

Senator DANFORTH. The President talks so much about money, balancing the budget, about the size of the deficit, of trying to control the cost of the size of the deficit, if you have a payroll tax, that is inflationary, clearly; so if this is financed by a payroll tax, that is going to be inflationary for everybody. It is a hidden tax, but it is inflationary for everybody. It is going to be passed on to the consumer.

If it is financed out of the deficit, that is, by definition, inflationary for everybody. What are the options? How are we going to pay for this thing?

Secretary CALIFANO. Let me underline one thing. A significant portion of what you pay for can be paid for out of hospital cost containment. If you just took your bill alone, assuming your cost figures are correct at $2 billion or $3 billion a year, you would more than pay for that with hospital cost containment. You would have your bill and some left over.

There is a lot of gross waste that can be moved out of the system that will pay for this.

Senator DANFORTH. Your bill is not going to pay for hospital cost containment.

Secretary CALIFANO. At the lower end of that spectrum, $8 billion a year would be saved if Congress enacts the hospital cost containment legislation. There would still be a need for more money, but the budget could be balanced and the President's plan put into place easily.

Senator DANFORTH. Senator Long and I fought long and hard, a losing battle, against the user fees on the inland waterways. The administration's position was that people who use the inland waterways should pay for them by virtue of paying the user fee. And it would seem to me that under the same logic that those who used hospitals disproportionately to the rest of the population should bear their fair share of the cost rather than leave it to the rest of us to pick up.

I do not say that out of any sense of self-righteousness. I do not happen to smoke myself but, as I say, I am not on a crusade. The fact of the matter is that to the extent that you can put the real cost where it belongs, to the extent that you can put that cost where it belongs in a society, you have a much more realistic economic system than you do where you shift the cost from those, in fact, incurring it to those other people sitting out there to whom it is being spread.

Secretary CALIFANO. Senator, I understand what you are saying about cigarettes and the cigarette tax. I will make sure the administration looks at it. We will look at it. I gave you my personal views.

I would like to make one little footnote. I do not consider the cigarette issue to be some sort of righteous campaign. It is just a simple reality.

What got me involved in that issue was not that I had quit smoking or how hard it was to do that, it is the fact that the people who decide to smoke are the children of this country. No adult 30 years of age says, I weigh the risk of emphysema, cancer, and heart disease and whatever the dubious pleasure of a cigarette is, and I will take the cigarette. That never happens.

Seventy-five percent of the adults who smoke were regular smokers when they were children, before they were 21. It is that fact, the fact that the cigarette companies are targeted on the children of this country, that targeted me on that problem. Targeting is a matter of education and research on why do they do it.

It was a function, also, of the tremendous public price we are paying as taxpayers for that habit in terms of health care cost in medicare and medicaid, among others.

Senator DANFORTH. Do you believe if we were to impose a 10 cent, an additional 10 cents of excise tax on cigarettes earmarked to finance catastrophic health insurance, would the cigarette companies I suppose—I am sure my office will be filled with lobbyists within the next hour, right?

Secretary CALIFANO. No question about it.

The CHAIRMAN. Senator Dole?

Senator DOLE. One way we can make certain is to bring in other groups, alcohol, anything else that might cause us to put a tax on it. It would be pretty complicated, though.

Senator DANFORTH. I would like the chairman to give us the words of that song, "One Step at a Time."

Senator DOLE. "One puff at a time."

It is difficult to know what the administration's proposal will contain. I understand you are still in the process of developing your bill and you indicate in the coming weeks we will have the precise language. Do you have any target date for that?

Secretary CALIFANO. No. I do not have any target date for that, Senator, but we will try to do it as promptly as we can.

Senator DOLE. Would it be some time after the cost containment matter was disposed of?

Secretary CALIFANO. In this committee, at least, and apparently in the Human Resources Committee they are moving very fast on cost containment, so I think that you will probably move on cost containment in the Senate before we come forward, but we may not move that fast in the House.

Senator DOLE. It is not a strategy to wait until we act on cost containment before you bring up your bill?

Secretary CALIFANO. No; that is not a strategy. We are not doing that as a strategy. We do think as we indicated that the single most important act the Congress can take to fight inflation is to pass the hospital cost containment legislation.

We are very grateful and appreciative, and the President is also, for the fact that this committee is currently in the lead on that. You have already started on the markup on that legislation and will pick it up in the week of April 3.

Senator DOLE. We are also moving very rapidly on at least addressing one area of coverage, that is the catastrophic area. Do you suggest we wait until we have the administration's proposal?

Secretary CALIFANO. Of course I would, Senator. There will be so much more additional wisdom in that proposal, that what I have been unable to persuade you of today, you will see when you get the President's message.

Senator DOLE. I think there is a possibility of that, however; I would not want to wait too long.

There is a real problem, as you know, as we are getting into April, May, June, July, a month's recess—of course, maybe we could do it next year. That may be a better time.

I assume that the committee will certainly, in deference to the administration, will wait to see what you propose.

Secretary CALIFANO. We will move as fast as we can on that. We would like to have it appear so that it can be considered as a part of all the other things you are considering.

Senator DOLE. I can understand your position, somewhere between Kennedy and Long must be very comfortable.

Secretary CALIFANO. It is easier than between Kennedy and Carter.

I think that if President Carter can get agreement between Prime Minister Begin and President Sadat, he might be able to get an agreement between Chairman Long and Chairman Kennedy.

Senator DOLE. I think that is a possibility, if you do not go for the comprehensive, if you just go for the one step at a time, which is what finally emerged in the Middle East. I only use that analogy, because I think it does explain our situation. I can see emerging in this committee a consensus. I have looked at at least the highlights of Senator Long's proposal introduced yesterday where the payroll tax was dropped. That would avoid any criticism you had, and it does mandate employers to provide catastrophic coverage. That is in line with the administration's approach, at least in part.

It does allow small employers to take deductions or a tax credit. It does mandate the insurance plan up to dependents aged 26.

If we look at Senator Long's proposal and the 3-D proposal—Domenici, Dole, and Danforth—and what you said this morning, it indicates that there are a lot of areas where there is common agreement and perhaps we could put together a package. In addition, you may have some other areas that we could accommodate.

That is the part we would like to know about.

Secretary CALIFANO. I have given some indication of those areas this morning for the first time and we will move as fast as we can on specific details.

Senator DOLE. Do you know for certain whether you are going to cover the purchase of out-patient drugs?

One problem the elderly face is the increasing out-of-pocket expense and the failure of medicare to cover certain drugs.

Secretary CALIFANO. Senator, that is something that has to be considered. We have looked at that extensively. In fact, I have looked at it abroad as well as here. To the extent they are covered, if they are covered, there would clearly have to be a deductible, I think.

Even when I was in Israel last year, they had tried to provide drugs without any deductible and simply by putting a 5-cent charge per prescription, a nickel charge per each prescription, they re-

duced drug consumption by 10 percent. Even Britain has had to put a deductible on drugs.

Second, I would like to avoid the situation—I gave you the example of cancer patients before—in which we have thousands of people in the hospital that really do not have to be there, but a doctor, acting out of compassion by not wanting to break that person financially, because these cancer drugs cost $200 or $300 a month, puts them into the hospital where medicare pays for it.

If you are home, they will not pay for it, nor if you are in a nursing home. I think we ought to look at that kind of problem.

What we will do, I do not know but we are looking at that.

Senator DOLE. And long-term care, are you looking at that?

Secretary CALIFANO. Long-term care is a very difficult problem. I think we have a modest amount of money to do demonstration projects in that area. I think the extent that long-term care should be included as a part of a health program is questionable, but it should be considered separately.

I think that what we reimburse under some of these programs is accelerating the cost of long-term care. The way the medicare law and regulations are now written, if you own a nursing home and you pay $500,000 for it and you sell it to me for $1 million on the very day, the Federal Government and the States start reimbursing on a depreciation base of $1 million, which some Governors feel have created a lot of sales of nursing homes.

I think we have to change that eventually, and stop that process.

Senator DOLE. Finally, I think both—at least, what I can determine from the general statements and our proposals and Senator Long's, what we are trying to do is make insurance available, guarantee the opportunity to buy health insurance. I assume that is the objective in what I gleaned from your statement, not necessarily pay for everything through the Federal Government, but make certain it is available and in some instances mandated.

That, in itself, based on the statistics that Senator Long addressed, would go a long way in providing coverage.

Secretary CALIFANO. There is common ground, but the kind of mandate we are talking about is not simply for catastrophic coverage. We are talking about other mandating.

I think all of us should look at it. To the extent a consensus develops and it appears we are on the brink of a major new step, like medicare and medicaid in the health area, we should look at ways to get the system skewed a little bit toward ambulatory care and toward preventive care, either as part of the package that we mandate, or in other ways.

Now it is very much skewed toward the most expensive end of the spectrum. I think we would all agree if we are ingenious enough to find a way to change that, we should do that.

The CHAIRMAN. Senator Heinz?

Senator HEINZ. Mr. Secretary, in terms of the mandate that you have in mind for expanding existing private health insurance coverage, I note that approximately 45 percent of all the people in the United States who are now uncovered are members of a family where the head of the household is covered by some form of health insurance; and 23.9 percent of that 45 percent are, in fact, people

who are uncovered, whose insurance is privately provided for the head of the household, the family head.

Do you anticipate that your proposal will mandate coverage of all such uncovered individuals?

Secretary CALIFANO. Ultimately.

When a final plan is in place, every man, woman, and child would be covered. How much of that problem you mentioned we would take care of in the first phase, I cannot answer at this point in time.

Senator HEINZ. I would hope that when you do send your plan down, phase I, so to speak, in terms of the actual legislation in respect to the other phases, that you will be as specific as possible on items such as this and supply to us your estimated cost and who is going to bear those costs.

It seems to me that that is terribly important if we are to understand how these changes are going to be financed.

We have a $2 billion health care expenditure now. It would be nice to know if we are going to have a $250 billion or $300 billion a year expenditure in constant 1979 dollars 10 years from now.

Secretary CALIFANO. In constant 1980 dollars, the kind of national health plan that we have been considering, if fully implemented by 1990, would cost 10 percent less, or more than 10 percent less, than the system we are now in. Without any cost containment, the system we are now in would cost well over—as I have said many times—would cost almost three-quarters of a trillion dollars by 1990, and if we just stay the way we are going, any national health plan with effective cost controls would be maybe as much as $100 billion less.

Senator HEINZ. Not in constant dollars?

Secretary CALIFANO. Yes; less, in constant, in 1980 dollars.

Senator HEINZ. I hope you will supply us with a summary of those statistics in some kind of constant dollar measurement. One can play all kinds of numbers games depending on what kind of inflation rate is projected.

Secretary CALIFANO. No inflation rate; those are 1980 dollars.

Senator HEINZ. Turning to a more discrete part of that, the plan you are now putting together in the Department, is it going to provide such complete coverage for elderly people under medicare that they are no longer going to fall prey to the pushers of medigap insurance?

Secretary CALIFANO. Yes; I would hope so. We put out some regulation in the program through medicare and medicaid to try to deal with that program. I think there are two additional important pieces: A million elderly people not now covered who were not grandfathered in when the program became effective and not on social security; and the deductibles, the first day deductible and the deductible under part B.

Senator HEINZ. Is that to say that after phase I goes into effect, elderly people will not need supplemental policies at all?

Secretary CALIFANO. I am not sure that will be the case. One of the options under consideration would look at that problem, but all these things have to weighed to decide the extent you want to take care of that. It costs money and would increase the cost of the 3-D $2 billion bill.

First, we will make recommendations that will be very clear in that area, and we will hopefully be prepared to run a kind of alternative cost as we were in respect to the welfare program when we recommended that last year.

Senator HEINZ. Thank you, Mr. Chairman.

Thank you, Mr. Secretary.

The CHAIRMAN. Thank you very much, Mr. Secretary. I think our discussion today has been enlightening. It provided both the media and all those who are here covering this for the Senators for whom they work some very useful information on which we can proceed.

Senator Stewart of Alabama was here and he had planned to make his statement but he had to leave, and I would like to ask unanimous consent that his statement appear in the record just as though he had sat at that witness stand and presented it.

[The prepared statement of Hon. Donald W. Stewart follows:]

STATEMENT OF SENATOR DONALD W. STEWART

Senator STEWART. Mr. Chairman, members of the health subcommittee, I appreciate the opportunity to testify on behalf of Senate bill 351, the catastrophic health insurance bill. The catastrophic health insurance program proposed by this bill will meet a serious need among millions of Americans.

While I recognize the need for some sort of broader comprehensive national health insurance, I am convinced that we cannot afford this type of program in this tight budget year. The most pared down comprehensive national health insurance proposal has a price tag in excess of $20 billion. The taxpayers of this country want some protection against medical bills, but I believe that they want relief from high taxes and runaway inflation more. The President has said that one of his top priorities is slowing the rate of inflation. According to the most recent figures, prices in the American economy are growing at a rate of 15.8 percent per year. A major new budget expenditure for national health insurance can only worsen our present inflationary spiral.

I believe that the American public wants us here in Congress to approach the serious problem of adequate health care in America in the same way that they must approach their serious problems every day. As bad as junior needs a new coat, John Q. Taxpayer must see whether he can afford it first. If he can't, then junior will just have to make do for a while.

Mr. Chairman and Members of the committee, I believe we cannot afford any type of comprehensive health insurance at this time. I also believe that there is a critical need in a specific area of health cost that we can address within our budgeting capacity. I believe that S. 351 addresses that specific problem at a cost that won't break the back of the American taxpayer and will not add substantially to the already runaway inflation rate.

Furthermore I am opposed to any further Government involvement in health care. Our experiences with existing government health care programs should have taught us an important lesson. That lesson is that health care is most effeciently and effectively administered by the private sector.

The problem that S. 351 will address is one that millions of Americans face each year. That problem is catastrophic medical expenses. This problem cuts across all classes and age groups. Let me show you what I'm talking about. A fellow in Alabama who worked as a laborer making about $6,500 a year found out his wife was expecting a child. Unlike many of us, his family was not covered by a health insurance program at his job. What he did was to set the money aside so that he could pay the hospital bill when his wife was ready to deliver. In 7 months, he was able to put away almost $2,000. Under ordinary circumstances this would have been more than enough to cover the cost of the delivery.

Unfortunately, my constituent had a little surprise. It became apparent that his wife would deliver twins. This fact alone would make many of us happy. However, because his wife was diabetic, complications developed and both babies had to be kept in the hospital for an additional week. This not only consumed the $2,000 that our friend had set aside for the medical cost, but came to more than $3,000 in additional costs. My constituent just could not pay it. He had to sign a note for the remainder of the bill to get his wife and babies out of the hospital. Quite frankly with a $6,500 a year income and a wife and two babies to support, I don't see how he's going to pay it.

Another couple I know get their only income from social security. The wife is 80 years old and her husband is 89 years old. The only thing of any great value they own is the house they live in. Last year the husband broke his hip. As a result of his advanced age and a persistent prostate condition, there were complications. He had to have a prostate operation and spent almost 6 weeks in the hospital. The bill for this was more than $10,000. Although the couple was covered by medicare they found that a portion of the bill would not be paid for by medicare. What that meant is that this elderly couple was left with a substantial hospital bill and had absolutely no way of paying it, short of selling their home. They couldn't qualify for medicaid because they owned the house. I ask you, what do we tell this couple?

As I said before, this problem of catastrophic health expenses puts us all in financial jeopardy. A recent HEW report estimated that at least 36 percent of the Americans are not protected against high cost health catastrophies. In 1977, national health expenditures were $162.6 billion or $737 per person. An increasing proportion of these expenditures were catastrophic expenses coming out of the pockets of the patients. In many cases this meant selling the family home or going into debt.

One of the major killers in America today is cancer. According to a recent HEW study on health in the United States in 1975, the total cost for cancer treatment was over $5 billion. More than $4 billion of this amount was for hospital stays. In 1975, 172,000 Americans died from cancer. Many, if not most, of this number died in debt as a result of the cost of cancer treatment. At current hospital and treatment costs a year of cancer treatment could bankrupt an American with an income in excess of $30,000 per year and owning his own home.

Another one of my constituents found out that he had lung cancer about 1½ years ago. He was admitted to a hospital to have

surgery to remove the cancer. Unfortunately, the doctors found that the cancer was still present in another part of his body. They then began to administer chemotherapy. This fellow had been teaching at a university. After the operation and the chemotherapy, he wasn't able to do this anymore. The health plan at the university paid many of the hospital bills at first. About 2 months after he started receiving the treatments he was informed that he had reached the limit of his coverage. He was forced to draw on money which he had set aside for retirement. Soon this too was exhausted. He ended up taking another mortgage out on his home. Last June this fellow died. His family was not only saddened by his departure, but left with huge debts to be paid.

I could go on with more of these kinds of incidents. They are happening right now. Millions of hard working American families are being ruined by catastrophic health expenses. They need some relief right now. I sincerely believe that S. 351 offers the relief that these folks need.

Please don't reject this sound solution to the problem catastrophic health expenses just because it doesn't deal with all the problems in that area. Although I am new in the U.S. Senate, my experience has taught me to be wary of one shot solutions to a multiplicity of related problems. Now is the time for us to identify problems in the area of hospital cost and address them in a focused and fiscally responsible way. That is just the approach the S. 351 takes to the problem of catastrophic hospital cost.

I will not address specific provisions of the act because others wish to express their views on this subject, and the members of the subcommittee will have an opportunity to examine the bill in great detail. However, I will say that the bills incentives for private insurers involvement in the catastrophic health insurance field insure that we won't be creating another massive bureaucracy and that the consumer will get the benefit of private competition in the marketplace.

I'd like to thank the chairman and members of the subcommittee for the opportunity to testify on behalf of S. 351. I hope that what I have said will be helpful in your consideration of this important legislation.

The CHAIRMAN. We appreciate your appearance here, Mr. Secretary. We are pleased to see Mr. Mongan back with you. We think he has given some very useful information here today.

Secretary CALIFANO. Thank you, Mr. Chairman. I appreciate the opportunity, as always, to appear before this committee.

The CHAIRMAN. Thank you very much, sir.

[The prepared statement of Secretary Califano follows:]

STATEMENT OF SECRETARY JOSEPH A. CALIFANO, JR. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Mr. Chairman, I appreciate the opportunity this morning to discuss with this distinguished Committee an issue of major importance to our citizens—a national health plan.

It is appropriate that I appear before you since this Committee has historically provided leadership in health care finance. In the last Congress, for example, this Committee reported a number of important measures—ranging from expanded Medicare and Medicaid benefits under the rural clinics bill to improving the management of those programs under the fraud and abuse bill.

In addition to your important work on Medicare and Medicaid, you and other members of this Committee have, in recent years, contributed to the national health insurance debate.

We believe that this hearing marks an important turning point in the development of national health policy.

President Carter hopes that the 96th Congress can take a significiant step towards a comprehensive national health program. In the coming weeks, the Administration will propose a Phase I bill—a bill that, contrary to some reports, does not just provide protection against the costs of catastrophic illness. Indeed, we oppose a "catastrophic only" approach. Instead, we will seek to improve coverage for all segments of the population—the aged, the poor, the employed and others—and will seek to put in place new structures which will require only future expansion for the realization of President Carter's goal of a universal, comprehensive plan.

The 96th Congress has the opportunity to be remembered in history as the Health Care Congress—has the chance to enact a seminal piece of legislation that has eluded Presidents and Congressional leaders for three decades.

Few ideas have been the subject of more national debate and less Congressional action than National Health Insurance. Not only have Presidents since Harry Truman sought passage of a National Health Insurance Plan, but in the last decade a number of proposals have been introduced in the Congress.

Yet only one of these bills has emerged from a full Committee of the Senate—the Committee on Finance. None has been reported out by a full Committee of the House. And neither house of the Congress has approved a National Health Insurance proposal

It is imperative, therefore, that we in the Administration and you in the Congress who are deeply concerned about the state of health care in the United States work together to devise a strong piece of legislation—but a piece of legislation that, unlike past proposals in this area, can be enacted into law.

THE PRESIDENT'S DECISION

Last July, the President directed me to develop a tentative National Health Plan to assure that "all Americans have comprehensive health care coverage." He also directed me to develop several "alternative methods for phasing in the plan over time."

He asked for a plan that would not only increase health insurance coverage but that would seek to bring skyrocketing health costs under control, to increase the efficiency and fairness of our health care system, to make quality health care more widely available, and to devote more health resources to disease prevention and health promotion.

We developed that tentative plan and some phasing alternatives. In January, the President asked me to consult widely so that he could determine the best course of action for introducing a bill in the 96th Congress.

Since January, my colleagues and I have consulted Members of Congress, including committee and subcommittee chairmen, and health industry experts.

With few exceptions, the consensus among legislators is that the 96th Congress cannot and will not digest a complete National Health Plan in one bite. The overwhelming number of those who favor eventual adoption of a National Health Plan urged me to bring this message back to the President: Ask the President to limit his legislative recommendation to the first phase of a National Health Plan and to describe his vision of a total plan so we can put that phase in context.

There were, of course, many specific suggestions, but that was the general consensus, with a strong sense of the need to contain costs, to reform the system and to focus more attention on prevention.

Based on those consultations and on important budgetary, economic and administrative considerations, the President last week made a broad decision that has two main features:

First, the President has decided to send to the Congress a message outlining a universal, comprehensive National Health Plan. As noted, the President remains committed to the goal of providing every American with coverage for basic health services.

Second, the President will at the same time send to the Congress specific legislation that will embody the first phase of a universal, comprehensive plan. This bill, which would have no significant budgetary impact until fiscal 1983, will constitute a significant step towards instituting basic reforms in our health system and ensuring that all Americans have adequate protection against the costs of medical care. The Phase I legislation will, when fully in place, represent an additional $10 to $15 billion investment, in today's dollars, in health care for Americans—an investment

which can be substantially offset by effective cost containment and health system reforms.

In the coming weeks, we will develop this final Phase I bill and the final description of the comprehensive, universal plan in consultation with key Congressional and other leaders.

The President's Phase I bill will build upon the strengths not only of the Administration's work, but also the work done in this area by members of the Congress. I hope that the proposal will attract a broad base of support, both from those who think that Phase I is all that we should do and from those who wish to do more.

It is rarely possible to solve every problem in an important sphere of our national life in a single bill. But, by proceeding step-by-step, we can nonetheless make advances of extraordinary significance. Lyndon Johnson recognized that Medicare and Medicaid would not meet the health needs of all Americans—but he also knew it would help millions of our citizens.

President Carter recognized that the Child Health Assurance Program would not meet the health needs of every low income citizen—but he also knew when he proposed it two years ago, just as he knows when the bill is reintroduced this year, that it will help more than 2 million low income mothers and children. And President Carter recognizes that our Phase I bill will not solve every health problem in this nation—but he also knows that, if enacted, it will represent a giant stride forward in providing equitable, adequate and cost-conscious health protection to all Americans.

Let us not be mesmerized—or immobilized—by our desire to achieve a universal and comprehensive plan. Let us instead bend every effort in the 96th Congress to make an important part of that noble dream reality.

Let me emphasize one other point: Enactment of a Phase I bill must be based on passage of effective hospital cost containment legislation. Only when we contain unnecessary costs in the health care system can we responsibly seek to implement necessary new health benefits.

THE HEALTH CARE INDUSTRY

As we open the national health plan debate in the 96th Congress, we all recognize that we will be dealing with a highly complex subject—with significant implications for our health care system, for the fiscal and budgetary policy of the Federal Government and for the state of our nation's economy.

Health care in the United States is not just men and women dressed in white coats carrying little black bags ministering to the infirm. It is also, as this Subcommittee knows well, big business.

In fact, the health care industry is our nation's third largest—with expenditures of $206 billion, or 9.1 percent of the Gross National Product, in Fiscal 1979.

6 million persons—about 6 percent of the labor force—are employed in the health care industry.

More than 12 and a half cents of every Federal tax dollar—nearly $62 billion in the Fiscal 1979 Federal budget—is spent on health care costs, and States and localities spend an additional $25 billion annually.

In Fiscal 1978, there were 38 million hospital admissions; 162 million Americans visited a physician at least once (with the average person making 4.8 visits annually); more than a billion and a half prescriptons were filled; and 5 billion laboratory tests were ordered.

These figures alone reflect the complexity—and the potential difficulty—of making needed changes in an industry that is not subject to the normal economic forces of the free market.

THE NEED FOR A NATIONAL HEALTH PLAN

Yet, both the Administration and the members of this Committee share a strong belief that it is imperative to make some basic changes in the health care industry. Our present health care system is fundamentally flawed—with nearly $87 billion in Federal and State health spending for Fiscal 1979, and with Federal, State and local governments paying nearly 55 percent of all hospital bills, we already have part of a national health "plan". But this plan does not meet the primary objective of our nation's health policy—providing quality care to all Americans at an affordable price.

To be sure, there is a good deal that is right with the health system in the United States today. Health status has been gradually improving, and health insurance protection through public and private programs has been growing.

But there is also a good deal wrong with the health system in the United States today. We believe that there are three sets of problems facing our health care

system today which can only be effectively addressed through a national health program.

First, millions of Americans lack coverage for basic health services and lack protection from extraordinary medical expenses.

Some 7 million Americans below the poverty line have no health insurance, and, depending on estimates, about 11 million above the poverty line have no coverage.

More than 19 million Americans have inadequate insurance that fails to cover basic hospital bills, doctors' services or medical tests, and, of these, 16 million have incomes above the poverty line, 3 million below the poverty line.

About 83 million Americans (40 percent of the population) have no insurance against very large medical bills.

Moreover, the very common exclusions and limitations which are present in current coverage severely limit health coverage for the average American family.

Many middle class families in the United States find that when a child becomes 21 years old, he or she loses coverage and is not able to afford coverage on their own.

Because of the existence of a pre-existing medical condition, literally millions find they are unable to obtain health insurance protection.

Other citizens find they are without health insurance during periods of unemployment and do not qualify for public programs.

In sum, Mr. Chairman, the problem of inadequate insurance coverage is pervasive. I believe that it can only be dealt with in the context of a broadly structured national health program which includes not only protection against the cost of major illness, but also provisions which begin to address the other serious failures of present health insurance coverage.

Second, the costs of health care are sharply increasing, adding to inflation and threatening the stability of governmental budgets. Spending in the health care industry rose at an average annual rate of 12.7 percent from 1968 to 1978. Unless we can institute meaningful cost containment measures through hospital cost containment and effective restraints in a National Health Plan:

National health care costs will rise to $368 billion by fiscal 1984—nearly 10.2 percent of GNP.

Federal health care expenditures will rise to nearly $116 billion by Fiscal 1984—more than 15 cents of every Federal tax dollar under current projections for that year.

The cost of individual health care will rise steeply. The average cost for a family of four will leap from $2,372 in 1979 to $4,064 in 1984, and the average cost for an elderly individual will soar from $2,259 to $3,868 during the same period.

The rise in health costs can be partly explained by increased demand for health care with the passage of Medicare and Medicaid and by advances in medical technology. But sharply escalating health care costs are primarily the result of other factors, the most salient being the failure of the traditional competitive forces of the marketplace to operate in the health care industry.

More than 90 percent of all hospital bills are paid by third parties—insurance companies, Medicaid, or Medicare. Thus neither the consumer (the patient) nor the provider (the doctor and the hospital) directly feel the pinch of rising costs.

The third parties customarily pay for services rendered to these beneficiaries on an inefficient and inflationary cost-plus basis.

Customary interactions between buyers and sellers do not take place in the hospital industry. Most decisions in the health care marketplace are made by the provider, not the consumer: physicians control 70 percent of all health care decisions. As a result, the normal mechanisms of the marketplace, like competition, have not worked to bring down costs. Physicians often know little about the cost of the services they order—and they have little incentive to find out.

These factors have combined, we believe, to give us a health care system which is not only inefficient in its operations, but also incapable of producing disciplined financial judgments.

Government shares the blame with those in the medical care sector for this current state of events because we have created a system which has rewarded profligacy and penalized effective management. The reimbursement methods of Medicare and Medicaid, for example, have failed, and so have some of our administrative techniques. This time we must make sure that as we seek to solve health problems, we do not create financial ones.

Mr. Chairman, the pervasiveness of these problems also leads us to the conclusion that the only way to deal with escalating health costs is in the context of a broadly based national health plan, including fundamental changes in our reimbursement mechanisms.

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Third, systematic reforms are needed to increase access to health services, to provide more appropriate types of services and to eliminate the inefficiency and lack of competition in the health care industry. For example:

Health services are poorly distributed within our nation—we estimate that almost 51 million citizens live in medically underserved areas.

Private health insurance contracts often do not cover preventive and ambulatory services—those services which are among the most beneficial and the most cost effective.

In many areas of this nation, citizens do not have the option of choosing efficient health maintenance organizations or other alternative systems of health care delivery.

Mr. Chairman, these are the fundamental problems that demand solution if our health care system is truly to serve the American people.

THE ADMINISTRATION'S APPROACH

I have been deliberately referring to the Administration's concern in establishing a national health program not a national health insurance program. I choose these words carefully. From the outset, the President instructed us to put together a program which dealt not only with the lack of insurance coverage in the health care industry, but with the broad range of problems which exist in our health care system today.

The existence of this broad and varied set of defects in our present health system again has led us to the conclusion that we must deal with these interrelated problems, to the greatest extent possible, in the context of a broadly conceived national health plan.

In the 2 years that this Administration has been in office, we have undertaken a number of initiatives designed to remedy these defects. We have, for example, proposed hospital cost containment legislation, sought to improve the administration of Medicare and Medicaid, fostered needed competition in the health care system by strongly supporting Health Maintenance Organizations, developed proposals in the vital areas of alcoholism and mental health, and emphasized critically important disease prevention and health promotion activities, including a campaign against our nation's number one preventable health hazard: smoking.

Thus, the President has decided that our Phase I bill should, when it is sent to the Congress, be accompanied by, and be consistent with, a broader National Health Plan and with the important initiatives we have taken to date. The Phase I bill should, in other words, be constructed so that it can evolve easily towards a completed National Health Plan.

Although, as noted, we are in the process of developing our Phase I bill, I can sketch in broadly this morning some of its major elements.

General structure.—The overall structure of Phase I will have three major components:

First, coverage of full-time employed individuals and their families will be predicated upon mandated employer coverage that will effectively require most, and possibly all, employers to provide private insurance that has a core level of protection and that meets other basic standards. To the extent possible, this coverage should provide incentives for less expensive preventive and outpatient services over more expensive services within a hospital.

We believe that to minimize federal involvement and efficiently deploy available resources it makes sense to build on the foundation of existing private insurance coverage.

Second, Publicly financed health care programs will provide coverage for the aged and the poor.

To the greatest extent possible, we will seek to integrate, to make uniform and to make efficient program administration and reimbursement systems in these public programs. For example, serious administrative difficulties exist in Medicaid because we have 53 different programs (in all the States except Arizona and in the territories), not a single program.

Third, for those not protected by employer coverage or by the public programs for the poor and the aged, the Federal government will guarantee the opportunity to buy health insurance at a reasonable rate. In the Phase I bill, this Federal guarantee will provide the opportunity to purchase more affordable quality protection against the costs of major illness. At present, such an opportunity for coverage does not exist for millions of non-poor, non-aged, non-employed Americans.

The aged and disabled.—The Phase I bill will obviously continue to provide the benefits offered under the current Medicare program and will also include additional protection for our elderly and disabled citizens. We must especially ensure that

our elderly citizens are not devastated by the cost of major illnesses. We will also consider making more accessible to the elderly methods of therapy that could reduce the need for extended hospitalization.

The poor.—The Phase I bill would significantly expand the number of America's poor who would be covered fully for their medical expenses. The plan would expand coverage, in part, by setting eligibility for millions of our poor at uniform income levels nationwide, thus remedying the striking interstate inequities that exist in the present Medicaid program.

The employed.—As indicated above, the Phase I bill will establish mandatory standards for private insurance coverage provided by employers. These standards could include:

quality requirements,

a core benefit package that includes hospital and physician services, X-rays and laboratory tests and that, to the extent possible, encourages preventive services and outpatient care, and

extension of coverage for a certain period beyond termination of employment.

The Phase I bill will mandate that qualified employer plans protect families against major expenses by limiting their financial obligation to a reasonable ceiling in a given year. This financial protection could be expanded in subsequent years.

In addition, the plan may mandate that employers maintain their current financial contributions per employee for health insurance coverage.

We will look carefully at the impact these requirements have on business, especially on small and low-wage firms.

All others.—For all those who are not employed and who are not otherwise covered through the provisions for the aged and the poor or through other private insurance, the Phase I bill would, as noted, seek to make quality coverage against major illness more affordable.

Thus, health coverage that puts a ceiling on the direct health costs that must be borne in any year will be universally available.

Cost containment and other health system reforms.—Finally, and of critical importance, the plan would include a series of cost containment and delivery system reform provisions.

The hospital provisions will build upon the President's Hospital Cost Containment bill which was introduced earlier this month and which is currently before this Committee. We will also be considering provisions to reform our current open-ended mechanisms of physician reimbursement.

The system reform provisions will, as noted, also build on a number of important on-going Administration efforts such as encouragement of health maintenance organizations, limitations on capital expenditures, and provisions aimed at assessing the appropriateness of new technological advances in the health care area. In a few weeks, we will be proposing legislation that will encourage many more Medicare beneficiaries to join cost-effective HMO's by allowing them to benefit directly if they choose this health delivery system.

Moreover, the legislation we will submit later this year seeking reauthorization of the health manpower laws will also be linked to resource planning for our Phase I bill.

Cost sharing.—The Phase I bill will involve cost-sharing for all but the poor. As noted, a reasonable ceiling will, however, be placed on the amount any family or individual would be required to pay for direct medical expenses in any year.

Federal financing.—There will be no payroll tax increases required by President Carter's Phase I bill. Additional federal expenditures will be financed by general revenues.

In sum, our proposal for the first phase of a national health program will contain provisions aimed at improving coverage from the outset for all groups in the population and putting in place necessary cost control and system reform provisions. I must emphasize the importance of laying a firm foundation for eventual expansion of the program to deal with problems beyond the reach of our current resources.

THE PROPOSALS BEFORE THE COMMITTEE

Mr. Chairman, let me now briefly summarize the two health insurance measures currently before this committee as we understand them.

S. 351 consists of two parts:

The first title of the bill is a catastrophic health insurance program which provides protection for all residents. It operates primarily through a federally administered public plan for the unemployed, welfare recipients, the aged and persons who do not opt for private insurance coverage. The program would be

financed through a 1 percent tax on the payroll of employers, tax credits and an offset for private insurance premiums. Employers and the self-employed could buy a private catastrophic insurance plan and the premium costs would be subtracted from the payroll tax obligation.

Benefits would be similar to those offered currently under Medicare, but would be subject to two deductibles—$2,000 of medical expense and hospital stays of 60 days. With the cost of a hospital day averaging $215, this could mean that a hospitalized person, without any other hospital insurance, would have to pay $12,900 in hospital expenses before he or she would receive financial protection.

The second title of the bill consists of a voluntary federal certification program for basic private health insurance designed to encourage private insurers to make such coverage avialable in all parts of the country.

The second bill—S. 350—contains the features just described plus a third title which would replace Medicaid with a uniform, national program of medical benefits for low-income persons. The plan would be administered like the Medicare program and would be financed by federal general revenues and a "maintenance of effort" level by State governments.

We are concerned about both of these proposals, Mr. Chairman, because of the nature of the catastrophic component and because they do not contain enough structural reforms to control costs and to make the health care system more efficient and effective.

We share important common ground, however. Similarities between the key elements of your broader proposal S. 350 and our thinking on the first phase of a national health program include the following:

Both would move towards an improved and more uniform program for the aged, poor, and disabled,

Both would seek protection for the employed population,

Both would involve establishing standards for private insurance coverage, although the voluntary standards in S. 350 and S. 351 will not do the job.

Both would make protection against the cost of major illness universally available although I would underscore our commitment to cost containment and to ensuring that only necessary costs are covered by these provisions.

Mr. Chairman, perhaps our most important concern about the measures before this committee involves the danger of enacting a proposal that deals only with the problems created by the high costs of major illness. We realize the political appeal of and the real need for catastrophic health insurance protection. Our citizens want universal coverage of catastrophic health expenses because they feel it is wrong that Americans continue to face the possibility of being destroyed financially by a major illness or accident.

While we recognize this appeal and affirm this as a real need, we would oppose enactment of a catastrophic health insurance proposal alone because such a proposal poses signficant dangers.

First, we are deeply concerned because a catastrophic proposal, standing alone, could, and I believe would, lead to an escalation of unnecessary expenditures for high cost, high technology care—unless it were to be combined with adequate reimbursement, utilization, and technology controls.

Although catastrophic coverage will meet real needs, and will thus involve necessary costs, it will, without proper structural changes, be an open invitation to profligacy, especially in the hospital sector. With the present cost-plus hospital reimbursement system, increasing coverage for high cost hospital care will, without adequate accompanying reforms, especially reimbursement reforms, lead to additional waste of scarce public funds.

We must thus take great care to ensure that a Phase I bill will not unnecessarily increase expensive inpatient care. And we must, as noted, base a Phase I bill on passage of hospital cost containment legislation.

Second, we are deeply concerned because passage of only a catastrophic bill would not be equitable. Although we all agree that some scarce Federal resources should be allocated to protect Americans from major medical costs, we must use scarce dollars fairly and this means seeking to provide basic health benefits—coverage for regular services, not just those that entail high expense—to those aged and poor who desperately need adequate health care.

Indeed, unless a catastrophic program were combined with more adequate arrangements for basic coverage for the low-income population, it would be a cruel illusion for those citizens. Millions of low-income families would be driven to financial despair before qualifying for assistance under the catastrophic program.

Thus, fairness demands that we take a more balanced approach in order to meet other fundamental health care needs, not just the need for protection against the expense of major illnesses.

Third, we are concerned because enactment of a catastrophic only bill will not establish a framework for realizing our ultimate goal—universal, comprehensive health protection that provides *all* Americans with basic health coverage, for preventive and primary care services, not just protection against the costs of major illness.

Mr. Chairman, catastrophic coverage *alone* while politically responsive may be economically and socially irresponsible, whereas, coverage against the costs of major illness in concert with appropriate structural reforms that lead to a universal, comprehensive plan can be both responsive and responsible as a first step towards a more complete national health program.

Mr. Chairman, let me now briefly describe in a bit more detail some of the problems that we have with S. 350 and S. 351.

Our additional concerns with the catastrophic proposal include the following:

Payroll Tax.—The catastrophic approach in S. 351 is based on a payroll tax. It would, as noted, impose an additional 1 percent tax on taxpayers. By contrast, we favor a using employer coverage.

This approach eliminates any additional increases in the payroll tax, and is more compatible with our eventual goal of using private insurance to mandate greater coverage for our employed citizens.

Deductibles.—The approach in S. 351 has split deductibles, one for physician services and one for hospital services. In addition, the deductibles are "unbalanced" in the sense that many more families would trigger the two thousand dollar medical deductible than would trigger the sixty day hospital deductible. For example, an individual requiring intensive care for an accidental injury might easily run up physician bills of $3,000 and hospital bills of another $10,000. Yet if he were hospitalized for 45 days and had no other insurance, the S. 351 would only help him with $1,000 in doctors' bills and do nothing to help offset the much greater hospital costs of $10,000.

A single method of cost-sharing, with less financial exposure for individuals, would be more equitable in its application to medical and hospital expenses and would also be easier to administer.

This is a point of great significance, Mr. Chairman. As presently designed, the deductible in S. 351 could be so large that they would cause some American families great hardship. Our Phase I bill would provide significantly more financial protection.

Incentives and controls.—The approach in S. 351 is based on continuing present Medicare reimbursement and utilization controls. As noted, we favor reimbursement controls based on our hospital cost containment legislation. We also favor strengthened controls on capital expenditures and health care technology. We feel that the strengthened controls are essential for a catastrophic program and that our current Medicare controls are not enough.

There are many similarities between the "Standards" title in S. 351 and our own thoughts on setting out standards for private insurance as part of a first phase of a national health program. Our key difference in this area is that the standards under the S. 350 and S. 351 are only applied in a voluntary fashion to the insurance industry. In other words, if an insurance company offers a policy meeting the standards that policy can receive a "good housekeeping seal."

To make any standards effective, the incentive probably should go beyond the mere receipt of a government seal. For example, the provisions of the tax code could be changed so that a policy which did not meet standards would not be eligible for a tax deduction. Further, we could mandate that any policies offered by employers must meet any standards established in the Phase I bill.

Finally, there are many similarities between our approach to the problems of improving coverage for the low-income population and the approach embodied in S. 350. However, both S. 350 and our Phase I bill will, to the extent possible, have to deal with two major problems.

The near poor.—In designing subsidies for those near-poor who are not fully covered under the low-income public plan, we must seek to reduce heavy financial burdens and provide work incentives to the greatest extent possible.

State financing.—S. 351 essentially limits present State financing for Medicaid acute care services and would require States to maintain that level of financing. This kind of provision would tend to penalize the States which had done the most under Medicaid and would reward those States which had done the least. An

equitable approach to States roles under a Phase I bill is one of the key problems that our bill will seek to address.

Mr. Chairman, we have described our differences and problems. But, in closing, I would emphasize our desire to build upon important areas of agreement between the administration and your commitment to improve health benefits for millions of Americans in a fiscally responsible way. The broader bill, S. 350, sponsored by you and Senator Ribicoff, is a constructive starting point for our discussions.

The Finance Committee, the other Committees in both the Senate and the House with health jurisdiction, and the Members of the Congress as a whole have an historic opportunity. Together we can make significant, structurally sound improvements in our nation's health care system—improvements that would expand coverage to meet critical needs, that would help contain escalating health costs, that would increase the quality, efficiency and fairness of America's health care system and that, most importantly, would lay the groundwork for the universal and comprehensive health plan that is President Carter's ultimate goal.

In the coming weeks, as we present our legislative proposals to you, I hope that we can find substantial common ground in our mutual quest for a health care system that responds to our citizens' health care needs and reforms the structure of our delivery system to contain costs, increase efficiency and make quality care more widely available.

The CHAIRMAN. Now, we will hear from Mr. William R. Hutton; executive director, National Council of Senior Citizens.

Mr. HUTTON. Mr. Chairman, I am accompanied this morning by Miss Betty Duskin, the director of research with the national council, and an economist, and she would be prepared to answer questions with me, if that is acceptable.

STATEMENT OF WILLIAM R. HUTTON, EXECUTIVE DIRECTOR, NATIONAL COUNCIL OF SENIOR CITIZENS, ACCOMPANIED BY BETTY DUSKIN, DIRECTOR OF RESEARCH, NATIONAL COUNCIL OF SENIOR CITIZENS

Mr. HUTTON. I am William R. Hutton. I am executive director of the National Council of Senior Citizens.

The National Council is a nonprofit, membership organization of over 3,800 affiliated clubs, and State and area councils, representing 3.5 million older Americans.

As you may recall, Mr. Chairman, the National Council was born in the fight to enact medicare. Although it has been said that we won that battle, with hindsight that alleged victory appears shallow. Not that we would have been better off without medicare, but we would have been better off if we had been steadfast in opposing the private insurance model. To our undying regret, we compromised.

The results of that compromise haunt us to this day. The program, which was intended to provide financial access to health care for millions of elderly and disabled, has experienced continuous erosion of its value to beneficiaries. Today, it protects only providers. On average, only 38 percent of the health care costs of the elderly are reimbursed by medicare.

The part A deductible has risen from $40 at the inception of the program to $160 today; acceptance of assignment by physicians under part B continues to decline. The conditions under which assignment is most likely to occur are where there is a risk of collection, and the risk grows as reasonable charges become more and more unreasonable.

Although the program has been a personal boon to providers, it has effected only modest gains to the intended beneficiaries. These

modest gains have extracted an enormous price. Our impatience and our consequent willingness to accept half a loaf created an open-ended checkwriting machine that has fueled inflation—it has not created an improved health care system, just a more expensive one.

Secretary Califano is right when he says that for 30 years efforts to pass a national health insurance proposal have not succeeded.

I was taken with your statement, this morning, Mr. Chairman, that something has to be done for the poor people of this country who really cannot afford any kind of health care. There are 22 million people who have neither any insurance or inadequate insurance, 22 million. They are dying out there, with little attention being paid.

I know that you feel it. I have heard you speak many years on this subject. I hope that something can be done about it. I do not think that $2,000 deductible is going to help those poor people very, very much.

The CHAIRMAN. If I have my voice, we will do something now My approach is we ought to do something now, not wait until kingdom come to do the job. A lot of your people would be dead and gone if we waited on the schedule the administration is talking about.

Mr. HUTTON. Many died in the fight over medicare. If there is one thing about older people, they are looking to a future America. They are not just interested in themselves—interested in their sons and daughters and their grandchildren, and they are willing to fight to improve their lot, not just their own.

As I said, the catastrophic health insurance and medical assistance reform legislation supposedly fills the gaps in medicare and medicaid and provides an umbrella of protection for all Americans against the financial ravages of catastrophic illness and injury. The National Council of Senior Citizens is not against protection from the financial consequences of catastrophic illness, but we submit that the proposed legislation would not do what it purports to do.

First, there is a hospital deductible which triggers coverage after 60 days of utilization. The Congressional Budget Office reports: "For both the aged and the nonaged, most hospital stays will last less than ten days. More than 90 percent will end before the 30th day; and less than 1 percent will exceed 100 days."

Moreover, following the first consecutive 90-day period during which an individual was neither an inpatient in a hospital nor an inpatient in a skilled nursing facility, the individual would once again be liable for the 60-day hospital deductible applicable to catastrophic benefits. This means that a catastrophic occurrence which requires periodic rather than continuous care would subject an individual to more than one hospital deductible during the course of a calendar year.

In fact, it is unclear in the bill whether only catastrophic benefits terminate after a quarter without inpatient status or, even more restrictively, hospital days do not even cumulate to satisfy the deductible when broken by a quarter without an admission. In either case, the plan certainly qualifies as modest.

Second, there is a $2,000 deductible for medical expenses. The same qualifications as above apply with regard to a quarter with

less than $500 in medical expenses. And both deductibles are independent; both must be satisfied for full catastrophic coverage. Again, a modest plan.

Third, uniform deductibles are creatures of the private insurance sector; they in no way take into account the catastrophe that even lesser sums may represent to families with modest or low incomes.

Fourth, the scope of benefits is grossly inadequate. Benefits excluded under medicare would also be excluded under the proposed catastrophic plan. These exclusions include dental care, prescription drugs, and all but very limited mental health and long-term care benefits, among other restrictions. For the elderly, this translates into no catastrophic coverage.

The major catastrophe to the elderly in financial terms is nursing home care. The most frequent length of stay in a nursing home for the elderly is a year or more. Under the bill, the limitations in medicare or skilled nursing care would be retained; no intermediate care is covered.

Fifth, the reimbursement would also be the same as in medicare: a reasonable charge basis, and copayments without a limitation or maximum liability.

Yes, the plan is modest from the beneficiaries standpoint. Very few would satisfy the deductibles; for most, catastrophe would occur long before benefit eligibility. But there are extremely important ways in which it is not likely to be modest.

It will reinforce the trend towards high cost, high technology care which may supplant equally effective and appropriate lower cost alternatives.

It will create incentives for longer hospitalization.

It will aggravate the maldistribution of services toward the financially more prosperous.

It will reward specialists with even greater incomes than currently and add to their oversupply.

It will pander to the private insurance interests by legally permitting administered pricing, price discrimination and collusion among private insurers on benefit packages. The 1-percent payroll tax liability on employers will set an effective floor on the cost of private insurance premiums. And the offering by private insurers would be voluntary. They will not be mandated to do anything that is not in their financial interest.

The 50-percent employer tax credit will overcompensate large, prosperous firms and industries relative to current expenditures; it will undercompensate marginal firms and declining industries that cannot now afford such coverage.

To our dismay, the bill also commits an error of omission: The nontreatment of appropriate reimbursement for prepaid practices or HMO's will seriously damage their very existence. Prepaid organizations effect savings to the system because they internalize the risks of providing appropriate care. Yet, they will not be able to recoup the savings generated by their efficient structure under the catastrophic proposal.

In sum, it is the single most effective way to add to medical insurance, bar none. The distribution of benefits to individuals will be regressive. The distribution of financing liability across firms and industries, given the likely effect of the tax credit, will also be

regressive. The benefits that are paid out will accrue to very few. But we will all pay the unnecessary price of continued acceleration of medical inflation.

In regard to the other titles, we are strongly in favor of the federalization of medicaid. Fiscal relief to States is desirable; providing incentives and absolute limitations on States which will work against a more generous program is not desirable. Without incentives for system reform, even a well-intentioned effort bodes disaster for the Nation.

The program for certification of private basic health insurance is too modest for comment.

Senators, we do not fear that these less than comprehensive measures will solve so much of the real problem that the need for comprehensive cradle-to-grave coverage will be eliminated. On the contrary, we fear that the lessons of medicare have gone unnoticed. If we cannot learn from our mistakes, we, the citizens of this country, are forever doomed to inefficient and maldistributed sick care and to medical inflation which robs us of the discretion to address other important needs.

The current catastrophic proposals, as well as the administration's piecemeal approach, remind us of the blind men and the elephant. Each, from his limited vantage point, perceived the elephant differently. Each was in error. But we do know what the elephant, in this case the health care system, looks like. Anything less than comprehensive, universal coverage which addresses reform and containment of the system will be an error on our part. This Nation can afford nothing less.

I would be happy to answer any questions you may have, Mr. Chairman.

The CHAIRMAN. Let me ask you this question, sir.

We have heard a reference to the high-cost, high-technology care that some seem to feel would be provided under the catastrophic insurance proposal. Which of those procedures or services would you recommend that we exclude from the comprehensive program that you advocate?

Mr. HUTTON. Well, I am a supporter of hospital cost containment. In fact, I have a particular example of a hospital bill in front of me from Hollywood Medical Center. It is for a man who was in the hospital 23 days at $195 a day. He died at the end of the 23 days and the bill was passed, of course, through medicare.

The total bill was $77,167.26. He only had to pay $44, his estate had to pay $44, but some of the costs are just amazing to me. $37,652 for drugs in those 23 days in that Hollywood, Fla., hospital. I can understand the $4,495 at $195 a day. Laboratory, $7,496. I can understand some of that, but 37,000 dollars' worth of drugs in 23 days seems to me to be utterly incredible.

These are some of the areas.

Do you have some recommendations?

Dr. DUSKIN. As far as the high-technology reference is concerned, I do not think either Mr. Hutton or myself would want to supplant the discretion of a physician in judging what should and should not be done. However, I believe if we proceed in the direction of catastrophic coverage, we will not only have the problems of the high-technology choices we have today which are not restrained, but at

the unfettered development of other high-technology options which will benefit people very little.

The $77,000 investment paid for by everybody in this country, because the system bears the cost, which did not even provide any significant prolongation of life, leads me to believe that there might have been something there that was not worth doing.

The CHAIRMAN. We are going to go for some sort of hospital cost control legislation. It will be whatever the majority of the Senate wants to do, and what the majority of the House wants to do about the matter.

I am frank to say that I was around here back in the days long before medicare and I recall some of your people said they were not getting anywhere with this effort to have a comprehensive national health insurance program, and they wanted to move to try medicare.

At that particular time, I was not ready to move with it. I thought it was a little ahead of its time, but Senator Anderson was willing to cosponsor it along with Cecil King over there on the House side. Eventually I found myself supporting something along that line. Obviously they had picked up quite a few amendments, refinements that people thought of in the course of the years of study and going through the legislative mill.

But I was concerned about the cost of it then. At that time, your people did not seem to be so concerned. I think their philosophy then was, "Let's get this program into effect and we will try to do something about the cost later on, or those who vote for it can worry about the costs later." That is the impression I gained.

Mr. HUTTON. Some of them, perhaps, but the National Council for Senior Citizens was absolutely opposed to bringing in the Federal intermediaries. We wanted to handle it by social security because it would be much more efficient that way, and I said earlier on on what one of your staffers sitting near me referred to, the Health Insurance Benefits Advisory Council, destined for final death and I sat there for 3 years and listened to the wastage of money because really, the whole thing was controlled by the AMA and its providers.

And the people who represented the people were an absolute minority. They were people who represented, 2 of the 19, who represented the people and the remainder represented providers and every step of the way, the providers were in control.

The CHAIRMAN. All those people you are talking about were selected by the Secretary of HEW to serve on that particular group, too, were they not?

Mr. HUTTON. That is true.

The CHAIRMAN. I am not here to cry screams of anguish about the medicare experience. But the complaints we have had about the cost I predicted before we ever had the program. The kind of thing that I was complaining about from the beginning was that doctors were completely accustomed to looking after a lot of poor cases for which they were not being paid. They were accustomed to looking after their relatives and old friends of the family and so on. They were accustomed to doing those things and not charging. When you put a Government program into effect to do all of that a

lot of otherwise free care is going to be picked up by the Government.

I do not recall anybody's asking me to amend that bill to say we would not be paying for those things.

Mr. HUTTON. We tried several times to reopen discussion on that bill. We were told at that particular time by Members of the Senate and the House that it was much too soon. After all, we had just gotten started on medicare and we had better wait awhile before we offered changes. And we kept doing that for about 10 years and we still had not succeeded in changing any bit of that medicare program.

The CHAIRMAN. For example, if you get around to trying to control the cost of drugs, you will find yourself voting for necessary controls. I do not think we ought to pay whatever is asked, especially for drugs in the public domain.

I think the Secretary ought to have an approved drugs list. While he is approving the drugs themselves, I think he ought to also approve a cost level that he thinks would be fair, not necessarily the lowest cost for which the drug is available on the market, but a range that would preclude somebody charging 3 or 4 or 10 times what it costs to make and market the drug.

I debated that issue down through the years. Someone tried to say that the generic drugs were not good enough, and I would say that is what they gave President Eisenhower when he went over to Walter Reed. They gave him generic drugs. That is what they gave President Johnson when he went over there. That is what they give Senators when they go to Bethesda.

I think that if it is good enough for a Senator or a Member of Congress or the President of the United States, it ought to be good enough for some poor soul who needs the same drug.

Mr. HUTTON. That is right. Generic drug manufacturers make a good profit.

The CHAIRMAN. Sure. They could make a fair profit without putting a new color package on it and saying the drug is better. If it is all tested out to be what it is supposed to be, I do not see where it improves the quality to put a fancy name on it. But I think that the private companies have done a lot to contain costs.

However, look what we have in the Governments' disability program. We have a program exceeding the cost by more than 3 to 1. It may be 5 to 1.

I know why it is doing that. When people apply and ask to be classified as disabled—let's assume it is a person who has had a stroke or has cancer—the sympathy of the Federal employee who processes that claim goes out to the unfortunate victim of the stroke or the cancer.

In many cases, the cancer has been removed but you will not know for 5 years whether they are going to die of cancer. So then, because of the sympathy for the individual, they classify those people as disabled when those people are not totally disabled.

What we ought to do is slot those sort of people into some sort of work that we know they are able to do. Many employers who have sympathy for people of that sort keep them on even though they have reduced productivity.

But of course, if the Government is going to pay the whole thing, you can understand why people would have their Government pay them for total disability even though that is not the case. You have a lot of cases—I am not talking about the aged here, I am talking about people who are in their forties, fifties, and early sixties whose employer would keep them on at the same pay they had been making, knowing they cannot produce as much, but just out of the love of a fellow human being.

But if the Government is going to pay for it, people tend to go down and apply. And with people processing claims who are sympathetic to their plight, they end up on the rolls.

Mr. HUTTON. I agree with you, Mr. Chairman. I employ 10,000 older people out of the Government program. They are older poor people, all under the poverty level. They work 4 hours a day, 5 days a week. They average about $3.25 an hour and they do community service work under nonprofit organizations in the community.

They are proud to work, proud to lift themselves up by their own bootstraps, and that is a very successful kind of program. I am not opposed to that.

The CHAIRMAN. You see, if we had a private insurance company doing the same thing, when these people come in who are not totally and completely disabled as the statute provides, the companies would have to say no because the policy does not cover that and they do not have the money to pay for it. Also the courts could not add all those people to the rolls. They would be confined to holding those companies liable to what the policy requires.

I am not saying we in Congress should not go beyond that and provide benefits to the partially disabled. I am just saying that the tendency for someone working for Government is to be kind and sympathetic toward applicants because it is somebody else's money being handed out. The result is that the cost of the program runs up.

Where you pay an insurer to do a certain thing, he has only a certain amount of money. When the contract requires him to say no, he will have to say no, because he does not have the money to pay any more than that.

Mr. HUTTON. They should hire more of those goodhearted people in the social security offices where the older people stand for hours and get pushed and shoved around, not so much kindness at all, Mr. Chairman.

The CHAIRMAN. I am for treating people as kindly as we know how. One of these days we will get around to doing what we should have done a long time ago, that is, helping people who are disabled or partially disabled—I am talking about handicapped—there are very few people who are totally and permanently disabled.

Most people can do some work. Preference ought to be given for the job they can do. Why should you put somebody who is strong enough to lift 300 pounds over his head in a job that does not require a person to have any physical strength, when you have some dear old person who could do that job.

If you slot your elderly people and your people who are partially disabled into things that they can do and then take these able-bodied people and put them in things that require an able body, we

could make a lot better use of our senior citizens and our disabled people.

Thank you very much, sir.

Senator Dole?

Senator DOLE. Well, I have no question except that I would appreciate it if you would have the chance to comment in writing and make a part of the record both your views on S. 748 and also the proposal introduced by Senator Long, S. 760. I will make this request of the next witness too.

Mr. HUTTON. Yes, we will do that.

It was just announced yesterday; we have not had a chance to study it yet.

[The material to be furnished follows:]

NATIONAL COUNCIL OF SENIOR CITIZENS, INC.,
Washington, D.C., June 18, 1979.

Hon. RUSSELL B. LONG,
Chairman, Senate Finance Committee,
U.S. Senate, Washington, D.C.

DEAR CHAIRMAN LONG: We appreciate the opportunity to comment on S. 748 and S. 760, introduced subsequent to S. 350 and S. 351 on which we have previously testified.

To begin with, NCSC's fundamental and longstanding opposition to the catastrophic health insurance concept is unchanged. Our position with regard to both S. 748 and S. 760 is little different from our position on S. 350 and S. 351 as presented before the Finance Committee earlier this year.

NCSC shares your desire to protect individuals and families from financial ruin which so often accompanies major illness. But we do not subscribe to the belief that adding another increment to existing layers of health insurance is the solution. In fact, NCSC submits that catastrophic health insurance may have precisely the opposite effect than the one intended.

By limiting coverage to only the most expensive forms of treatment, catastrophic health insurance, with its high deductibles, will encourage high intensity medicine and discourage preventive care. Thus inflation in this sector of the economy will continue to rise unabated and indeed be reinforced.

Similarly, high deductibles rather than acting as a limit to individual liability liability tend to be seen as a floor above which the provider of care is guaranteed payment. In this case, the incentive is to increase the price charged the patient in order to trigger-in coverage. Once catastrophic health insurance is triggered, all the physician has to do is write off as a loss any money the patient could not afford to pay out-of-pocket to the doctor.

But even more important, neither S. 748 nor S. 760 protects the average senior citizen from financial bankruptcy. Deductibles as high as $2,000 or $5,000 are well beyond the means of the average social security pensioner whose monthly check is on average $264.00.

Senator Long, NCSC submits that experience with Medicare, including Medicare's deductibles and coinsurance and other large gaps in its coverage, provides overwhelming evidence of the need for a universal comprehensive national health insurance program. Such a program should provide first dollar coverage and force the health care decision-makers, that is the physicians and administrators, to work within a pre-determined negotiated budget. Only system-wide reform with strong built-in cost controls can possibly stave off bankruptcy not only for individuals but also for the nation as a whole. In short, we believe that enactment of a catastrophic health insurance program no matter what sweetners are added by way of improving Medicare, would be penny-wise and pound-foolish.

Sincerely,

WILLIAM R. HUTTON,
Executive Director.

Senator DOLE. The same general objection might apply, but there are some differences. I would appreciate your comments.

The CHAIRMAN. Let me say this to you, Mr. Hutton, while you are here, if it is not in the text of 760, I think if we pass that approach that we will put it in. It would be my estimate if we are

going to have private insurance handle a major portion of this, the catastrophic part if it, we would have the Secretary of HEW pass on the reasonableness of the rates that they charge as well as the service they must provide. And it is my thought that there would be profit.

I do not think there is much profit in group insurance, and basically there should not be much profit in it. They should be paid for what they are doing. Personally I think that they could provide a service, because I think they would not be privileged to do what the Government employee is privileged to do, that is, add people to the rolls pay claims that you should not be paying. I do not think if I were an insurance company and I were providing drugs to somebody, I would pay $40 for a drug that I could get for $4 if I had it within the power of my contract to do so.

Thank you very much.

Mr. HUTTON. Thank you, sir.

[The prepared statement of Mr. Hutton follows:]

STATEMENT OF WILLIAM R. HUTTON, EXECUTIVE DIRECTOR, NATIONAL COUNCIL OF SENIOR CITIZENS

Mr. Chairman, members of the Committee, I am William R. Hutton, Executive Director of the National Council of Senior Citizens. The National Council is a nonprofit, membership organization of over 3,800 affiliated clubs, and state and area councils, representing over 3 ½ million older Americans.

As you may recall, Mr. Chairman, the National Council was born in the fight to enact Medicare. Although it has been said that we won that battle, with hindsight that alleged victory appears shallow. Not that we would have been better off without Medicare! But we would have been better off if we had been steadfast in opposing the private insurance model. To our undying regret, we compromised.

The results of that compromise haunt us to this day. The program, which was intended to provide financial access to health care for millions of elderly and disabled, has experienced continuous erosion of its value to beneficiaries. Today, it protects only providers. On average, only 38 percent of the health care costs of the elderly are reimbursed by Medicare. The Part A deductible has risen from $40 at the inception of the program to $160 today; acceptance of assignment by physicians under Part B continues to decline. The conditions under which assignment is most likely to occur are where there is a risk of collection, and the risk grows as reasonable charges become more and more unreasonable.

Although the program has been a personal boon to providers, it has effected only modest gains to the intended beneficiaries. These modest gains have extracted an enormous price. Our impatience and our consequent willingness to accept half a loaf created an open-ended check writing machine that has fueled inflation—it has not created an improved health care system, just a more expensive one.

Secretary Califano is right when he says that for 30 years efforts to pass a national health insurance proposal have not succeeded. And Medicare has not helped. It has carried within it the inflationary seeds of its own erosion. And it has frustrated our expectations.

But the legacy of frustration has given us something of value. We know now that we must not compromise again!

The Castrophic Health Insurance and Medical Assistance Reform legislation supposedly "fills the gaps in * * * (Medicare and Medicaid) and provides an umbrella of protection for all Americans against the financial ravages of catastrophic illness and injury." The National Council of Senior Citizens is not against protection from the financial consequences of catastrophic illness, but we submit that the proposed legislation would not do what it purports to do.

First, there is a "hospital deductible" which triggers coverage after 60 days of utilization. The Congressional Budget office reports: "For both the aged and the non-aged, most hospital stays will last less than ten days. More than 90 percent will end before the 30th day; and less than 1 percent will exceed 100 days." Moreover, following the first consecutive 90-day period during which an individual was neither an inpatient in a hospital nor an inpatient in a skilled nursing facility, the individual would once again be liable for the 60-day hospital deductible applicable to catastrophic benefits. This means that a catastrophic occurrence which requires

periodic rather than continuous care would subject an individual to more than one hospital deductible during the course of a calendar year.

In fact, it is unclear in the bill whether only catastrophic benefits terminate after a quarter without inpatient status or, even more restrictively, hospital days do not even cumulate to satisfy the deductible when broken by a quarter without an admission. In either case, the plan certainly qualifies as modest.

Second, there is a $2,000 deductible for medical expenses. The same qualifications as above apply with regard to a quarter with less than $500 in medical expenses. And both deductibles are independent; both must be satisfied for full catastrophic coverage. Again, a modest plan.

Third, uniform deductibles are creatures of the private insurance sector; they in no way take into account the "catastrophe" that even lesser sums may represent to families with modest or low incomes.

Fourth, the scope of benefits is grossly inadequate. Benefits excluded under Medicare would also be excluded under the proposed catastrophic plan. These exclusions include dental care, prescription drugs, and all but very limited mental health and long-term care benefits, among other restrictions. For the elderly, this translates into no catastrophic coverage. The major catastrophe to the elderly in financial terms is nursing home care. The most frequent length of stay in a nursing home for the elderly is a year or more. Under the bill, the limitations in Medicare or skilled nursing care would be retained; no intermediate care is covered.

Fifth, the reimbursement would also be the same as in Medicare: a "reasonable charge" basis, and copayments without a limitation or maximum liability.

Yes, the plan is modest from the beneficiaries standpoint. Very few would satisfy the deductibles; for most, catastrophe would occur long before benefit eligibility. But there are extremely important ways in which it is not likely to be modest:

It will reinforce the trend towards high cost, high technology care which may supplant equally effective and appropriate lower cost alternatives.

It will create incentives for longer hospitalization.

It will aggravate the maldistribution of services toward the financially more prosperous.

It will reward specialists with even greater incomes than currently and add to their oversupply.

It will pander to the private insurance interests by legally permitting administered pricing, price discrimination and collusion among private insurors on benefit packages. The 1 percent payroll tax liability on employers will set an effective floor on the cost of private insurance premiums. And the offering by private insurers would be voluntary. They will not be mandated to do any thing that is not in their financial interest.

The 50 percent employer tax credit will overcompensate large, prosperous firms and industries relative to current expenditures; it will undercompensate marginal firms and declining industries that cannot now afford such coverage.

To our dismay, the bill also commits an error of ommission: The "non-treatment" of appropriate reimbursement for prepaid practices or HMO's will seriously damage their very existence. Prepaid organizations effect savings to the system because they internalize the risks of providing appropriate care. Yet, they will not be able to recoup the savings generated by their efficient structure under the catastrophic proposal.

In sum, it is the single most effective way to add to medical inflation, bar none. The distribution of benefits to individuals will be regressive. The distribution of the financing liability across firms and industries, given the likely effect of the tax credit, will also be regressive. The benefits that are paid out will accrue to very few. But we will all pay the unnecessary price of continued acceleration of medical inflation.

In regard to the other titles, we are strongly in favor of the federalization of Medicaid. Fiscal relief to states is desirable; providing incentives and absolute limitations on states which will work against a more generous program is not desirable. Without incentives for system reform, even a well intentioned effort bodes disaster for the nation.

The program for certification of private basic health insurance is too modest for comment.

Senators, we do not fear that these less than comprehensive measures will solve so much of the real problem that the need for comprehensive cradle-to-grave coverage will be eliminated. On the contrary, we fear that the lessons of Medicare have gone unnoticed! If we cannot learn from our mistakes, we, the citizens of this country, are forever doomed to inefficient and maldistributed sick care and to medical inflation which robs us of the discretion to address other important needs.

The current catastrophic proposals, as well as the Administration's piecemeal approach, remind us of the blind men and the elephant. Each, from his limited vantage point, perceived the elephant differently. Each was in error. But we do know what the elephant, in this case the health care system, looks like. Anything less than comprehensive, universal coverage which addresses reform and containment of the system will be an error on our part. This nation can afford nothing less.

The CHAIRMAN. Well, next we will call Mr. James M. Hacking, assistant legislative counsel for Federal legislation, National Retired Teachers Association and also for the American Association of Retired Persons.

STATEMENT OF JAMES M. HACKING, ASSISTANT LEGISLATIVE COUNSEL FOR FEDERAL LEGISLATION, NATIONAL RETIRED TEACHERS ASSOCIATION AND AMERICAN ASSOCIATION OF RETIRED PERSONS

Mr. HACKING. Thank you, Mr. Chairman.

On my right here is Ralph W. Borsodi, a consulting economist with us.

For the record, my name is Jim Hacking, assistant legislative counsel for the National Retired Teachers Association and American Association of Retired Persons. These two organizations have a combined membership nationwide in excess of 12,300,000 older Americans.

We appreciate having the opportunity to be here today to comment upon the Catastrophic Health Insurance and Medical Assistance Reform Act.

In the interest of time, I have omitted certain sections of my prepared statement but I would like them included in the hearing record.

The associations recognize that the elderly have a vital interest in securing protection against the costs of catastrophic illness, and in upgrading and federalizing the medicaid program. While the elderly have a far higher incidence of illness—especially chronic and long-term illness—than any other population group, they are least able to afford the high costs associated with such illness.

In view of these factors, S. 350 is, at first blush, appealing. In addition, because it is a realtively modest proposal in terms of its initial cost and in terms of the health care financial protection it would attempt to provide, its legislative prospects are better than those of more ambitious, competing proposals and that fact adds a measure of lustre to its appeal.

Given these considerations and our associations' own pragmatic approach to obtaining legislation of benefit to the elderly, one would expect us to join with some enthusiasm in support of it. Indeed, when this legislation was first conceived 6 years ago we might have been naive enough to do so. However, we cannot do so now. What stops us—and stops us cold—is the recognition that the fruits of this legislation will be poison.

We now know enough about the incentives that exist in the health sector of the economy—the very incentives that are causing the explosion in health care costs that is creating the need for financial help in the first place—to know that enactment of S. 350 would simply cause providers, and especially hospitals, to escalate costs at even more rapid rates.

This will, in turn, cause the amount of gross national product allocated to medical care and especially to the hospital component of medical care to escalate along with the costs of Government programs, including the one under consideration and out of pocket expenditures by the elderly.

In short, S. 350 will create more catastrophic illnesses than anyone here today ever dreamed possible. Although protecting persons from ruinous health care costs is a laudable objective, this legislation, because it would do nothing to alter or reverse existing economic incentives in the health industry but would simply build on them and make them even more powerful would simply make matters worse.

Those on this committee who are concerned about Federal budget deficits and spiraling inflation in this country ought to think seriously about the economic and health care cost consequences that this legislation will have. We think they will be truly catastrophic.

We urge the members of this committee to consider the historical experience of the medicare program and that of the elderly under that program. In 1967, the program's first full year of operation, the average health bill for an aged person was $532. Medicare paid for 31.8 percent of that.

By 1977, the average bill had increased to $1,738 of which medicare picked up 43 percent. The program had assumed over the period 11 percent more of the tab, but in the meantime, the health bill had more than tripled. It should come as no surprise that the elderly are spending more out of pocket in real dollars for health care now than they did before medicare.

We have no doubt that medicare greatly increased the access of the elderly to health care when it was first implemented. However, Congress was overly generous to health care providers especially hospitals when it determined the manner in which they would be reimbursed. The reasonable cost formula for reimbursement disregarded the procurement safeguards of the Federal Government, dating back to the colonial days. Cost-plus reimbursement procurement without renegotiation has proved to be a blank check to hospitals.

Hospital costs prior to medicare and medicaid had already demonstrated a pronounced tendency to rise at rates higher than prices in general. Between 1950 and 1965, the Consumer Price Index showed an increase in the costs of semiprivate hospital rooms of 2 ½ times, wheras the general level of prices rose over the same period only by one-third. The Federal Government's method of reimbursing costs by blank check to the hospital providers under medicare simply added gasoline to the older inflationary fires.

Third-party payments now make up 92 percent of the income of hospitals. Under third-party-payment procedures, the patient, the Government, and the private insurance company all fail to raise any kind of a restraining hand against rising costs. Indeed, the Government has been using as intermediaries for their disbursements the same insurance companies that are doing private business with the providers; these intermediaries have no incentive to be tough with the providers for the purpose of conserving public funds.

Although the organization and purpose of hospitals may greatly vary, most were organized to serve communities rather than to exist as carefully run businesses. The consequences of pouring money into hospitals under these circumstances should not surprise anyone.

Since 1973, our associations have been pressing for reforms in the methods under which the Federal Government reimburses hospitals. We have also been working to restructure what has been called the delivery system of the health care industry. That delivery system is overly centered on the acute-care hospital.

Our associations strongly believe that the preferable way to control the rise of hospital costs over the long term is to create a variety of health care facilities throughout the urban and rural areas of the country so that the demand on acute-care, high-cost, inpatient hospital facilities is greatly lessened. The promotion of health maintenance organizations, intermediate and long-term-care facilities, community health centers, smaller clinics of all kinds, and home health care should tend to lower costs by creating alternatives to highly specialized care in the acute-care hospitals.

The fact that hospitals are not competitive does not preclude the fostering of competition in the health sector of the economy as the ultimate means of dampening inflation. The type of competition we have in mind is the product competition that would result from encouraging the growth and expansion of alternatives to costly inpatient hospital care. We recognize that there will never be an orderly, competitive market for health care, but the promotion of a variety of health care facilities can only tend to take price pressure off hospitals with respect to inpatient and outpatient facilities. At the same time, these varied facilities would tend to complement the differing health care needs of the elderly and other age groups in the population.

Unfortunately, since the economic stabilization program's phase IV controls expired in 1974, there has been little change in the Nation's dependence on the hospital as the keystone of its health structure, and with the exception of mandatory cost control initiatives in some nine States, reimbursement reform remains largely a matter of debate.

If the program that S. 350 contemplates is simply superimposed on the existing structure of the health industry, even more of our limited financial resources will flow into acute care, hospital facilities, leaving little or nothing for the promotion of less costly alternatives such as home health services and ambulatory care facilities that could help accommodate the presently unmet health care needs of the elderly and enable them to remain active in the community and out of institutions.

While our associations support the idea that all persons, and especially the elderly, ought to be protected against the financial costs of catastrophic illness, any program that undertakes to achieve that goal must come as part of a comprehensive national health program that undertakes to control costs, restructure completely the health care industry, alter the existing incentives and make medical care services available in a cost-effective manner.

While it may be argued that the total cost of S. 350, if enacted this year, would be far less than the cost of any national health

insurance program, the cost of providing catastrophic protection under S. 350 would inevitably exceed the cost of providing the same protection under the kind of NHI program that we have in mind.

Because of the economic consequences that S. 350 would inevitably entail, the NRTA and the AARP chose not to support it. However, because we recognize that this proposal does have some surface appeal and some important political support, I have appended to this statement a detailed and constructive analysis of its provisions.

This concludes my statement. I thank the committee for having had this opportunity to present the associations' views.

The CHAIRMAN. Thank you very much.

Can you tell me what percentage of hospital bills for the elderly are presently being met by medicare?

Mr. HACKING. Medicare, I think, is about 74 percent, or perhaps it is higher than that. It is very high.

The CHAIRMAN. My information is that medicare is providing 95 percent of the hospital costs of the elderly.

When we put medicare into effect, the idea—at least in the beginning—was to pay for hospital costs, not to pay for doctors' bills. It was an afterthought that the proposal was made to add part B, which seeks to protect against medical and other costs.

My proposal would cover medical costs in excess of $2,000.

But the thought occurs to me we are talking about taking care of the costs not presently being provided for. That being the case, it would seem to me it is just a matter of how you want to cover it. The Federal Government could do it with taxes or we could use the private insurance system?

I do not think there is anything especially wrong with either approach. I do believe that more and more people like to have their costs prepaid because they feel that the burden is not as great if you do it that way.

Mr. HACKING. Well, Mr. Chairman, I can simply say that the whole third-party-payment structure, including medicare, medicaid, and private insurance pushes people right through the doors of the hospital in the first instance. The elderly are paying more out of pocket now, more than $600 a year, and most of that out of pocket expense goes for long-term care, which is inadequately covered under medicare.

To have long-term care services covered under a Government program at all, the elderly have to have to impoverish themselves to come in under the medicaid program. What we want to see done is to put together a program that puts emphasis on ways of controlling and containing costs and putting into place incentives that are the reverse of those presently in place. That is going to create a great deal of savings compared to what might otherwise occur under the present system. Those savings will be large and will be sufficient to provide the catastrophic protection we think the elderly and the non elderly need, and also provide basic protection for the general population.

The CHAIRMAN. I have further questions, but I will submit them to you and you can answer them in writing.

[The material to be furnished follows:]

NATIONAL RETIRED TEACHERS ASSOCIATION,
AMERICAN ASSOCIATION OF RETIRED PERSONS,
Washington, D.C., April 9, 1979.

Hon. RUSSELL LONG
Chairman, Senate Committee on Finance,
Dirksen Senate Office Building, Washington, D.C.

DEAR CHAIRMAN LONG: At the conclusion of my March 27 testimony before your committee you asked that I submit a response for the record on the question of whether or not the insurance which the associations endorse for their members covers long-term nursing home and intermediate care services.

The associations sponsor through their group health insurance several health care plans that include among their benefits long-term nursing home care. However, these covered services are limited to the skilled nursing level of care. Moreover, the facility which provides for the services must be Medicare approved or must meet certain other tests indicating a capability of meeting skilled nursing care standards. The exclusions under the plans include sickness or injury caused by acts of war, care for mental, psychoneurotic or personality disorders and a 3 month pre-existing conditions clause.

Although one of the plans does not require a prior hospital stay, the others state that the insured must have been confined in a qualified hospital for at least three days for covered sickness or injury during each benefit period. Also, the insured must enter the skilled nursing facility for the same or related cause for which he was hospitalized and do so within 14 days after leaving the hospital. Finally, the confinement must have been recommended by a physician.

The associations endorse these plans because they are convinced that these plans are among the best available in the private health insurance market place. Although with one exception these plans require prior hospitalization before payment can be made for skilled nursing home services, that fact should not obscure the point made in the testimony before your committee—namely, that the entire structure of the health care industry and third-party payment mechanisms both public and private tend, in the first instance, to push persons into the hospital and thus into the most expensive level of care. Unfortunately, that is the way public and private programs are designed and the hospital is the place where patients must go first if third-party payors are to be called upon to pay for the care received.

As we at the associations see it, S. 350, the Catastrophic Health Insurance and Medical Assistance Reform Act would, because it focuses its financial protection primarily on catastrophic illness treated in the in-patient, acute care hospital setting, have the effect of making even more powerful the incentives that push patients into hospitals, cause hospitals to escalate their costs as they add new beds, equipment and personnel, and absorb even more of the nation's scarce health care financial resources to the detriment of the promotion of less costly means of delivering needed services. At the same time, the elderly, for whom the major cause of financial catastrophy is the cost of long-term care services needed for the treatment of chronic illness, will still have to rely on their own resources to cover these kinds of costs which the current structure of government programs and third party payment mechanisms does not meet.

Sincerely,

JAMES M. HACKING,
Assistant Legislative Counsel.

The CHAIRMAN. Thank you.

[The prepared statement of Mr. Hacking follows:]

STATEMENT OF JAMES M. HACKING FOR THE NATIONAL RETIRED TEACHERS ASSOCIATION AND AMERICAN ASSOCIATION OF RETIRED PERSONS

Mr. Chairman, I am James M. Hacking, Assistant Legislative Counsel for the 12.3 million member National Retired Teachers Association/American Association of Retired Persons. I am accompanied today by Ralph W. Borsodi, one of our Associations' consulting economists and Laurie A. Fiori, one of our Legislative Representatives. We appreciate having this opportunity to address the legislative proposal that is the subject of these hearings—the Catastrophic Health Insurance and Medical Assistance Reform Act of 1979.

The Associations recognize that the elderly have a vital interest in securing protection against the costs of catastrophic illness, and in upgrading and "federalizing" the Medicaid program. While the elderly have a far higher incidence of illness—especially chronic and long term illness—than any other population group, they are least able to afford the high costs associated with such illness. Per capita

health care spending in fiscal 1977 for the elderly was $1,745, more than 2 ½ times that for persons under the age of 65. These statistics, when juxtaposed with income statistics which show that elderly family units have roughly one-half the median income of their younger counterparts, demonstrate just how vulnerable the aged are to high medical costs.

In view of these factors, S. 350 is, at first blush, appealing. In addition, because it is a relatively modest proposal in terms of its initial cost and in terms of the health care financial protection it would attempt to provide, its legislative prospects are better than those of more ambitious, competing proposals and that fact adds a measure of lustre to its appeal. Given these considerations and our Associations own pragmatic approach to obtaining legislation of benefit to the elderly, one would expect us to join with some enthusiasm in support of it. Indeed, when this legislation was first conceived 6 years ago we might have been naive enough to do so. However, we cannot do so now. What stops us—and stops us cold—is the recognition that the fruits of this legislation will be poison.

We now know enough about the incentives that exist in the health sector of the economy—the very incentives that are causing the explosion in health care costs and creating the need for financial help in the first place—to know that enactment of S. 350 would simply cause providers, and especially hospitals, to escalate costs at even more rapid rates. This will, in turn, cause the amount of gross national product (GNP) allocated to medical care and especially to the hospital component of medical care to escalate along with the costs of government programs, including the one under consideration, and out-of-pocket expenditures by the elderly. In short, S. 350 will create more "catastrophic illnesses" than anyone here today ever dreamed possible. Although protecting persons from ruinous health care costs is a laudable objective, this legislation, because it would do nothing to alter or reverse existing economic incentives in the health industry but would simply build on them and make them even more powerful would simply make matters worse. Those on this Committee who are concerned about federal budget deficits and spiraling inflation in this country ought to think seriously about the economic and health care cost consequences that this legislation will have. We think they will be truly catastrophic.

We urge the members of this Committee to consider the historical experience of the Medicare program and that of the elderly under that program. In 1967, the program's first full year of operation, the average health bill for an aged person was $532. Medicare paid for 31.2 percent ofthat. By 1977, the average bill had increased to $1,738 of which Medicare picked up 43 percent. The program had assumed over the period 11 percent more of the tab, but in the meantime, the health bill had more than tripled. It should come as no suprise that the elderly are spending more out-of-pocket in real dollars for health care now than they did before Medicare.

We have no doubt that Medicare greatly increased the access of the elderly to health care when it was first implemented. However, Congress was overly generous to health care providers when it determined the method under which providers, especially hospitals would be reimbursed. The "reasonable cost" formula for reimbursement disregarded the procurement safeguards of the federal government, dating back to the colonial days. Cost-plus reimbursement procurement without renegotiation has proved to be a blank check to hospitals.

Hospital costs prior to Medicare and Medicaid had already demonstrated a pronounced tendency to rise at rates higher than prices in general. Between 1950 and 1965 the Consumer Price Index (CPI) showed an increase in the costs of semi-private hospital rooms of 2 ½ times, whereas the general level of prices rose over the same period only by one-third. The federal government's method of reimbursing costs by blank check to the hospital providers under Medicare simply added gasoline to the older inflationary fires. Third party payments now make up 93 percent of the income of hospitals. Under third party payment procedures, the patient, the government and the private insurance company all fail to raise any kind of a restraining hand against rising costs. Indeed, the government has been using as intermediaries for their disbursements the same insurance companies that are doing private business with the providers; these intermediaries have no incentive to be tough with the providers for the purpose of conserving public funds. Although the organization and purpose of hospitals may greatly vary, most were organized to serve communities rather than to exist as carefully run businesses. The consequences of pouring money into hospitals under these circumstances should not surprise anyone.

Since 1973, our Associations have been pressing for reforms in the methods under which the federal government reimburses hospital care. We have also been working to restructure what has been called the delivery system of the health care industry. That delivery system is overly centered on the acute-care hospital.

Our Associations strongly believe that the preferable way to control the rise of hospital costs over the long term is to create a variety of health care facilities throughout the urban and rural areas of the country so that the demand on acute-care, high-cost, in-patient hospital facilities is greatly lessened. The promotion of health maintenance organizations, intermediate and long-term care facilities, community health centers, smaller clinics of all kinds, and home health care should tend to lower costs by creating alternatives to highly specialized care in the acute-care hospitals. The fact that hospitals are not competitive does not preclude the fostering of competition in the health sector of the economy as the ultimate means of dampening inflation. The type of competition we have in mind is the product competition that would result from encouraging the growth and expansion of alternatives to costly in-patient hospital care. We recognize that there will never be an orderly, competitive market for health care, but the promotion of a variety of health care facilities can only tend to take price pressure off hospitals with respect to in-patient and out-patient facilities. At the same time, these varied facilities would tend to complement the differing health care needs of the elderly and other age groups in the population.

Unfortunately, since Phase IV controls expired in 1974, there has been little change in the nation's dependence on the hospital as the keystone of its health structure, and with the exception of mandatory cost control initiatives in some nine states, reimbursement reform remains largely a matter of debate. If the program that S. 350 contemplates is simply superimposed on the existing structure of the health industry, even more of our limited financial resources will flow into acute care, hospital facilities, leaving little or nothing for the promotion of less costly alternatives such as home health services and ambulatory care facilities that could help accommodate the presently unmet health care needs of the elderly and enable them to remain active in the community and out of institutions.

While our Associations support the idea that all persons, and especially the elderly, ought to be protected against the financial costs of catastrophic illness, any program that undertakes to achieve that goal must come as part of a comprehensive national health program that undertakes to control costs, restructure completely the health care industry, alter the existing incentives and make medical care services available in a cost-effective manner. While it may be argued that the total cost of S. 350, if enacted this year would be far less than the cost of any national health insurance program, the cost of providing catastrophic protection under S. 350 would inevitably exceed the cost of providing the same protection under the kind of NHI program that we have in mind.

Because of the economic consequences that S. 350 would inevitably entail, the NRTA and the AARP choose not to support it. However, because we recognize that this proposal does have some surface appeal and some important political support, I have appended to this statement a detailed and constructive analysis of its provisions.

This concludes my statement. I thank the Committee for having had this opportunity to present the Associations' views.

Appendix—The Analysis of the Catastrophic Health Insurance and Medical Assistance Reform Act of 1979

THE CATASTROPHIC HEALTH INSURANCE PROGRAM (TITLE I OF S. 350)

A. Benefit scope

The catastrophic plan would basically cover the same types of services currently covered under Medicare subject, however, to a 60-day deductible for hospital services and a $2,000 deductible for medical services. Covered hospital services would include inpatient hospital care, post-hospital extended care services, and home health services. The catastrophic plan's medical services would include medical, physician and other health services (as defined under Medicare), home health services, outpatient physical therapy and rural health clinic services.

The major improvements over Medicare Part A coverage of the above services are that the catastrophic plan contains no limitations on hospital stays or home health visits and no payment of deductibles or coinsurance charges for covered services would be required. The catastrophic plan would also cover the full amount of hospital charges after the 60th day, whereas Medicare subjects the beneficiary to a coinsurance amount (currently $40) at that point and ceases coverage with the 90th day unless the lifetime reserve of 60 days is used.

With respect to Medicare Part B, the $60 deductible as well as the total cost of medical services—that part which is reimbursed by Part B Medicare, that part which is not (representing out-of-pocket costs or costs paid by private insurance) and

coinsurance amounts paid by the Medicare beneficiary—would all be counted toward the $2,000 deductible. Once the $2,000 deductible is met, the catastrophic plan would pay the full amount of reasonable medical charges (rather than 80 percent as under Medicare) and the costs of all home health visits (rather than limited to 100 visits annually as under Medicare).

In general the catastrophic plan's benefit coverage seems to mesh well with Medicare's benefit structure in that it begins coverage where Medicare Part A begins charging coinsurance amounts and pays the full amount of reasonable charges under Part B once the $2,000 deductible is met. In all instances, except for post-hospital extended care, the catastrophic plan would be the primary payor.

Despite the expanded coverage offered by the catastrophic plan, one of its more serious flaws lies in the fact that its coverage is limited only to the categories of benefits covered under Medicare and only expenses for these covered services are countable toward the deductible. This limited coverage ignores many essential benefit areas where the elderly's expenditures can be extremely high, such as prescription drugs, dental services, eyeglasses, hearing aids, and homemaker/chore services. (We note that coverage of mental health services is somewhat expanded; however, it is unfortunate and discriminatory that mental health expenses in excess of $500 are not counted toward the $2,000 deductible.)

In addition, the catastrophic plan would not address the escalating problem of physicians refusing to accept assignment (the rate of assignment acceptance under Medicare has dropped to below 50 percent). The "reasonable charge" method of reimbursement used under Medicare would be utilized by the catastrophic plan for payment purposes. This procedure would result in many elderly persons continuing to incur sizeable out-of-pocket expenses which the catastrophic plan would not reimburse.

Another serious benefit gap that requires comment relates to the catastrophic plan's extremely limited coverage of skilled nursing home care. This virtual non-coverage of long-term care services makes the "catastrophic" plan something of a mirage for a large number of elderly. The lack of a well-designed long-term care system that encompasses both health and social service is, without question, the greatest deficiency in the present health delivery structure and the catastrophic plan perpetuates this deficiency.

This problem cannot be ignored much longer in light of the dramatic increase we are experiencing in the numbers of older and old-old (or frail) elderly. The implications of this demographic shift for long-term care policy is significant since the elderly have the highest incidence of functional disability. Not only is the demand for long-term care services going to increase rapidly, but current demand is not even being met. Of the 8 million persons estimated to be functionally dependent in 1975—that is, in need of assistance with daily activities such as eating, bathing, etc.—only 2.3 million received long-term care services under government programs.

Medicare and Medicaid pick up very little of the elderly's long-term care bill and the catastrophic plan would basically continue this non-coverage. Over half of nursing home costs in 1975 were paid from private sources; 44 percent of these costs were paid out-of-pocket rather than by insurance or philanthropy. While half of the elderly families had incomes of less than $8,721 in 1976, the average annual cost of a nursing home stay was $8,774. In 1977, the elderly represented 85 percent of all nursing home residents. It is obvious from these statistics that nursing home care is the main cause of "catastrophic" expenses for the elderly. This situation forces the elderly to deplete their resources or "spend down" (impoverish themselves) to become eligible for Medicaid nursing home assistance.

While it is clear that further delay in dealing with the issues of providing, coordinating and financing a comprehensive long-term care program ought not to be tolerated, the financial difficulties faced by the Medicare/Medicaid program have been inhibiting any significant expansion of long-term services. The estimated costs of a long-term care program are being driven up by high rates of inflation, emerging demographic trends, and increased utilization of services. The combined effect of these factors has more than doubled total (government and private) spending for long-term care from approximately $11 billion in 1975 to an estimated $28 billion in 1980.

Nevertheless, further delay in setting up and gradually implementing a rational, coordinated long-term care framework is seriously compounding the already serious financing problem because current government programs are strongly biased in favor of institutional (nursing home) care. Less than 10 percent of public funds go for home-based services. There is a large unmet need for community-based services, such as sheltered living arrangements, congregate housing, and homemaker/home health care. If all these services were available, the CBO estimates that 20 to 40

percent of the present nursing home population could be cared for at less intensive and, we believe, less expensive levels of care.

The findings of a recent GAO study confirm that, until older persons become extremely impaired, the cost of nursing home care exceeds the cost of home health care. A recent Levinson Policy Institute report funded by the NRTA/AARP Andrus Foundation examined the costs of diverting nursing home patients to home care and found that 16 to 38 percent of the 50 patients studied could be cared for at home more cheaply than in the institutions to which the patients were actually discharged.

The catastrophic plan, while not covering most of the "catastrophic" costs of skilled nursing care, would somewhat expand coverage of home health visits by imposing no limitation on these visits once deductibles are met. Although the catastrophic plan does not cover the full array of home health services needed (such as homemaker/chore services) and requires prior hospitalization as under Medicare, our Associations consider removal of this limit to be a step in the right direction.

With respect to the details of post-hospital extended care services, we understand the catastrophic plan retains Medicare's 100 day limitation imposed per benefit period. If the beneficiary is eligible for Medicare Part A coverage of these services, then the catastrophic plan does not pay benefits. What is left unclear, however, is whether the catastrophic plan would cover Medicare's coinsurance charges imposed for the 21st through 100th day of care. Also unclear is whether the catastrophic plan will cover for each calendar year the costs of 100 days of skilled care (which occurs after Medicare's Part A 100-day limit on skilled care is reached). Our Associations hope payment of Medicare coinsurance charges and coverage of 100 days per calendar year are intended by the catastrophic plan.

B. Financing

Our Associations have some concern with financing the cost of the catastrophic plan through a 1 percent tax on the payroll of employers and self-employment income. This tax is likely to be inflationary and could dampen employment at a time when the economy would not be able to sustain such pressures. Most economists agree increased taxes imposed on payroll are usually shifted forward or backward in some combination of higher prices or lower wages. In addition, a payroll tax is a direct tax on employment and therefore, could have the adverse effect of increasing unemployment rates.

For these reasons, our Associations believe it is unwise to levy a payroll tax at a time when reducing inflation and unemployment are priority economic goals. We note that general revenues will be used to defray partially the costs of the catastrophic plan through an income tax credit equal to 50 percent of the employer's payroll contribution. This scheme of offsetting increased payroll taxes with decreased income tax liability will not mitigate the adverse economic consequences of a new payroll tax. In our opinion, an economically more wise source of financing would be a direct use of general revenues.

With respect to some of the catastrophic plan's specific financing provisions, our Associations are pleased to see the creation of a contingency reserve and the provision for alternative financing to assure prompt payment of benefits. We also note that the Secretary of HEW has the discretion to request appropriations be made to the Federal Catastrophic Health Insurance Trust Fund out of general revenues for catastrophic benefits paid to individuals who would have otherwise been eligible to receive benefits under Medicare and Medicaid. We recognize that this could lead to a very limited use of general revenue funds for the catastrophic plan, showed the HEW Secretary exercise his authority and the Congress agree to make such appropriations.

THE MEDICAL ASSISTANCE PLAN (TITLE II OF S. 350)

Title II of S. 350 proposes to replace the Medicaid Program with a uniform national program of medical benefits for low-income persons financed out of general revenues and state government contributions. Such a federalization of Medicaid has been sorely needed for many years to equalize the many state-to-state disparities in eligibility criteria and benefit coverage. The elderly poor would undoubtedly benefit a great deal from this proposal.

The increased costs of this new Medical Assistance Program are expected to be high (nearly $15 billion) with the federal government bearing largely all the increased costs and using current Medicare reimbursement procedures to establish benefit payment levels. Again, our Associations question the advisability of adding significantly to the current health care benefit structure without first, or at the same time, reforming the content and financing of that structure so that it is made more cost-effective.

The provisions governing eligibility for the Medical Assistance Plan are a significant improvement over the existing Medicaid Program's varying eligibility standards which often cause an uneven distribution of health care protection to low-income persons. We are pleased with the assurance that no one presently eligible for Medicaid would lose entitlement because of the new program.

Our Associations suggest, however, that the annual income standards used to determine eligibility should be automatically indexed according to annual rises in the CPI. The spend-down provision which permits low-income persons to reduce their income by amounts spent for medical care is also an important feature.

Benefits available under the Medical Assistance Plan seem to mesh well with the deductible under Medicare and the catastrophic plan. Payment of the elderly's Part B premium as well as Part A deductible and coinsurance amounts under the Medical Assistant Plan is important. The $3 copayment requirement with respect to the first ten physician visits is minimal in amount and is apparently designed to restrain excessive utilization of such services. While such a copayment structure may be acceptable, the "special copayment" imposed on persons residing in a long term care facility for more than 60 days is confiscatory in nature and difficult to justify, especially in light of the fact that an individual institutionalized for a long period of time may still find it necessary to maintain a home, if not for himself, then at least for his family. Moreover, the income which would be confiscated (an amount equal to the patient's monthly income minus $50), would include social security benefits, railroad retirement payments and various other forms of retirement income which the individual receives as a matter of right.

Our Associations are pleased to see that states will be encouraged to supplement the basic medical assistance plan services by having the federal government share half of the cost of providing optional services such as drugs, dental services, etc. However, we do not agree that this federal cost-sharing should be limited to only those optional benefits which the states were providing prior to the effective date of the new program. This restriction would curtail state expansion of many necessary health benefits and, furthermore, would do nothing to help reverse the more recent trend of states cutting back on Medicaid benefits due to mounting fiscal pressures and escalating medical costs.

The CHAIRMAN. The committee will stand in recess.

[Whereupon, at 12:50 a.m., the committee recessed, to reconvene at the call of the Chair.]

CATASTROPHIC HEALTH INSURANCE AND MEDICAL ASSISTANCE REFORM

WEDNESDAY, MARCH 28, 1979

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, D.C.

The committee met, pursuant to notice, at 10:05 a.m. in room 2221, Dirksen Senate Office Building, Hon. Russell B. Long, chairman of the committee, presiding.

Present: Senators Long, Talmadge, Ribicoff, Byrd of Virginia, Bentsen, Bradley, Dole, Danforth, Heinz, and Durenberger.

The CHAIRMAN. The committee will come to order.

Let me point out a couple of things. Under the rule, witnesses are expected to have their statements to us at least 24 hours before they make it. That gives Senators, also our staff members, a chance to read and study these statements before the witnesses make them, and I would like to urge that, hereafter, that witnesses try to comply with that 24-hour rule.

We will try to cooperate if we can, but they should comply, if it can be done.

We will be operating under a 10-minute rule this morning, which means that the witness will have 10 minutes to make his or her statement. Thereafter each Senator can interrogate the witness for 10 minutes if he wishes to do so.

We will call as our first witness, Mr. James A. Lane, on behalf of the Group Health Association of America. You are recognized for 10 minutes.

STATEMENT OF JAMES A. LANE, ESQ., ON BEHALF OF THE GROUP HEALTH ASSOCIATION OF AMERICA

Mr. LANE. Thank you, Senators and Mr. Chairmen, members of the committee, my name is Jim Lane, representing the Group Health Association of America, which is the national association of prepaid group programs now popular, called group health maintenance organizations, HMO's. I am also vice president and counsel of Kaiser Foundation health plan.

The catastrophic health insurance features in the bills you are considering do not fill that function well. Many persons who do not belong to an HMO or do not have hospital insurance would have to spend $15,000 to $18,000 before they could receive any hospital benefits under these proposals.

That is a conservative estimate. Many cases would run higher than that.

Having to spend this amount can be a financial catastrophe for many low and middle income persons and could force many of them into bankruptcy or require them to heavily mortgage their future, or apply for Medicaid long before they are eligible for these catastrophic benefits. On the other hand, many high income persons could pay such amounts with little problem, even if they had no health care coverage, which would be unusual.

The deductible for medical and other health services is only $2,000 which is relatively low, especially when compared to the hospital deductible. Once the deductible has been reached, there is no cost sharing. All future medical services are fully covered, even though they are routine, and without regard to whether services are provided through an HMO or merely insured.

This disparity in coverage for hospital and medical services may lead many persons and groups to consider seriously self-insurance for medical services while continuing their hospital coverage. This would result in a pattern of hospitalizing patients in order to obtain insurance coverage for procedures which could be done on an outpatient basis.

The provisions of these bills are not catastrophic health insurance, they constitute a major medical insurance program with a reasonably high deductible for medical services, an exceptionally high deductible for hospital services and no coinsurance for either. They do not make sense as a health insurance contract.

I doubt if many contracts like this are sold in this country.

From a public policy viewpoint, the financing is regressive. It is based on the social security tax system which is considered regressive by most experts. In addition, for moderate-income and high-income persons, the tax credit should cover the entire cost of the coverage. However, for low-income persons and employers of such persons, the tax credit will usually be less, and often substantially less, than the cost of coverage.

Thus, low-income persons and employers of such persons may not be able to afford coverage and will be covered under the public program. The irony is that they will pay taxes toward the public program and have no better coverage than wealthy persons who pay no taxes because they have no earned income.

The bills rely upon the private sector to a great extent and thus do not attempt to establish a public program for persons who are already covered by private carriers. However, there are two notable exceptions: Provision for health maintenance organizations which I will discuss later, and provision for medicare beneficiaries who have private supplemental coverage.

With the exception of those who are employed or self-employed, medicare beneficiaries will be covered by the public program, even though many of them, including those who are members of HMO's have comprehensive supplemental coverage. These persons should be allowed to continue their coverage and not be forced into the public program.

This can be accomplished by having the actuarial committee determine the actuarial value of coverage for persons with medicare and paying that amount to qualified HMO's and carriers which provide certified health insurance policies on behalf of medicare beneficiaries whom they cover.

This objective would be accomplished by our proposed amendments three and four.

In addition, I have a comment on title XIX. We have no position on the federalization of medicaid. I personally think there are some policy reasons for supporting such a change.

However, we do have a position of requiring payment under medicaid on the basis of section 1876 of the Social Security Act. We are opposed to that provision. We do not think it is appropriate for medicaid, to payers. Even the new provision which will be proposed by the administration in the near future does not appear to be appropriate.

Under Secretary Champion has requested that we develop an appropriate payment provision for HMO's under medicaid. We are in the process of developing that and will submit it to this committee in the future.

From a health policy viewpoint, the bills present a number of problems. So called catastrpohic only coverage, without underlying basic coverage, is likely to contribute to inflation in health care costs and to cause undue investment of health care resources in esoteric, expensive services that will benefit very few people.

There is a risk that this could result in pulling resources away from primary care which could affect the health care of large numbers of Americans.

As I have indicated, these bills may distort coverage and health care services toward increased hospital utilization. This could result because of the disparity between hospital and medical care coverage. This is not a desirable outcome from a health policy viewpoint and should be avoided.

Finally, the bills do not contain adequate provisions for HMO's and their members. I want to stress, qualified HMO's and all other HMO's provide coverage substantially more comprehensive than that provided in this bill with practically no deductibles or coinsurance feature and only moderate copayments. This is a serious omission.

Section 1504(b) does provide for comprehensive prepaid group practice plans, but it does so in the context of health insurers. Also it is in the section relating to certified health insurance plans, not in the section relating to plans which are to be approved for tax credits.

HMO's are not health insurers and health insurance rules and regulations cannot be appropriately applied to them. They are now governed by the Secretary under a complex set of rules and regulations promulgated pursuant to the HMO Act and its amendments. There is no need to require the Secretary to apply health insurance rules on top of the rules he now applies to qualified HMO's. Our amendments one and two would solve this problem.

Thus, GHAA concludes that these bills should not be enacted in their present form because:

One, they will result in low-income persons subsidizing major medical coverage for high-income persons;

Two, they may distort health care delivery toward increased hospitalization and esoteric, expensive services; and

Three, they do not contain adequate provision for qualified HMO's and their members.

Thank you very much.
[The attachment to Mr. Lane's statement follows:]

AMENDMENTS TO S. 351

1. Add § 2122(f) to read:
"(f) Notwithstanding the other provisions of this section, a plan offered by a health maintenance organization qualified pursuant to title XIII of the Public Health Service Act shall be approved by the Secretary for purposes of this title.
2. Amend § 2123(b)(3) to read:
"(3) Such table of values developed by the Secretary shall be made available to all carriers who offer catastrophic health insurance plans approved under section 2122, to health maintenance organizations qualified pursuant to title XIII of the Public Health Service Act and to all other interested persons.
3. Amend § 2124(d)(2) to read:
"(2) Such table of values shall establish, for each State, the actuarial value of one year's catastrophic health insurance coverage for an individual not entitled to benefits under title XVIII and individuals entitled to benefits under title XVIII, depending upon the benefits to which they are entitled, as estimated for the calendar year for which such table of values is to be in effect, and shall be designed (with the use of the table of adjustment factors) to enable employers, carriers, and others involved with plans approved under section 2122 to determine the actuarial value of the catastrophic health insurance coverage provided under any such plan.
4. Add § 2125 to read:

"CATASTROPHIC INSURANCE FOR MEDICARE BENEFICIARIES"

"SEC. 2125. (a) The Secretary shall provide for participation under this title by carriers and health maintenance organizations qualified pursuant to title XIII of the Public Health Service Act that provide medicare supplemental plans to Medicare beneficiaries. The Secretary shall make a monthly payment to the appropriate carrier or health maintenance organization on behalf of each person covered under this title who is a beneficiary under title XVIII and is covered by a health insurance policy certified pursuant to title XV or a health maintenance organization plan approved pursuant to title XIII of the Public Health Service Act. The payment shall be one-twelfth of the actuarial value of one year's catastrophic health insurance coverage for such individual set forth in the table of values developed by the Secretary pursuant to paragraph (b)(1) of section 2123.

The CHAIRMAN. Thank you.
Any questions, gentlemen?
Senator TALMADGE. Very briefly, Mr. Chairman, we have a lot of witnesses here today. I want to expedite the hearings as much as possible.
Mr. Lane, are you familiar with the report on HMO's of the Senate Subcommittee on Investigations?
Mr. LANE. Yes, sir.
Senator TALMADGE. Are there any of the HMO's referred to in that report that the members of GHAA?
Mr. LANE. Yes, sir. I believe so.
Senator TALMADGE. Thank you very much.
The CHAIRMAN. Any other questions, gentlemen?
Senator RIBICOFF. No questions.
Senator BAUCUS. No questions.
Senator DURENBERGER. No questions.
The CHAIRMAN. Next we will call Mr. Ronald H. Brown, vice president of the National Urban League.
Mr. BROWN? He is not here.
Then we will call the next witness, Mr. Bert Seidman, director of the Department of Social Security and Mr. Robert McGlotten, legislative representative, AFL-CIO.
He is not here.

Then we will have to call Mr. Phil L. Aiken, president; Ralph L. Guenthner, chairman of the board; and Harry N. Rosenfield, Washington counsel, American Chiropractic Association; Mr. James E. Reese, Jr., president and J. F. McAndrews, executive vice president, and Gen. Joseph P. Adams, counsel, International Chiropractors Association.

We are pleased to have you.

STATEMENT OF RALPH L. GUENTHNER, DISTRICT OF COLUMBIA, CHAIRMAN OF THE BOARD, AMERICAN CHIROPRACTIC ASSOCIATION, ACCOMPANIED BY PHIL L. AIKEN, DISTRICT OF COLUMBIA, PRESIDENT; HARRY N. ROSENFIELD, ESQ., WASHINGTON COUNSEL, AMERICAN CHIROPRACTIC ASSOCIATION; JAMES E. REESE, JR., DISTRICT OF COLUMBIA, PRESIDENT; BRUCE NORDSTROM, DIRECTOR OF SPECIAL PROJECTS; AND GEN. JOSEPH P. ADAMS, ESQ., COUNSEL, INTERNATIONAL CHIROPRACTORS ASSOCIATION

Dr. GUENTHNER. My name is Ralph Guenthner, chairman of the board, American Chiropractic Association. I would like to introduce to you Dr. Phil Aiken, president of the American Chiropractic Association; Dr. James Reese, president of the International Chiropractors Association, and Dr. Bruce Nordstrom director of special projects for ICA.

Mr. Chairman, I was not scheduled to make this presentation. Dr. Aiken was. He has developed throat problems and has asked me to substitute for him.

The Nation's two national chiropractic associations, the American Chiropractic Association and, the International Chiropractors Association, jointly urge this committee to include chiropractic health care in any form of S. 350 and S. 351 which may be enacted by the Congress.

First, a very short statement on chiropractic itself. Chiropractic has been licensed in all 50 States, plus the District of Columbia and Puerto Rico, and has been incorporated in the workers' compensation programs of all States and of the Federal Government, as well as in the present medicare program. For your information, we attach as an exhibit a description of the programs of the Federal Government which have authorized chiropractic health care. In addition, the U.S. Office of Education has officially recognized the Council on Chiropractic Education as the authorized accrediting agency for chiropractic colleges, on a par with accrediting agencies for medical, nursing, engineering, law schools, and others.

The American Chiropractic Association and the International Chiropractors Association believe that, in the public interest, a national health plan should have the following characteristics: First, it should be comprehensive in coverage, applicable to all of the people in the United States. Like the public school system which is available to everyone in the country, a health system should be available to all.

Perhaps such a program may not be comprehensively initiated immediately. It is likely that, for financial reasons, the realities of administrative capabilities, and the need to obtain experience in the operation of such a program, it may be wise to phase in such comprehensive coverage incrementally as is planned under S. 350

or S. 351. But such phased-in schedule should be set forth at the outset, so that all may know and plan for the full coverage from the start.

Second, we urge that a national health plan under S. 350 or 351 be comprehensive in its benefits. While title I of S. 350 includes chiropractic, title II—Medical Assistance Plan for Low-Income People—does not. We recommend that title II be conformed to title I in this regard. To this end, we recommend that: *(a)* Section 1932(b)(1) be amended by adding: "* * * (R) chiropractic services," and that *(b)* section 1932(b)(1)(e) and section 1941 be amended to include section 1861(r)(5).

Otherwise low-income people would not be given the same health care options as others, an invidious form of discrimination.

The proposed amendments would assure achievement of Senator Long's objective stated when he introduced S. 350 on February 6, 1979, that "no person presently eligible for medicaid would lose entitlement to benefits because of the new program."

Our amendatory proposal would also provide compliance with Senator Ribicoff's comment that "title II's benefits would mesh with the catastrophic program—of title II" of S. 350.

For the same reason, we urge that title III of S. 350 and title II of S. 351 should require inclusion of chiropractic services in private health insurance policies to the same degree that chiropractic is required to be provided in title I. Otherwise there could be an unfortunate gap harmful to the public.

If for financial reasons the Congress should decide to place a reimbursement ceiling on benefits authorized from any category of health provider, we urge that such ceiling be established by a national formula at a level equivalent to the optimum provided for such health care service under existing Federal law and regulations, after consultation with appropriate professional representatives.

It is reasonable to suppose that the national health plan will become the standard form of health service for the vast majority of the American people. Therefore, it is wholly inappropriate for such a basic health program to be limited so that it provides, in effect, second grade health care for national health plan participants and first grade care only for those with sufficient funds to be able to seek nonplan health care. To use education as an example, the States provide not only elementary and secondary education but also collegiate, university, graduate, and professional education as a part of the State services they render to their citizens. We believe that this same concept should apply to the national health plan. The Federal program under S. 350 or S. 351 should encompass all the healing arts.

However, we are aware of the financial restraints which have concerned both Congress and the administration, especially in connection with the early period of implementing a comprehensive plan of national health. If fiscal determinations require a ceiling on Federal reimbursement for certain health services, as is now the case in medicare with dentistry, optometry, and chiropractic, then we recommend that such reimbursement ceiling be *(a)* national in scope, and *(b)* at a level no less than the upper-reimbursement

ceiling provided in existing Federal law or regulations for such health service.

Third, the relative roles of the Federal Government and the private health insurance industry are a matter on which we have no special expertise and on which therefore, we shall make no recommendations.

However, if the congressional policy decision is to retain the program participation of the private insurance industry, then we believe that it is necessary for the Federal Government, and not the insurance carrier, to specify the benefits structure and the operational rules. There are two reasons for this:

(a) *Nondiscrimination against beneficiaries.*—At the present time, there are wide divergencies among plans offered by various carriers. However valid such a diversified system may be under private auspices, it is unjustified under a national, congresionally established system. There is no reason why some Americans should be provided less benefits and services because they have chosen a particular carrier, than others who have chosen another carrier, especially since all will pay the same amounts. The benefits, the requirements and the basic pattern of health-care distribution should be determined congressionally as a national decision and the carriers should merely be administrative arms for carrying out a policy decided by the Congress. This should apply not only to commercial insurance carriers but also to HMO's, the Blue Cross/Blue Shield and all other third-party providers and insurers.

(b) *Nondiscriminatory against some health care providers.*—In some instances, the medical "establishment" has such strong views against certain other provider groups (including but not restricted to chiropractors, optometrists, podiatrists, and psychologists) that they, as a matter of private monopoly, refuse to cooperate with some of such other groups. There is no public justification whatsoever for allowing any one private group of health-care providers to so dominate the health-care delivery system as to discriminate against other groups (and their patients). Therefore, whatever the administrative structure, Congress should require that all State-licensed care providers must be included in the national health plan.

Fourth, when the Congress enacts a comprehensive and national health-care delivery system, or the incremental plan under S. 350 or S. 351, it will be necessary to assure that all parts of the country, and all segments of the population have access to the kinds of health care providers they may wish to choose within the system. Therefore, the education and training of all such State-licensed health care providers—not merely those now provided for in the current health manpower and training laws—should be encompassed by Federal grants to their schools and tuition grants and loans to the students, on an equal basis. Likewise, programs for the distribution of health care providers in locales with under-supplied health-care providers, such as the National Health Service Corps should include all such State-licensed health care providers and not merely the limited groups now chosen for the program.

In this way, the American people will have a fair and reasonable distribution of all authorized health care providers, to be available under the national health plan at their own choice.

In this same vein, advisory committees of various kinds, and administrative structures and operations such as PSRO's and HMO's should include and provide for equal participation by all health care providers.

Senator, these are some of the remarks from the prepared statement that you have. If you have any questions, Dr. Reese would be pleased to answer them.

[The attachment to Mr. Guenthner's statement follows:]

FACT SHEET ON CHIROPRACTIC

This Fact Sheet briefly describes the position of chiropractic in the health-care delivery system of the United States.

I. STATE LICENSING AND AUTHORIZATION

a. All 50 States, plus the District of Columbia and Puerto Rico, license and officially recognize chiropractic as a health profession.

b. All 50 States authorize chiropractic services as part of their workmen's compensation program.

c. Over three-fifths of the states, representing some 70 percent of the nation's population, require inclusion of chiropractic services under all commercial health and accident policies written in those states.

d. The National Conference of Insurance Legislators adopted a model bill for State health insurance programs, which defines "physician" to include doctor of chiropractic.

II. FEDERAL AUTHORIZATION AND RECOGNITION

A. For all Americans:

a. Medicare

b. Medicaid

c. Vocational rehabilitation program and

d. Under the Internal Revenue Code, chiropractic health care is a "medical" deduction.

B. Specifically for Federal employees:

a. in Federal employee health benefit programs,

b. in Federal employee workmen's compensation, and

c. in leave approvals for civil service excuse of illness.

C. Chiropractic Education:

a. The U.S. Office of Education, HEW, officially recognized a chiropractic accrediting agency for chiropractic colleges.

b. To obtain a diploma as a Doctor of Chiropractic, a candidate must have 2 years of pre-professional college education and 4 years of resident instruction at a chiropractic college.

c. In almost three-fifths of the States, candidates for a chiropractic license must qualify under the same basic science exams as required for M.D.'s.

D. Specifically for Veterans: GI Bill of Rights covers education in chiropractic colleges.

E. Research: As a result of Congressional action and funding of research in chiropractic, the National Institute on Neurological Disease and Stroke held a Workshop on "The Research Status of Spinal Manipulative Therapy," February 2-4, 1975, opened by Dr. Donald B. Tower, Director of NINDS, and directed by Dr. Murray Goldstein, Director, Extramural Programs and Associate Director of NINDS. Papers were read by leading MD's, DO's, DC's and Ph.D's.

F. Miscellaneous:

a. Under the immigration law, aliens are admitted as students in order to study in chiropractic colleges.

b. The U.S. Public Health Service:

i. Classifies doctors of chiropractic among "medical specialists and practitioners," and

ii. Includes DC's in its Health Manpower Source Book.

III. PRIVATE SECTOR

a. Virtually all major commercial health insurance carriers include chiropractic in their private policies.

b. Major industrial employers, such as General Motors, have included chiropractic in the health plan for all their own employees.

c. Substantial numbers of major international, national and local unions include chiropractic in their own health and welfare plans (including the railroad and rubber unions, for example).

The CHAIRMAN. Thank you for your statement. Are there questions, gentlemen?

Thank you very much.

Dr. GUENTHNER. We appreciate your courtesy.

The CHAIRMAN. I understand that Mr. Brown of the Urban League has arrived.

STATEMENT OF RONALD H. BROWN, VICE PRESIDENT, NATIONAL URBAN LEAGUE, INC.

Mr. BROWN. Thank you very much, Mr. Chairman and members of the committee. I am Ronald H. Brown, vice president for Washington operations of the National Urban League. We, of course, welcome the opportunity to present our views on this legislation. You have a full copy of our statement. I will attempt to summarize it in accord with the groundrules laid by the committee.

At the outset, let me say that the National Urban League at the present time is opposed to the initiatives of S. 350 which amends the Social Security Act and provides for catastrophic health insurance and is opposed to the initiatives of S. 351 which provides only limited health services and, we believe, detracts from a much needed, broader health reform system.

As Vernon E. Jordan, Jr., president of the National Urban League, testified before the Subcommittee on Health on October 13, 1978, the National Urban League feels very strongly that a national health plan which includes universal and comprehensive medical coverage for all is the only hope for most poor people and particularly for the minority poor in their struggle to enjoy a healthy life.

Today, our testimony will be primarily directed toward the initiatives proposed in S. 351, although there is an admitted need to reform the existing medicaid and medicare programs to include some of the approaches outlined in S. 350. Both programs, as the two major vehicles for financing health care to the poor, contain defects which have caused many of us to seek even more forcefully a national health insurance program.

Needless to say, much of the congressional action focuses not on the reform effort but on the proposal to provide catastrophic insurance coverage as outlined in S. 351.

The National Urban League believes that a comprehensive national health program is absolutely essential. Millions of Americans do not receive needed health care services either because they are too poor to afford the costs, or because they live in areas where medical services are not readily available.

These problems are especially acute for the poor, for members of minority groups, and for the elderly. Indices of health care and health status are constant reminders to us that the conditions of the poor, a disproportionate number of whom are black Americans, is indeed tragic.

The League believes that part of the answer to the problems of health care of minorities and of the poor lies in a comprehensive health insurance program, not in catastrophic health care coverage.

If, as Senator Long has stated, truly comprehensive legislation cannot be expected over the next several years, then any new health legislation which is enacted must be designed to have the widest possible impact on that part of the population with the greatest risk and with the poorest general health.

Such legislation should involve a shift in focus from the present emphasis which now, No. 15 discourages periodic checkups and health reviews; two, encourages longer term hospitalization; and three, provides overemphasis on hospital-based specialty care.

Experience has shown us that proper medical treatment has followed the focus of the health dollar. Extended hospital stays and higher medical bills seem to be almost predestined.

What must be realized is that catastrophic health insurance does nothing to increase access or to improve the quality of health care for those in our Nation who have the lowest health status and who experience the greatest health risk.

Although medicare and medicaid have improved the health status of many poor and minority citizens, some 8 million persons below the poverty line are not covered by any form of medical assistance. In addition, nearly 45 million Americans, 1 in 5 people in this Nation, have either no health insurance or totally inadequate coverage.

Twenty-six million persons have neither health insurance nor access to free care through VA or public health service. Another 37 million Americans, again low-income workers with either no, or with inadequate, health insurance may not receive needed medical services at all because they cannot afford them.

At the same time, health care costs continue to rise faster than any perceived benefits of increased health or life expectancy. Admittedly, catastrophic health coverage as provided in S. 351 will reduce the financial burden costs by indefinitely rising higher costs for seriously debilitating illnesses for some, but for the poor, the disadvantaged and low wage earners, it will have limited impact.

The bill seems more to be designed as a supplement to the broader private insurance health plans than as a health costs relief mechanism. It seems to provide, for the most part, as much relief for the private health insurance industry as it does for the private insurance purchaser.

Clearly, the passage of S. 351 will remove much of the pressure on private plans to expand coverage and to more closely monitor expenditures. It is unfortunate that, with so many receiving little or no health care, and with the need to focus on preventative and comprehensive health care for the poor, that we are now concentrating on a health insurance plan which is so limited and which is designed in reality, we believe, to serve only a small segment of the population.

The catastrophic health insurance plan as proposed would not meet the health care needs of the majority of the population and would further serve as a barrier to the attainment of comprehensive health care, particularly for those who most need it.

We all know that most illnesses can be catastrophic to the Nation's poor, low-wage, and middle-wage earners. These individuals and families are financially wiped out long before the $2,000 or $3,000 60-day qualifying conditions of S. 351 coverage have been met.

Although catastrophic health may appear to be a good measure for some people, the National Urban League does not believe it meets the needs of those who are most in need of improvement in health care.

Catastrophic health insurance we believe will divert public attention from serious consideration of a comprehensive national health insurance program on the theory that the most serious problems are being dealt with by providing coverage for catastrophic costs, while in actuality it will fail to deal with better access to health care. By leaving the present delivery system intact, catastrophic health insurance will accelerate the current acceleration of health care costs by adding two incentives for very expensive health care and disincentives for the most cost-effective preventive and ambulatory care.

Catastrophic health insurance will provide no incentive for an equitable distribution of general practitioner services or for general care facilities, but will reinforce the trends toward greater concentration of specialty practitioners.

Catastrophic health insurance will require a low-income person to pay in part for a program whose principal benefactors will be the nonpoor. Catastrophic health insurance will do little or nothing to provide protection against the expensive long-term care and excludes outpatient care, drugs, and other general health care services.

In conclusion, Mr. Chairman and members of this committee, the National Urban League strongly urges this committee to recognize and seriously consider that this country needs a plan that will attend to the health care needs of all Americans. We must not concentrate our efforts on catastrophic health care, but look to the prevention and early detection of health problems to keep and maintain healthy individuals and, as a result, combat catastrophic illnesses, particularly for the poor and disadvantaged.

We must continue to move toward a health care system that will, No. 1, increase the efficiency and fairness of health care delivery; No. 2, allow adequate and fair distribution of benefits; No. 3, seek to bring skyrocketing health costs under control; and, No. 4, devote more health resources to disease prevention and health promotion.

If we are dedicated to assuring a nation of healthy individuals, then we must work to develop a comprehensive health care plan that incorporates medical care as well as other aspects of health care, such as nutrition, health education, and other supporter services.

Thank you very much, Mr. Chairman, for this opportunity to present our views on this important piece of legislation.

The CHAIRMAN. Thank you.

Let me ask you, how long has the Urban League been in existence?

Mr. BROWN. Since 1910.

The CHAIRMAN. That has been a good while.

How long have they been involved in the health care issue?

Mr. BROWN. I would say since that time, as well. Our principal focus in the early days was employment-related issues dealing with the problems of minorities who were migrating from South to North, but we have been involved in health-care issues of low-income people since the early days, and certainly since the major debate has started in this country.

The CHAIRMAN. I would like to feel that I have been involved with these issues and directly with health care for 50 years. That is

because I am a second generation politician. My father was Governor of the State of Louisiana 50 years ago and I was just a kid at the time. I was old enough to know what some of the issues were what we are talking about. He presented an idea that we ought to be able to provide hospital care for all the poor who could not afford it, and we had State hospitals all over Louisiana long before the Federal Government got involved in providing care for poor people. And they were well provided for.

I really think we are doing as well as any State in the Union, maybe better, in reducing the death rate in those State hospitals to where it is the same as it is in the private hospitals. There may not be as many private rooms, but the care is on the par in terms of the result we are achieving.

As a Senator, it has been my privilege to support medicaid which is providing about $13 billion of Federal support for the poor and disabled to match what States are doing, and to support medicare to help our elderly. Together those problems are costing about $50 billion of Federal money in addition to what the States are doing. We are doing a lot to help the so-called poor.

But a lot of people who are not poor, are poor by the time they get through paying medical bills. I am for doing something for them.

I am sponsoring several bills, at least one of which will put another $14 billion on top of the $50 billion we are already spending for health care. That makes $64 billion out of a total of $180 billion. That would be over one-third of all the money that is being spent to help provide health care. That is not counting what the states are doing.

In addition to that, it seems to me we ought to do something for the people who are not poor but who are paying taxes to look after the poor. Many of these people may be poor by the time they get through paying some very large medical expense. It is all right with me to drop down the threshold level, to drop it down from the $2,000 and 60 days to a total of, let's say, $3,000.

I look and I see private insurance is doing quite a job. They have 76 percent of people covered for major medical, but there are still about 25 percent who are not covered. Even after you add Federal and state health care programs, you still get a considerable percentage not protected. It seems to me they ought to be protected.

That is what we are talking about with catastrophic insurance. That is what we want to get at. We want to see that everybody is protected against catastrophe, and for the poor that you are concerned about, we want to pay all of that cost, every blessed nickel of it.

With regard to the others, we would like to see that these insurance policies do what they are supposed to do. I note that 95 percent of the hospital costs of the aged and disabled people are being taken care of. We can do more, maybe we cannot move it up to 100 percent for the aged and for the disabled. We think we should try to see to it that there are more uniform policies, that people are provided for.

I don't understand how you and the previous witness can come in here and say that these people who are paying the taxes for our existing health care programs should not be protected against

being wiped out by catastrophic illness. I am not talking about the rich. I am not worried about that. They can pay for the catastrophic illness, but these middle-income people who are paying taxes to help their less fortunate neighbors, it seems to me that they ought to be protected. I guess that is where you and I have a difference of opinion.

Everything I am advocating as a part of catastrophic protection is a part of what you are advocating as a bigger program. It seems to me in terms of priorities, when you are looking at something that a person is well able to pay for himself out of his pocket, such as going down to the drug store and buying himself a dozen aspirin tablets, it is cheaper for him to do that for himself than the Federal Government to do it for him.

In those areas, I think it is a mistake for us to jump into this thing of putting another $100 billion worth of programs on the American people where they could get a better buy by looking after certain things for themselves.

Why should the Federal Government have to tax a citizen in order to pay for a package of aspirin tablets?

Mr. BROWN. Senator Long, if I might respond, certainly we applaud many of the things that you and other members of this committee and other Members of the Congress have done in the area of health care and health care for poor people, and I would like to put what you characterized as a difference of opinion into context. We would support this as a part of a comprehensive package. I think our problem is that this debate is now going within the context of the debate over national health insurance, which we think that many members of this committee support also.

What we are concerned about is that in the context of this debate, in the context of the concern about large expenditures of taxpayers' dollars, that, in fact, concentration on catastrophic health care might have a detrimental effect on all of our efforts to get national health insurance, and it is in that context that I raised the question about catastrophic health care, not in principle.

Certainly, as part of a national health insurance package, a comprehensive health care package that looks at the delivery of health care services to all people, would be a very important part, and useful part, of that legislation. We are concerned about the kind of impact it might have on the national debate where many Americans, we fear, might believe that, in fact, we have solved the problem of the inequitable distribution of health care services in this country.

I think, Senator Long, too, you fully understand who the constituency of the National Urban League is and what a tremendous impact these decisions have on them. When you look at life expectancy statistics; when you look at diseases like hypertension and cancer; when you look at infant mortality, you might conclude, just looking at the data, that being black in this country is dangerous to your health, and I think the statistics, if you look at them, would bear that out.

We are concerned about addressing ourselves, and having this nation address itself, to the problems of the lack of equity in the present health care system. Anything which keeps us from focusing

on that we think might have a negative effect on solving those problems.

The CHAIRMAN. Let me just make this point, now.

Your group and the coalition with whom you are associated for the socalled cradle-to-the-grave type approach, many of them came to me and urged me to support medicare, and I did support it. I did not support it the first time they asked, but in due course, after we got through with the compromises and the debates and the discussions that took place, I found myself supporting it—not only supporting it, I was a floor manager for it, urging other Senators to vote for it.

At the time that we did that, we were going exactly contrary to what your logic is now and the position that you and the American Federation of Labor here are taking. You could have taken the view at that point that you should not have this health insurance for old people because it does not do anything for preventive medicine, it does not help the board of health. You should not have done anything for these poor people because it does not do everything. It is not a complete answer to the problem.

Now, long before I decided I was going to be for medicare, Senator Paul H. Douglas, who was highly respected by your organization, and perhaps a member and, if so, one of your most highly regarded members, said you should at least take care of people when medical expenses wipe them out.

He was quoting that fine, old hymn, "Lead Kindly, Light": "I ask not to see the distant shore, one step enough for me." This is something that we ought to do.

I am not saying that we should not do many of the other things you are talking about. As far as I am concerned, I think we will do more and more of them as time goes by.

Why should we forever have tremendous numbers of Americans paying their taxes right now to support the poor and the aged and the disabled in programs which many of them will never benefit from? Why should they be denied some protection where they are carrying the load for themselves and neighbors, and find themselves in a situation where they are wiped completely out?

Why should we not have a program where they get something out of it, for a change?

Mr. BROWN. I think we should, Senator. I think most rational people believe that we should. I think the context of the debates on these issues have shifted somewhat since the early debate on medicare-medicaid. We have acknowledged that those programs have had a significant impact on improving health care services for poor people, but now we are in the process, Mr. Chairman, of putting together a national health care plan, a comprehensive plan the administration proposed when others have proposed another. The debate is now in a different context than it was then.

It is in that context that we do have great concern about separating the issue of catastrophic health care out from the rest of the health care problems, and acting separately on that, because we fear, as I indicated earlier, that that will draw attention away, draw commitment away, draw resources away, draw the debate away, from where we think we ought to be and that is improving the overall health care system.

I would certainly not want to leave the impression with the chairman or anyone else that we are opposed to dealing with the problems that you so eloquently specified; that is, the problems of people who just cannot afford the cost of catastrophic health care and the kind of impact it has on them.

We would just like to have that considered in the larger context, because we fear that the rest of the issues might well be lost in the present climate.

The CHAIRMAN. Let me just say this. In my judgment, we are not going to be able to find the votes to pass this comprehensive thing you are advocating. If you cannot do that, I do not think we ought to postpone for another 10 years doing the things that, in the judgment of Congress, take the highest priority.

In the package that you are advocating, there is a lot of things in there that have a sufficiently high priority in the views of most Members of Congress that we can act. I just do not think that we ought to be delaying that action, waiting for something that is going to be the end of everything.

It has been my impression that most of what we do is done step by step, finding answers to problems. Sometimes we make mistakes. If so, we have to back away. But basically we should progressively find answers to this nation's problems.

Senator RIBICOFF. If the Senator would yield, I think one of the problems that we have is really the national misrepresentation of what S. 350 really is. In drawing 350, Senator Long and myself are really deeply concerned with the problems of the disadvantaged and the poor. In title II, for all practical purposes, it gives full coverage to the disadvantaged and the poor.

The poor have catastrophic problems; they are covered, and because of our reform of medicaid, making it a national program, the poor are covered for all practical purposes for almost every illness or any hospital stay, every representation of Long-Ribicoff, has been a misrepresentation, because those who criticize it are very careful to avoid mentioning what we tried to achieve and what we believe we have achieved, Mr. Chairman, in title II.

Under the impetus of Chairman Long, I think we are finally going to come to grips with health care and health care that will do the job.

Are you part of the coalition now working for a change in the Kennedy approach to the health care program?

Mr. BROWN. We are working, Senator Ribicoff, for a comprehensive health care program which has a chance of enactment.

Senator RIBICOFF. Let me say this, Mr. Chairman. Senator Kennedy talked with me about a new program that his group has evolved. I have looked at it fairly carefully; I do not have all the details, but I do not think that he is too far away from the Long-Ribicoff approach.

There is a realization, my feeling is, by those who have been through the previous Kennedy approach that it will be another ten years before it can be achieved. I believe they, too, are seeking an incremental approach.

You have the administration program; you have the chairman's program; Senator Dole and other associates have come up with a

program; Senator Kennedy will soon unveil another program; and it is amazing how close they are to one another.

We are in a position, my feeling is, to finally come up with a health program that the country can afford under a system of payment that they can take without breaking the budget.

It is my understanding that the Kennedy approach goes to catastrophic first. It is my understanding that the Kennedy approach is for the administration and payment through private insurance. So, we are finally reaching a consensus and realization of what can be, and what cannot be. I hope, Mr. Chairman, that you would give Senator Kennedy an opportunity to come and present his program. My feeling is, before you are through, you are going to have a Long-Kennedy bill that is going to do the job, and he is not too far away from where you are, Mr. Chairman.

The CHAIRMAN. I am pleased to see—I really think that the administration, those of us on this committee, both Republicans and Democrats, are beginning to coalesce to a position that we are going to do things, and that we think we are going to vote for things we ought to do, now.

I do not think we are going to go to a point where we are going to commit ourselves to go as far as the government of the United Kingdom has gone, but I think we are going to take care of the problems that we think are the most pressing to the American people—I hope we will.

Senator Talmadge?

Senator TALMADGE. No questions.

The CHAIRMAN. Senator Baucus?

Senator BAUCUS. No questions.

The CHAIRMAN. Senator Bradley?

Senator BRADLEY. No questions.

The CHAIRMAN. Senator Dole?

Senator DOLE. I was not an early bird, but I want to comment on the statement just made by Senators Ribicoff and Senator Long. It does appear that there is a consensus developing. I visited briefly yesterday with Senator Kennedy to see if he would cosponsor a bill. He did not indicate he would do that right off, but he would like an opportunity to appear before the committee and certainly he should have that chance. I understand they are about to complete work on his new proposal, and it is my belief as I have said before, that some have the headlines and some have the votes, and I think we are in that latter category, and perhaps we can work out a Long-Kennedy bill, or some combination, where somewhere in the footnotes you will mention the Republican input. We can have legislation this year.

I wanted to ask one question. In our legislation, we have some cost-sharing arrangement. Do you agree that some cost-sharing is appropriate?

Mr. BROWN. Yes. I think consideration of the cost-sharing approach would be appropriate. I was thumbing through my folder because I received a letter from you this morning, Senator Dole with a copy of the legislation to which you refer. I have not had a chance to review it, but I certainly think consideration of that would be appropriate.

I might comment further that it is impossible to have been around Washington for any length of time and to be a rational person and not be an incrementalist of some sort. I think that we do have to think in terms of reaching some longterm goal.

We have favored, in the past, the Kennedy approach. We continue to favor that, but we are very helpful that there can be compromises which will not adversely affect the interest of health care delivery to low-income people and people who are not presently receiving services, because we, too, are interested in votes. We are interested in getting some legislation enacted that will be of benefit to all Americans, and we would certainly support any efforts to find that kind of solution.

Senator DOLE. I agree with that. The Kennedy approach is changing all the time. We may end up supporting the Kennedy approach as he keeps coming around to the middle. So the Kennedy approach has been one thing one year, another thing another year—I do not fault that. I just suggest that there is a change going on, and perhaps sometime this year, hopefully, there will be a consensus, not just on this committee but generally in the Senate. I think one improvement in the chairman's bill is the new version which drops financing through a payroll tax.

We have just about reached the limit on payroll taxes and that modification, I think, is in the right direction.

You indicate that you have just gotten a copy of ours. I hope that you might comment on S. 748 and we could put your comments in the record at the appropriate time.

Mr. BROWN. We would be glad to do that, Senator Dole.[1]

Senator DOLE. Finally, you indicate that S. 351 provides relief to private insurance companies. Could you explain that more fully?

We also have a provision—we tried to preserve the private sector, where we subsidize premiums. We do not look upon that as relief to profit companies. We look at that as recognizing the private sector.

Mr. BROWN. We, as you know, recognize the private sector as well. We have strong and longterm relationships with many in the private sector. We are not opposed to the private sector by definition.

We are concerned about focus and about thrust. We are concerned about emphasis. We are concerned about being in an era of overwhelming desire to control costs, that we not do things that cause people to look away from the control of costs, because they think there is some kind of subsidy that will keep them from greater scrutiny. We are concerned about that kind of impact.

That was the nature of the comment in that regard.

Senator DOLE. Thank you.

Senator TALMADGE. Thank you very much, Mr. Brown. We appreciate your testimony.

I see that Senator Melcher of Montana has arrived. We would be delighted to hear from you now, Senator Melcher.

Mr. BROWN. Thank you, Senator Talmadge, and members of the committee.

Senator TALMADGE. Thank you.

[The prepared statement of Mr. Brown follows:]

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[1] At presstime June 18, 1979, the material referred to had not been received by the committee.

Statement of Ronald H. Brown Vice President National Urban League, Inc.

SUMMARY

The National Urban League opposes S. 350, which provides for catastrophic health insurance and opposes S. 351, which provides only limited health services and detracts from a much needed broader health system.

Catastrophic health may appear to be a good measure for some Americans but the League opposes it because:

(1) It will divert public attention away from a comprehensive national health insurance program on the theory that the most serious problems are being dealt with by coverage for catastrophic costs.

(2) It will accelerate the current inflation of health care costs by adding to incentives for very expensive care and disincentives for more cost care.

(3) It will provide no incentive for an equitable distribution of general practitioner services or for general care facilities.

(4) It will require low-income persons to pay for a program whose principal benefactors will be the non-poor.

(5) It will do nothing to provide protection against the expense of long term care and excludes out-patient drugs and other general health care services.

The National Urban League does support a comprehensive national health program to cover health care of the over 45 million Americans who have either no health insurance or inadequate coverage. The League believes such a comprehensive program would:

(1) Increase the efficiency and fairness of health care delivery;

(2) Allow adequate and fair distribution of benefits;

(3) Seek to bring skyrocketing health costs under control; and

(4) Devote more health resources to disease prevention and health promotion.

STATEMENT

Mr. Chairman and members of this Committee, good morning. I am Ronald H. Brown, Vice President for Washington Operations of the National Urban League, Inc. We welcome this opportunity to present the League's views on Catastrophic Health Insurance.

The National Urban League is a non-profit, community-based social service organization committed to securing equal opportunities for Black Americans. Founded in 1910, the League has since expanded its scope to include all minority groups, and poor and disadvantaged Americans. But its major thrust continues to be on behalf of Black people facing problems in our nation's cities. As a result, we are keenly aware of the social and health problems of the poor, particularly the minority poor.

At the outset, let me state that the National Urban League is opposed to the initiatives of S. 350, which amend the Social Security Act and provide for catastrophic health insurance, and is opposed to the initiatives of S. 351, which provide only limited health services and detract from a much needed broader health system. As Vernon E. Jordan, Jr. testified before the Subcommittee on Health, October 13, 1978, the National Urban League feels very strongly that a national health plan, which includes universal and comprehensive medical coverage for all is the only hope for most poor people and particularly for the minority poor in their struggle to enjoy a healthy life.

Today, our testimony will be primarily directed toward the initiatives proposed in S. 351, although there is an admitted need to reform the existing Medicaid and Medicare programs, to include some of the approaches outlined in S. 350. Both programs, as the two major vehicles for financing health care to the poor, contain defects which have caused many of us to seek even more forcefully, a national health insurance program. Needless to say, much of the congressional action focuses not on the reform efforts, but on the proposal to provide catastrophic insurance coverage as outlined in S. 351.

The National Urban League believes that a comprehensive national health program is essential. Millions of Americans do not receive needed health care, either because they are too poor to afford the costs or because they live in areas where medical services are not readily available. These problems are especially acute for the poor, minorities, and the elderly. Indices of health care and health status are constant reminders to us that the condition of the poor, a disproportionate number of whom are Black Americans, is indeed tragic. Infant mortality rates are 50 to 100 percent higher in urban than rural areas and 70 percent higher for non-whites than whites. Life expectancy for Blacks is five years less than whites. For example, in 1976, the life expectancy was 69.7 years for a white male, 64.1 for a non-white male;

79.3 years for a white female, 72.6 for a non-white female. These statistics are an example of many which were included in the recent National Urban League publication, The State of Black America, 1979 (see attachment A).

Statistics notwithstanding, we all have some vague notion of the need for such coverage. We have some idea of what a catastrophic condition or illness is and what it can do to any family. If any of us individually were asked to define the most serious, and probably the most frightening of potential illnesses, cancer would probably rank number one or two. Recent studies have certainly highlighted the disparate impact of cancer on Blacks versus white. Those figures have shown that for some types of cancer, the Black rate is double, or in some instances, more than double that of whites. The survival rate of Black with cancer is lower than that of whites. Several reasons exist for this differential. But the most important is the lack of early diagnosis, when prospects for a cure are best.

Cancer is but one example. The same is true of numerous other conditions and diseases including cardiovascular disease, diabetes, disease of the liver and tuberculosis. Again, looking at the statistics contained in The State of Black America, 1979 (see attachments B and C) the Black/white differential is vividly made. What these numbers do not show, however, is how many of these deaths could have been prevented by early detection of the illness, or how many were the result of accumulated health problems.

The League believes that part of the answer to the problem of health care of minorities and the poor lies in a comprehensive health insurance program and not in catastrophic health coverage. If as Senator Long has stated, truly comprehensive legislation cannot be expected over the next several years, then any new health legislation which is enacted must be designed to have the widest possible impact on that part of the population with the greatest risk and with the poorest general health. Such legislation should involve a shift in focus from the present emphasis which now, (1) discourages periodic check-ups and health reviews, (2) encourages longer term hospitalization, and (3) provides over-emphasis on hospital-based specialty care. Experience has shown us that private medical treatment has followed the focus of the health dollar. Extended hospital stays and higher medical bills seem to be almost destined.

What must be realized is that catastrophic health insurance does nothing to increase access, or to improve the quality of health care for those in our nation who have the lowest health status and who experience the greatest health risks. Although Medicare and Medicaid have improved the health status of many poor and minority citizens, some eight million persons below the poverty line are not covered by any form of medical assistance. In addition, nearly 45 million Americans—about one in five people in this nation—have either no health insurance or inadequate coverage. Twenty-six million persons have neither health insurance nor access to free care through VA or the Public Health Service. Another 37 million Americans, again low-income workers with either no or with inadequate health insurance, may not receive needed medical services at all, because they cannot afford them. At the same time, health care costs continue to rise faster than any perceived benefits of increased health or life expectancy.

Admittedly, catastrophic coverage as provided in S. 351 will reduce the financial burden caused by indefinitely rising higher costs for seriously debilitating illnesses for some; but for the poor, the disadvantaged and the low-wage earners it will have very little impact. The bill seems more to be designed as a supplement to the broader private insurance health plans than as a health cost relief mechanism. It seems to provide, for the most part, as much relief for the private health insurance industry as it does for the private insurance purchaser. Clearly, the passage of S. 351 will remove much of the pressure on the private plans to expand coverage and to more closely monitor expenditures.

It is unfortunate that with so many receiving little or no health care and with the need to focus on preventive and comprehensive health care for the poor, that we are now concentrating on a health insurance plan which is so limited and which is designed, in reality, to serve only a small segment of the population. The Catastrophic Health Insurance Plan as proposed, would not meet the health care needs of the majority of the population and would further serve as a barrier to the obtainment of comprehensive health care, particularly for those who need it most. We all know that most illnesses can be catastrophic to this nation's poor, low-wage, and middle-wage earners. These individuals and families are financially wiped out long before the $2,000 or $3,000—60 day qualifying conditions for S. 351 coverage has been met. Although catastrophic health may appear to be a good measure for some people, the National Urban League opposes the enactment of S. 351 for the following reasons:

(1) Catastrophic Health Insurance will divert public attention from serious consideration of a comprehensive national health insurance program on the theory that the most serious problems are being dealt with by providing coverage for catastrophic cost; while in actuality, it will fail to deal with better access to health care by leaving the present delivery system intact.

We, at the National Urban League, would hope that political compromise in the form of a less expensive insurance plan which only serves a targeted segment of the population and which concentrates on a specific health problem will not overtake the recognized health needs of the American people, especially of the minority poor. There is needed, a national commitment to the development of a comprehensive health plan to assure that all Americans have adequate health care coverage.

Though there is a real need to provide coverage for catastrophic health cost for many American families, the Catastrophic Health Insurance in itself is not sufficient to improve and maintain the overall health needs of the majority of American citizens.

(2) Catastrophic Health Insurance will accelerate the current inflation of health care costs by adding to incentives for very expensive care and disincentives for more cost effective preventive and ambulatory care.

Catastrophic Health Insurance would encourage further concentration on expensive specialty services as opposed to primary care which may only partially serve the interests of the poor, minorities, and the elderly. As a result, hospital and medical costs would escalate as physicians raise their prices, especially for the ill and the dying. The plan would also provide incentives for more frequent hospitalization as tremendous pressure would be exerted to keep the patient in the hospital until the trigger point for catastrophic coverage was reached. The absence of cost containment features in this plan, will allow hospital and medical costs to rise even faster than they are presently and further add to the problems of health care financing for the poor.

(3) Catastrophic Health Insurance will provide no incentive for an equitable distribution of general practitioner services or for general care facilities, but will reinforce the trend towards greater concentration of specialty practitioners.

Since the major beneficiaries of catastrophic costs would be those who are able to spend the deductible amounts, services for this health care would maldistributed. Existing medical manpower and facilities are already so maldistributed that large segments of the population, especially the urban poor and those in rural areas, get virtually no care at all. Catastrophic Health Insurance will further skew manpower away from rural and small town areas by increasing the funds available to pay lucrative specialists in urban areas. The numerous general illnesses of individuals often neglected in these areas will still go unmet.

(4) Catastrophic Health Insurance ill require low-income persons to pay for a program whose principal benefactors will be the non-poor.

The plan would benefit the wealthy by establishing limits for their health cost liability, but its deductibles of 60 hospital days and $2,000 in medical fees would be a disaster for middle-income families and a catastrophy for lower-income families many of whom already cannot afford primary health care coverage. Because of the high deductibles and emphasis on major illnesses, the plan would further distort the allocation of national health care resources away from health maintenance; early diagnosis of disease; home health care; and other neglected aspects of the system. In addition, the plan gives more benefits to people who already have basic coverage and does almost nothing to help those without such coverage. Though the cost to the government may be less, the cost of out-of-pocket expenses to the consumer because of the deductibles would be much more than would be provided by a comprehensive national health plan.

(5) Catastrophic Health Insurance will do nothing to provide protection against the expense of long term care and excludes outpatient drugs and other general health care services.

Ironically, long-term nursing home care has generally been excluded from the catastrophic insurance plan despite the obvious need for assistance in financing such care. This problem for persons with chronic health care needs is common among the elderly and a major source of catastrophic costs. Though the plan provides for home health care, like the Medicare plan, it only allows up to 100 days of hospitalization or nursing home care. In addition, outpatient drugs absorb significant amounts of costs for elderly and the poor, and could account for another $3 to $5 million of any health plan. But, to skim over these provisions for the sake of catastrophic coverage alone, would seriously affect the needs of the poor and the elderly.

CONCLUSION

The National Urban League strongly urges this Committee to recognize and seriously consider that this country needs a plan that will attend the health needs of all Americans. We must not concentrate our efforts on catastrophic health care, but look to the prevention and early detection of health problems to keep and maintain healthy individuals, and as a result, combat catastrophic illnesses, particularly for the poor and disadvantaged. We must continue to move toward a health care system which will (1) increase the efficiency and fairness of health care delivery; (2) allow adequate and fair distribution of benefits; (3) seek to bring skyrocketing health costs under control; and (4) devote more health resources to disease prevention and health promotion. If we are dedicated to ensuring a nation of healthy individuals then we must work toward developing a comprehensive health care plan which incorporates medical care as well as all other aspects of health care, i.e., nutrition, health, education, etc.

We were encouraged by the provisions of the National Health Insurance Act of 1979 which provided universal and mandatory coverage; comprehensive benefits; and accessibility to the populations in need. In fact, we need to be aware that a comprehensive program such as that embodied in that proposed National Insurance Plan, automatically provided protection against catastrophic threats without sacrificing the other essential objectives of a good system.

The realities of S. 351, Catastrophic Health Insurance Plan, are to us very simple:

It fails to provide a health care approach which emphasizes early detection, treatment and prevention; both of which are often unavailable to this nation's poor and minority populations.

It does not emphasize the overall primary health needs of poor and minority individuals.

It is another fragmented approach to health care which is not comprehensive and which offers no significant reform to the present system.

It will benefit the non-poor more than the poor, since the non-poor are the more likely individuals to afford to pay deductible costs.

It attempts to limit federal spending by concentrating on one specific area of health care, but does not contain cost containment factors which are sorely needed to combat medical inflation.

Though catastrophic health insurance may be a good measure in and of itself for some Americans, we recommend to the Congress and to this Administration that the enactment of a comprehensive health program would more expeditiously and effectively deal with the current problems of health care and would have the greatest impact on improving and maintaining the health care needs of the poor, minorities and the elderly.

To this end, we oppose S. 351 and we continue to strongly support a comprehensive health care program that will benefit all.

[Attachments follow:]

ATTACHMENT A

ESTIMATED AVERAGE LIFESPAN AT BIRTH*

	TOTAL			WHITE			NON-WHITE			DIFFERENCE BETWEEN WHITE AND NON WHITE		
Year	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female
1920	54.1	53.6	54.6	54.9	54.4	55.6	45.3	45.5	45.2	-9.6	-8.6	-10.4
1930	59 7	58.1	61.6	61.4	59.7	63.5	48.1	47.3	49.2	-12.3	-12.4	-14.3
1940	62.9	60.8	65.2	64.2	62.1	66.6	53.1	51.5	54.9	-11.1	-10.6	-11.7
1950	68.2	65.6	71.1	69.1	66.5	72.2	60.8	59.1	62.9	-8.3	-7.4	-9.3
1960	69.7	66.6	73.1	70.6	67.4	74.1	63.6	61.1	66.3	-7.0	-6.3	-7.8
1970	70.8	67.1	74.6	71.7	68.1	75.4	64.6	60.5	68.9	-7.1	-7.6	-6.5
1971	71.1	67.4	74.9	71.9	68.3	75.7	65.2	61.3	69.4	-6.7	-7.0	-6.3
1973	72.3	68.0	76.0	73.0	68.4	76.1	66.0	61.9	70.1	-6.3	-6.5	-6.0
1974**	71.9	NA	NA	NA	68.9	76.6	NA	62.9	71.2	NA	-6.0	-5.4
1975**	72.5	NA	NA	NA	69.4	77.2	NA	63.6	72.3	NA	-5.8	-4.9
1976***	72.8	69.0	76.7	73.5	69.7	77.3	68.3	64.1	72.6	-5.2	-5.6	-4.7

Source: Adapted and calculated from Statistical Abstracts of the United States, United States Department of Commerce, 1971, p.53, and 1973, p.57. All figures indicate a deficit in life expectancy among non-whites as compared to whites.

*1970, 1971, and 1973, preliminary data

**Source for 1974 and 1975, DHEW Publication No.(HRA) 77-1232 Health- United States 1976-77, (Table 19, p. 162)

***Source for 1976, Vital Statistics of the United States - 1976, Vol.II, Sec. 5, "Life-Tables". USDHEW PHS, Hyattsville, Maryland, 1978.

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ATTACHMENT B

AGE-ADJUSTED DEATH RATES FOR SPECIFIED CAUSES, BY COLOR, PER 100,000 POPULATION

UNITED STATES, 1974

CAUSE OF DEATH	Total	White	Non-white	Difference between White and Non-white	Differential Ratio[1]	% Higher for Non-whites[1]
All causes	666.2	635.4	901.3	265.9*	0.42	42%
Major cardiovascular disease	310.8	302.9	374.8	71.9*	0.231	24%
Hypertension	2.1	1.7	5.7	4.0*	2.35	235%
Cerebrovascular disease	59.9	56.4	90.9	44.5*	0.79	79%
Arteriosclerosis	7.6	7.6	7.3	0.3**	0.04	-4%
Malignant neoplasms	131.8	129.0	156.6	27.6*	0.22	22%
Accidents	46.0	44.3	58.5	14.2*	0.32	32%
Motor vehicle	21.8	21.7	23.2	1.5*	0.07	7%
All other	24.2	22.6	35.3	12.7*	0.56	56%
Influenza and pneumonia	16.9	15.7	25.4	9.7*	0.62	62%
Diabetes mellitus	12.5	11.4	23.4	12.0*	1.05	105%
Cirrhosis of the liver	14.8	13.4	25.0	11.6*	0.87	87%
Tuberculosis, all forms	1.3	0.9	4.6	3.5*	3.88	388%

*Indicates differences in higher death rates per 100,000 blacks and other non-whites
**Indicates differences in higher death rates per 100,000 for whites

Source: National Center for Health Statistics, Vital Statistics of the U.S., 1974. Vol. II, Mortality, Part A.

1. These figures supplied by author.

ATTACHMENT C

COMPARISON OF CHANGE IN AGE-ADJUSTED DEATH RATES FOR SPECIFIED CAUSES, BY COLOR, PER 100,000 POPULATION, UNITED STATES, BETWEEN 1969 & 1974

CAUSE OF DEATH	Difference between White and Non-white		Differential Ratio		% Higher for Non-whites	
	1969	1974	1969	1974	1969	1974
All causes	351.7	265.9	0.506	0.42	51%	42%
Major cardiovascular disease	116.5	71.9	0.340	0.231	34%	24%
Hypertension	7.1	4.0	2.960	2.35	296%	235%
Cerebrovascular disease	53.3	44.5	0.860	0.79	86%	79%
Arteriosclerosis	0.1	0.3	0.011	0.04	-1%	-4%
Malignant neoplasms	31.8	27.6	0.250	0.22	25%	22%
Accidents	22.9	14.2	0.430	0.32	43%	32%
Motor vehicle	5.8	1.5	0.210	0.07	21%	7%
All other	17.0	12.7	0.690	0.56	69%	56%
Influenza and pneumonia	19.6	9.7	0.880	0.62	88%	62%
Diabetes mellitus	14.5	12.0	1.100	1.05	110%	105%
Cirrhosis of the liver	11.1	11.6	0.860	0.87	86%	87%
Tuberculosis, all forms	6.3	3.5	3.710	3.88	371%	388%

STATEMENT OF HON. JOHN MELCHER, A U.S. SENATOR FROM THE STATE OF MONTANA

Senator MELCHER. Senator Talmadge and members of the committee I have a prepared statement. I want to briefly summarize some of the main points.

In 1977, there were 312 open heart operations in Montana. They cost $12,000 a piece.

In 1977, there were 126 cases of newborn infants requiring neo natal intensive care. The average cost was $20,000 per episode.

While successful treatment in each instance is a Godsend, the costs can be an economic catastrophe, especially in a State like mine where the median annual income for a family of four is $16,400 and the yearly income of many is far less than that.

For the Nation as a whole, the Congressional Budget Office tells us an estimated 2.5 million people under age 65 were expected to have medical expenses in excess of $5,000 in 1978. Beyond that, 12.3 million families were expected to have noninsured expenses exceeding 10 percent of their incomes. The Budget Office notes that only about 5 to 8 percent of the U.S. population did not have health care coverage in 1978. That is still somewhere between 11 and 18 million people. Even among those who are covered, it is estimated that 15 percent lack catastrophic protection.

There is a clear need to find some way to guard against the economic ruin that can follow a catastrophic illness or injury. The bills S. 350 and S. 351, of which I am a cosponsor together with S. 748 and S. 760 attempt, in varying degrees, to provide that kind of protection.

Under the catastrophic protection program proposed in S. 350 and S. 351, all medical expenses over $2,000 and hospital costs in excess of 60 days would be covered either through a private or public insurance plan. In Montana, the average cost of a day in the hospital is $183.07. For 60 days of hospitalization, the bill would be $10,980.

Add to that the $2,000 for medical expenses and at first glance, a person would appear to be liable for nearly $13,000 before the full catastrophic insurance provided under these bills would come in. It is for that reason I am glad that so many people in this country are already covered by insurance that would pick up at least a portion of that initial health care bill.

For those several million people who do not have even basic coverage, there is another encouraging feature of these bills. They would establish a system of voluntary certification for insurance companies, prodding them to offer one or more policies to provide coverage for the 60 days of hospital care and $2,000 in medical expenses not covered by the catastrophic plan. That push toward uniformity and reliability matched to the strong emphasis on private insurance company involvement is a solid argument in favor of this plan.

I will concede that as we begin these discussions, all of the bills have shortcomings. They do not, for example, cover long-term nursing care despite the fact that it is the most significant catastrophic expense problem. I realize providing that sort of coverage would cause certain problems because, as the Congressional Budget Office

points out, such care is often more custodial or residential than strictly medical.

Nevertheless, in fiscal year 1978 an estimated 1.3 million people were residents of nursing homes for 6 months or longer at an aggregate cost of about $14.7 billion. Almost 55 percent of that cost, or $8 billion, was paid directly by consumers. As these hearings continue and subsequent discussions proceed, we must not lose sight of the need to address this serious problem. That concludes my summary but I want to make a few other observations.

I have had 20 years of professional service in health care delivery for animals; I am a veterinarian. The owners of the animals and I have made decisions—sometimes based only on economics. If it did not seem medical or surgical help would really help the animal, quite often euthanasia was performed as more humane for the animal's welfare. Of course, I do not advocate euthanasia for human beings in any context.

So often in catastrophic conditions there is heartbreak for the family. There is great suffering for the patient.

Along with that heartbreak often comes bankruptcy. I think it would be absolutely cruel on the part of those of us in Congress to allow this to continue and not do what this country can afford to do in case of catastrophic illness and catastrophic injury.

I have been here in Congress for over 10 years. Ever since the first day I arrived, I have had an interest in catastrophic insurance which is often not covered in any adequate form by private insurance companies.

We have done fairly well with medicare and fairly well with medicaid, but for the great bulk of Americans, we have not plugged the gap of providing some catastrophic health protection.

I am very resentful personally that catastrophic health insurance has been held hostage for 10 years for the all or none approach. It may mean another 10 years of captivity if this committee does not push to bring this to the Senate floor. We have heard too long that there is either going to be complete cradle-to-grave coverage or we are going to hold catastrophic hostage until that fine day arrives.

As a matter of conscience, as a matter of conviction, I personally want a bill to vote on this year in the Senate and see the Congress pass it and the President sign it, and I want it to take effect.

I am not impressed with proposals to fit into some sort of fiscal planning, in 1982, 1983, or 1984, where we will arrive at the point, by stages, of doing what we know we should have done a long time ago.

This is the most pressing and urgent need facing Congress. In terms of ending suffering and heartbreak for so many individuals and so many families throughout America, I say go with the catastrophic plan this year, make it effective as soon as possible, not in 1980 or 1981. Make it effective by the end of this year, or the very start of 1980.

Whatever else we are going to do beyond that can be done later. If we continue to hold catastrophic protection hostage, for the final version of national health insurance, I think we are doing this country an injustice and I want to see that injustice end, and end this year.

Thank you very much.
Senator TALMADGE. Thank you very much, Senator Melcher.
Senator Long?
The CHAIRMAN. I am not seeking to interrogate the witness, but I am very happy to see him. I have no questions.
Senator TALMADGE. Senator Melcher, I want to congratulate you. I have read every word of your prepared remarks. I think it is logical, I think it is realistic, and I think it addresses the most serious problem that confronts this country.
If you were walking around Washington with only 50 cents in your pocket and were real hungry, you would buy a hamburger instead of waiting for the day when you could buy a sirloin steak.
Senator MELCHER. I sure would.
The CHAIRMAN. I heartily endorse your statement.
Senator MELCHER. Thank you very much.
Senator BAUCUS. I would like to thank my colleague from Montana for coming this morning; it is good to see you. Thank you very much.
Senator MELCHER. Thank you very much.
[The prepared statement of Senator Melcher follows:]

STATEMENT OF SENATOR JOHN MELCHER

Mr. Chairman, let me begin by citing some figures taken from the Montana Health Systems Plan.

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While successful treatment in each instance is a Godsend, the costs can be an economic catastrophe, especially in a State like mine where the median annual income for a family of four is $16,400 and the yearly income of many is far less than that.

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coverage would cause certain problems because as the Congressional Budget Office points out, such care is often more custodial or residential than strictly medical. Nevertheless, in fiscal year 1978 an estimated 1.3 million people were residents of nursing homes for 6 months or longer at an aggregate cost of about $14.7 billion. Almost 55 percent of that cost, or $8 billion, was paid directly by consumers. As these hearings continue and subsequent discussions proceed, we must not lose sight of the need to address this serious problem.

The new catastrophic insurance proposal, S. 760, simply requires that employers provide catastrophic protection rather than levying a tax directly on employers. Under the revised proposal, employers with taxable payrolls of under $250,000 a year, could either take a deduction for premium costs or a 50-percent tax credit for those costs. That is a significant refinement that needs serious consideration especially in terms of businesses like agriculture or retail trade which now have the lowest rates of group health coverage.

A week ago, it appeared that the President was moving in the direction of catastrophic health insurance, but from what Secretary Califano has told this committee, it does not appear that is entirely the case. Still, I hope we can win the President's cooperation so that we can adopt a focused and managable system of health insurance. It is important that we push the search and try to do the best we can with the resources we have.

None of the proposals now written are perfect answers standing alone and in their own right. While I am a co-sponsor of S. 350 and S. 351, I am not undividedly tied to all of their provisions. Nevertheless, I hope that with White House support and congressional persistence we can move quickly toward enactment of a system of catastrophic protection.

[Thereupon, at 11:15 a.m., the committee proceeded to other business.]

[Whereupon, at 11:45 a.m., the committee resumed its hearing.]

The CHAIRMAN. Now, let me call Mr. Seidman, American Federation of Labor, AFL-CIO.

STATEMENT OF BERT SEIDMAN, DIRECTOR, DEPARTMENT OF SOCIAL SECURITY, ACCOMPANIED BY ROBERT McGLOTTEN, LEGISLATIVE REPRESENTATIVE, AFL-CIO

Mr. SEIDMAN. Thank you very much, Mr. Chairman. We are very glad to be here. With me this morning, to my right, is Robert McGlotten who is a legislative representative of the AFL-CIO and to my left is Richard Shoemaker, assistant director of our social security department.

My name is Bert Seidman. I am the director of the AFL-CIO Department of Social Security.

The AFL-CIO welcomes this opportunity to present its views with respect to S. 350 and S. 351. We strongly oppose title I in both bills which would establish a catastrophic health insurance plan.

However, we strongly support the concept behind title II which would establish Federal standards for private health insurance plans. Title III, in our opinion, should be divorced from the catastrophic provisions and the minimum benefits specified provided without deductibles and coinsurance.

We also strongly support title II of S. 350 which is not a part of S. 351. We also believe that federalization of medicaid should be separated from catastrophic insurance.

In the full statement we are submitting, Mr. Chairman, we offer suggestions to improve both of these sections. While we shall concentrate on catastrophic insurance in this summary, the AFL-CIO urges that both titles II and III of S. 350, if enacted, be temporary until such time as Congress enacts a comprehensive and universal health insurance program.

While still paying lip service to comprehensive national health insurance, the administration last week announced its so-called phase I which, for all practical purposes, abandons the President's commitment to that goal.

Although the details of its provisions have not been spelled out, what has been released indicated the administration's proposal will not be different from S. 350. If this turns out to be the fact, this testimony would be applicable to the administration's plan as well as to this bill.

Medical care costs continue to escalate at about twice the rate of all goods and services, as measured by the Consumer Price Index, and these costs are nearly doubling every 5 years.

We believe that catastrophic insurance would greatly accelerate the already unacceptably high inflation in health care costs. For the American people, this would mean higher taxes, higher insurance premiums, and higher out-of-pocket payments if catastrophic insurance is enacted. Indeed, medical care costs could easily double in 3 years, rather than the current 5 years, if an open-ended catastrophic proposal is enacted—and that Mr. Chairman, would be the catastrophe of catastrophic insurance.

Catastrophic insurance would only perpetuate the factors most authorities consider responsible for the breakdown in the delivery of health services—that is, the lack of organization of the system, compounded by a distorted specialty and geographic distribution of health professionals, and an inadequate supply and inefficient use of trained personnel in certain allied health professions. This leads to unbridled medical care costs inflation, which catastrophic insurance would not correct.

Medical care in the United States is oriented to the unusual, interesting or medically challenging types of treatment. As a result, health care in the United States is notably weak in the area of preventive care and routine medical treatment for commonplace illness. Because catastrophic insurance is aimed at the more dramatic and most expensive areas of medicine, such as open heart surgery and organ transplantation, it is logical to conclude that an even greater disproportion of physicians will specialize in these areas, because that is where the most of the money can be found.

Most catastrophic illnesses are treated in hospitals and the vast majority of the estimated $5 to $7 billion cost of a catastrophic program. Secretary Califano yesterday estimated the cost of the program at not $5 to $7 billion, but $10 to $15 billion, which we believe would be a substantial underestimate by 1981, and it would go to hospitals.

This would distort the allocation of national health care resources to hospitals or other institutional treatment and take resources away from prevention, health maintenance, home care, outpatient surgicenters and hospices.

Most medical care is good for people, but too much care can be harmful at worst or superfluous at best. We frankly believe that S. 350 and S. 351 would make it too financially attractive to some unscrupulous doctors and hospitals to provide hospital care, surgery, and laboratory work that is not needed. Since the only quality controls in these bills are the inadequate medicare standards, both the taxpayers and the patients could be big losers.

Catastrophic insurance would underwrite the expansion and proliferation of high-cost medical technology. According to the Council on Wage and Price Stability, most of the increase in hospital cost inflation is due to the intensity of care—or, in other words, the use of more and more expensive diagnostic and therapeutic equipment. While the use of this new technology does save lives, its rampant proliferation, inappropriate use, and the lack of any assessment of the diagnostic or therapeutic value of this technology versus risk, greatly increases costs.

Title I of S. 350 and S. 351 would just pour billions of dollars into this extravagant and wasteful system without providing for more efficient utilization of this high-cost technology.

Mr. Chairman, catastrophic health insurance has had a trial run in the United States, and that experience demonstrates the high-cost factor of such a program. When the end-stage renal disease program under medicare became operational in July 1973 the Department of Health, Education, and Welfare estimated the cost of $250 million for the first year and close to $1 billion annually by 1978. Actual costs are now over $1 billion and are expected to rise to $2.3 billion by 1982.

Why costs have increased is symptomatic of the problems associated with gearing programs to the more costly forms of care. After the law passed, the proportion of patients on home dialysis—which costs between $7,000 and $14,000 a year—declined from 37 percent to 25 percent, while the percentage of patients treated in dialysis centers increased. Treatment in these centers costs about $25,000 a year. The number of dialysis centers has doubled between 1972 and 1977 and there are now more than 860 approved to receive medicare funds and many are operated on a for-profit basis.

For the poor and many working people, unless catastrophic health insurance is built on top of a foundation of a comprehensive national health insurance program, it would not pay for needed care until after they had incurred initial high expenditures they cannot afford.

The Health Care for All Americans Act, soon to be introduced by Senator Edward Kennedy, will provide for physician and hospitalization without limit and, therefore, includes catastrophic insurance as an integral part of a total health care program. We, therefore, wish to make it clear that we favor catastrophic protection for all Americans as part of a comprehensive program with a foundation of basic coverage which includes preventive and health maintenance benefits without financial deterrents.

In conclusion, catastrophic insurance standing alone is a program for the rich, hospitals, and doctors. For the American people, it would be a catastrophe.

Mr. Chairman, what is conspicuously absent from both bills is a rudimentary understanding of the basic economics of the health care industry. The laws of supply and demand are skewed beyond recognition in this industry.

Doctors control 70 percent of all expenditures for health services. S. 350 and S. 351 are an attempt to make health care fit into the principles of insurance, rather than adapting financing to the realities of the health care industry. The result is a massive misalloca-

tion of resources to acute illness and relatively few resources for prevention and health maintenance.

Title I of S. 350 and S. 351, which provides for catastrophic health insurance, would cover less than 10 percent of total expenditures for personal health services. It would accelerate the inflation in health care costs by channeling more dollars into intensive high-cost care, rather than financing prevention and health maintenance to avoid catastrophic illness.

Federalizing medicaid as provided by title II of S. 350 would be a major advance, but the $3 copayment for the first patient-initiated visit should be eliminated. We urge enactment of this title.

We have some comments on the other provisions of the bill in the rest of our statement, our full statement, Mr. Chairman.

The CHAIRMAN. Let me ask you this. How many unions in the AFL-CIO now have major medical or catastrophic health insurance?

Mr. SEIDMAN. I would like to ask Mr. Shoemaker to reply to that.

Mr. SHOEMAKER. There is no breakdown of health insurance coverage by unions. If I remember correctly, Nation expenditures for national health insurance indicates about 50 percent of all people have catastrophic coverage and major medical. As far as the unions are concerned, the vast majority have major medical on top of fairly comprehensive programs.

The CHAIRMAN. Let me ask you this. Do the automobile workers have such coverage?

Mr. SEIDMAN. I would assume so, but it would be better if you asked if they had somebody appearing.

The CHAIRMAN. My understanding is that they do.

Do the steelworkers have it?

Mr. SEIDMAN. I would think they do.

The CHAIRMAN. If you would provide that for the record.[1]

My thought is, Mr. Seidman, it is hard for me to see how there could be anything very bad about it if some of your best unions think enough of it that they are providing it to their workers and they have been fighting for it and getting it for their workers.

And frankly, I would have some doubts that anything is worth doing if it could not stand scrutiny and can be justified on its own merits.

Mr. SEIDMAN. Mr. Chairman, in our statement we have said that we are not opposed to protection for catastrophic illness provided that it is part of a comprehensive program. Through collective bargaining, our unions do provide—many of them, at least, have tried to provide—first dollar coverage for basic medical services in hospitalization. Some programs are very much better than others. Some do include major medical and some do not.

But we think that there should be protection against catastrophic illness as a part of the comprehensive program. That is why we favor legislation which would provide catastrophic protection as a part of a comprehensive program and that is why in collective bargaining our unions have also sought in the absence of legislation, to obtain both the basic protection as the foundation and some kind of catastrophic protection.

[1] See p. 425

We are not opposed to catastrophic protection; I want to emphasize that point. We are in favor of it as part of a comprehensive program.

The CHAIRMAN. Let me just say this, Mr. Seidman. When your people came to me urging me to vote for medicare, that was not a comprehensive package. The argument they gave the first time that they approached me on it was this idea of a cradle-to-the-grave program was not going very far, it was not moving, and they felt we had to start somewhere to get something done, so they asked me to support medicare, and I did.

Mr. SEIDMAN. And we are very glad that you did, Senator.

The CHAIRMAN. It took a little time, but I finally came around and said, "All right, I will support it." I usually say something like that I will support almost any bill if you will take my amendment. Of course, my amendment may be to strike everything after the number and start rewriting from there.

I said, "All right, if you will take these changes and do it this way, then you can take me along." So I climbed aboard and asked all the Senators to vote for it and we did. We went beyond that. In that same bill, we put medicaid into place and that is costing as much as medicare. It hardly attracted much of a ripple at all because that was something we were paying with public funds to the poor.

The principle was acceptable. Between those two, they are costing about $50 billion.

I would say that is almost 35 percent of all expenditures, public plus private. We did a lot more than just look at medicare, even though, at that point, all your people were really insisting on was that we take care of the aged. So we gave you something that did more than you asked for.

If I read the temper of the Congress, we are going to give you more than the catastrophic; we are going to do something for a lot of other people, too, but we may not do it all in one step.

Can you not find something to feel good about if we give you about $20 billion of a package that ultimately may run about $100 billion?

Mr. SEIDMAN. In the first place, Senator, we were strongly in favor of medicare, as you know. Medicare has gaps. It has defects. We think that there are improvements that can be made in it, but it was a program of essentially comprehensive care for the elderly and now it is for the severely disabled. The same thing is true of medicaid. It is essentially a comprehensive care program, although in some States, it is very much more comprehensive than in others and we would like to see those changes made.

As far as what you have said about what is likely to happen, what we are interested in is not having a comprehensive program take effect all at once. That was pretty much the nature of the bill that we had been supporting, the health security bill; the bill that Senator Kennedy is producing will provide for implementation in phases, although those phases will all be laid out in the legislation.

We are in favor of doing something for all elements of the population; we are in favor of a program that would include comprehensive protection and if you and we can get together on that kind of a bill, then I think it is going to be enacted. I think we are

going to have to look and see just exactly what is going to be in that kind of a bill.

The CHAIRMAN. Let me point this out to you, Mr. Seidman. Sometime in these conferences I find myself supporting something and they say, "We cannot do that because it does not solve all of the world's problems." I say, "Fellows, if this thing solved all the people's problems, they would not need us anymore. They would have to get rid of the Congress because it would all be over."

Really, I think it's like your coming up representing the American Federation of Labor and you go back and tell those people, "Fellows, I would have like to have gotten more but we have a $20 billion bank to show for what we did; next time we will get more."

That is usually how it works in organized labor. My impression is, if a labor leader got everything he asked for, he would be just as embarrassed as a lawyer who got everything he asked for when he filed a petition. He would feel like he should have asked for a lot more because he might have gotten it if he had asked for it.

So I think the same thing tends to apply to you fellows. I think if that is the prevailing view, they go in and get everything they ask for and say finally, "Why didn't I ask for more? I might have gotten that, too."

Mr. SEIDMAN. I would like to point out that it is exactly within that pragmatic spirit and having made an analysis of the situation that we are supporting a bill this year, or a bill that will be introduced which, in many important respects, we regard as embodying concessions that frankly we were not particularly anxious to be making. We think that is a realistic bill, a bill that is not going to put a tremendous burden on the Federal budget, a bill which will not result in any increase in payroll taxes, a bill that would utilize the private insurance industry. It represents substantial change from the bill we had been supporting, and that shows that we are realistic and we are pragmatic and we are not pulling back from our goals in health care and we think that the kind of legislation that we are going to support will move to the achievement of those goals, but we are prepared to look at anybody else's proposals. In fact, we have looked at your proposals very carefully before we drafted this.

The CHAIRMAN. I am pleased to hear your statement, Mr. Seidman. I think that is great.

I am pleased to say I gained the impression that practically all members of this committee are moving to coalesce on something and I very much hope that your people will be a part of what we coalesce on.

Senator DOLE? Senator Danforth?

Senator DANFORTH. I would ask a standard question that I have got. Whatever we do is going to cost money. Mr. Califano was saying yesterday he hoped that hospital cost containment was going to solve part of that, but the costs of hospitalization are not going to go down, let us face it. They will continue to go up, even with the most Draconian bill we draft.

So I introduced a bill yesterday. I do not know how much support it will get. I think I will know where the opposition is coming from, at least—to increase the excise tax on cigarettes by a dime a pack.

The excise tax on cigarettes has been at 8 cents a pack since 1951. Since 1951, some things have happened.

One, the value of that 8 cents has been pretty well eroded by inflation and two, the Federal Government has gotten into the business of paying for people's health care. Under today's law, it is estimated that over $3 billion of what the Government pays out for health care every year goes to pay for medical problems that are directly caused by smoking.

Maybe you have not thought it out, but do you have any sense as to whether or not we could get a little support from the AFL-CIO for such a bill? It would produce $3 billion a year by charging a dime a pack more for cigarettes.

Mr. SEIDMAN. I am not our expert, Senator, for tax policy but I have been with the AFL-CIO long enough to know that we are strongly opposed to all forms of excise taxes, because we think that they are regressive, that they have a larger impact on the poor than they do on the rich, and I have no reason to think that we would have a different position with respect to the particular type of excise tax that you are describing.

Senator DANFORTH. You do not think that people who smoke should pay for their medical problems caused by smoking, but rather that it is more equitable to spread that cost throughout all society, smokers and nonsmokers?

Mr. SEIDMAN. I think there are many other things that people do besides smoke. I do not smoke myself, but I probably do other things that contribute to health care costs and I think it is going to be very difficult to point to John Doe and say, "You are doing the kinds of things which are resulting in more health care costs and somebody else is not. I do not see——

Senator DANFORTH. Do you think the Surgeon General's report is wrong?

Mr. SEIDMAN. No, I am not saying that the Surgeon General's report is wrong. I have no reason to doubt what is in the Surgeon General's report. I am just saying that there are many things that contribute to illness. Smoking is only one of them, and I do not think we should utilize something in the form of a regressive tax to deal with this problem.

Senator DANFORTH. I do not see what is regressive about requiring—in effect, it is requiring that people who are going to be using a disproportionate amount of medical services to pay for those services to the extent of a dime a pack. It is like buying an insurance policy.

Mr. SEIDMAN. Rich smokers can afford that more than poor smokers, and we have a certain percentage of people in the United States who smoke, and this means discrimination against the less well off people who smoke.

Senator DANFORTH. You believe that essentially a health program should be paid for? How?

Mr. SEIDMAN. I think a health program should be paid for from a number of different sources. For poor people, I think it generally should be paid for out of general revenues. For the rest of the population it should be paid for out of some kind of insurance, whether it is in the form of social insurance or private insurance.

The bill we are supporting will be doing this in the form of private insurance.

Senator DANFORTH. The Government is going to pay part of the cost, is it not?

Mr. SEIDMAN. The Government would pay part of the cost for those people who would not be covered.

Senator DANFORTH. How much additional cost to the Government would that be?

Mr. SEIDMAN. The additional cost of what?

Senator DANFORTH. Of your bill.

Mr. SEIDMAN. For the Government?

Senator DANFORTH. Yes.

Mr. SEIDMAN. It is our estimate that it would be, when fully implemented, and it would be implemented in stages, no more than $30 billion.

Senator DANFORTH. No more than $30 billion?

Mr. SEIDMAN. Yes.

Senator DANFORTH. Do you have any notion of where that $30 billion is going to come from?

Mr. SEIDMAN. Yes. We think the $30 billion can come if the Congress enacts the kind of legislation we think it should from closing up some of the loopholes in our tax legislation which favor the wealthy.

Senator DANFORTH. I see. Which ones? To create $30 billion, which ones would you close?

Mr. SEIDMAN. Again, you are asking me to give you information on our tax policy and I am not the expert. I can mention some things that I know that we think are loopholes that can be closed.

We think that an important loophole is the differential taxes which apply to capital gains. We think another one is the DISC program—maybe Mr. McGlotten knows more than I do. This is not my area of expertise.

Senator DANFORTH. Do you envision success for that program, taxing capital gains as ordinary income? How would you assess the odds of accomplishing that in this Congress?

Mr. SEIDMAN. I do not try to assess the odds.

Senator DANFORTH. Do you think it ranges in the zero to 1-percent range?

Mr. SEIDMAN. I do not know, but we are going to continue to work for changes in the tax laws to make them fairer than they are.

Senator DANFORTH. The point is, we try to do what is practical. The deficits have been so large and we try to accomplish something that is not just going to wreck the economy.

Mr. SEIDMAN. We think the deficits have been large because of the combination of inflation and unemployment and we think different economic policies should be followed from those adopted.

I should say that we think the kind of program that is in the legislation that we are talking about today, S. 350 and S. 351, we think is going to result in a very large increase in health care costs, including the health care costs paid for by the Government.

Senator DANFORTH. Do you think we should repeal the present excise tax on cigarettes?

Mr. SEIDMAN. I think we should try to eliminate all excise taxes and to develop a taxation system that is based, as much as possible, on ability to pay. I would not single out the excise tax on cigarettes as opposed to other excise taxes, but that is our general position.

The CHAIRMAN. Senator Dole?

Senator DOLE. You mentioned, Mr. Seidman, on your summary page about the cost of the end-stage renal disease program. It has expanded, as you indicated, from $150 million to over $1 billion. What do you suggest we do for these people, if that is an example of what could happen if we had catastrophic coverage? What are the alternatives?

Mr. SEIDMAN. What we are suggesting is more of an emphasis in that program. In the first place, the alternative to covering disease by disease is to have a comprehensive national health insurance program of the kind we are advocating, but if you are talking about this specific program which has already been enacted, we think more encouragement should be given where it is appropriate to home dialysis rather than dialysis in residential centers.

Senator DOLE. We did that last year. In fact, we passed legislation last year.

Mr. SEIDMAN. It may be that that will have a leavening effect on this.

Senator DOLE. We are beginning to emphasize home dialysis, not only because it would be as effective, but also less expensive. Beyond that, unless there is some new technique or technology developed, I do not see what we can do about it.

Mr. SEIDMAN. We are suggesting that we think there are other diseases and it would be possible to do this on a disease by disease basis. We would strongly recommend against that approach. We would favor, instead, including treatment of all diseases in a comprehensive program.

Mr. Shoemaker wants to add something.

Mr. SHOEMAKER. In response, Senator, to your question, I think that most experts in the health care field today believe that increased emphasis on preventive care and routine health maintenance is necessary in order to cut down on the number of catastrophic illnesses. I want to make it clear that we want catastrophic insurance as a part of an extended program, and I would like to comment that there is a great deal of evidence that copayments on the patient in the form of deductibles and coinsurance increase cost because it is the doctor who creates the demand for health services.

Senator DOLE. We commented on that yesterday with Secretary Califano, to see what they were doing through the PSRO.

Mr. SEIDMAN. We are in favor of the PSRO effort, but we do not see where it is having much effect and, certainly, it is not having very much effect in terms of controling costs and, moreover, the doctors pretty much say that they do not want to have anything to do with PSRO efforts to control costs. 07At least, that is the impression I have. There was a very interesting article in the Washington Post on March 27 by Daniel S. Greenburg, who is a writer on medical subjects, in which he dealt with the subject that you are talking about and, in particular, with coronary care units. Coronary care units are something which I think should be included in any kind of health insurance program, but I think intensive care

units should be used only appropriately. It is a very expensive kind of care.

What has been found is that for patients with similar conditions, victims of heart attacks, the survival rate is actually higher among those treated at home rather than in coronary care units.

That would not be true for every patient, but we are saying that we should not emphasize this kind of expensive, high-technology, high-cost care when other kinds of care would be more appropriate.

The only way of being sure that the other kinds of care, the less-expensive kind of care is going to be given instead of the expensive care, would be if it is covered by a comprehensive insurance program.

Senator DOLE. I wonder if maybe you could submit for the reccrd, your comments on S. 748. I understand that you have not had a chance to thoroughly review our bill, but we believe that it has some merit and perhaps if we could have your comments, we could have them put in the record following comments on S. 350.

Mr. SEIDMAN. We have not had time to fully analyze that and we would be glad to have time to submit comments. I glanced through it this morning. I note you have some improvements in the medicare program which we would favor, but I have not had a chance to look at the bill as a whole.

[The following was subsequently supplied for the record:]

AMERICAN FEDERATION OF LABOR
AND CONGRESS OF INDUSTRIAL ORGANIZATIONS,
Washington, D.C., April 10, 1979.

Hon. HERMAN TALMADGE,
Chairman, Health Subcommittee, Senate Finance Committee,
U.S. Senate, Washington, D.C.

DEAR MR. CHAIRMAN: At the hearings on Catastrophic Health Insurance held March 28, 1979 with respect to S. 350 and S. 351, members of the Health subcommittee requested answers to a number of questions to which we now respond.

One question was to what extent AFL-CIO unions had negotiated supplemental major medical coverage on top of their basic health benefits package. We regret that we cannot supply this information in time for inclusion in the record of hearings. However, we will submit this information to the Health subcommittee at an early date.

Another question was the effect of major medical coverage on hospital utilization. Over the last 7 years, hospital utilization has been virtually unchanged. Many factors influence hospital utilization. Those factors that tend to increase utilization include:

(1) Major medical or catastrophic coverage.

(2) An excess supply of beds.

(3) Inadequate insurance coverage for outpatient care (i.e., no coverage for doctor visits or deductibles which deter patients from seeing a doctor early).

(4) Long waits and/or inconvenience in seeking care at hospital outpatient departments.

Those factors that contribute to decreased hospitalization utilization include:

(1) The availability of primary care physicians in a community and insurance coverage to pay for doctors office visits.

(2) The effectiveness of hospital utilization committees and/or PSRO's.

(3) Penetration of the health care market by HMO's. (For example, hospital utilization is lower in California and in Hawaii where HMOs have a substantial percentage of the population). We are not aware of any study that has attempted to isolate the effect of these positive and negative factors that bear on utilization separately.

With regard to the question as to whether the members of the Steelworkers union have major medical coverage, about 85 percent of its members do have major medical on top of a comprehensive basic plan.

Senator Dole requested our comments on S. 748. Our testimony of March 28, 1979 on S. 350 and S. 351 would also apply to S. 748. The AFL-CIO would support the

amendments to Medicare included in the bill if Title I, "Medicare Improvements" were to be introduced as a separate bill.

Sincerely yours,

BERT SEIDMAN,
Director, Department of Social Security.

Senator DOLE. I think also the chairman asked about catastrophic coverage for certain union members. I think it might be helpful if we could have the extent of the benefits and whether this coverage increases expenditures for the majority of hospitalized patients.

That is one of the criticisms leveled at catastrophic coverage. We are going to spend a lot of money and more will fall into the catastrophic category. It would be helpful to us if we could see how it works with the UAW and some other groups.

First of all, how much coverage is there, what are the benefits and how much has the cost increased because of it.

Mr. SEIDMAN. I do not know whether we can get that kind of information or not, but I tried to make the point before that what our unions have negotiated, by and large, is not just catastrophic coverage standing by itself but coverage for basic health services that do not constitute catastrophic illness, and by doing so, it may very well be that there was not an increase in hospitalization as a result of having the catastrophic coverage.

Catastrophic illness applies to a small proportion of the population, but that would not necessarily indicate that you would not get a tremendous increase in hospitalization if you had catastrophic insurance without the basic protection.

Senator DOLE. Do you share Secretary Califano's view that we should not do anything until we pass hospital cost containment legislation?

Mr. SEIDMAN. We are strongly in favor of the Nelson bill for hospital cost containment and we would like to see that enacted and cost containment would be part of the first phase of Senator Kennedy's Health Care for All Americans Act.

Senator DOLE. Does that control wage increases, or other hospital costs?

Mr. SEIDMAN. The Nelson bill rovides for an overall 9.7 percent cap assuming certain increases in the cost of the items purchased by hospitals, adjusted if that were to change, which would include the negotiated wage increases or other wage increases.

Senator DOLE. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much, sir.

Mr. SEIDMAN. Thank you, Mr. Chairman.

[The prepared statement of Mr. Seidman follows:]

SUMMARY OF STATEMENT OF BERT SEIDMAN, DIRECTOR, DEPARTMENT OF SOCIAL SECURITY, AMERICAN FEDERATION OF LABOR AND CONGRESS OF INDUSTRIAL ORGANIZATIONS

The AFL-CIO welcomes this opportunity to present its views with respect to S. 350 and S. 351.

We strongly oppose title I in both bills which would establish a catastrophic health insurance plan.

However, we strongly support the concept behind title III in the proposals which would establish federal standards for private health insurance plans. Title III, in our opinion, should be divorced from the catastrophic provisions and the minimum benefits specified provided without deductibles and coinsurance. We also strongly support title II of S. 350, which is not a part of S. 351. We also believe that federalization of medicaid should be separated from catastrophic insurance.

In the full statement we are submitting, Mr. Chairman, we offer suggestions to improve both of these sections. While we shall concentrate on catastrophic insurance in this summary, the AFL-CIO urges that both Titles II and III, if enacted, be temporary until such time as Congress enacts a comprehensive and universal health insurance program.

While still paying lip service to comprehensive national health insurance, the Administration last week announced its so-called Phase I which, for all practical purposes, abandons the President's commitment to that goal.

Although the details of its provisions have not been spelled out, what has been released indicated the Administration's proposal will not be different from S. 350. If this turns out to be the fact, this testimony would be applicable to the Administration's plan as well as to this bill.

CATASTROPHIC INSURANCE (TITLE I OF S. 350, S. 351)

Medical Care costs continue to escalate at about twice the rate of all goods and services, as measured by the Consumer Price Index, and these costs are nearly doubling every 5 years.

We believe that catastrophic insurance would greatly accelerate the already unacceptably high inflation in health care costs. For the American people this would mean higher taxes, higher insurance premiums and higher out-of-pocket payments if catastrophic insurance is enacted. Indeed, medical care costs could easily double in 3 years, rather than the current 5 years, if an open-ended catastrophic proposal is enacted—and that Mr. Chairman, would be the catastrophe of catastrophic insurance.

Catastrophic insurance would only perpetuate the factors most authorities consider responsible for the breakdown in the delivery of health services—that is, the lack of organization of the system, compounded by a distorted specialty and geographic distribution of health professionals, and an inadequate supply and inefficient use of trained personnel in certain allied health professions. This leads to unbridled medical care costs inflation, which catastrophic insurance would not correct.

Medical care in the United States is oriented to the unusual, interesting or medically challenging types of treatment. As a result, health care in the United States is notably weak in the area of preventive care and routine medical treatment for commonplace illness. Because catastrophic insurance is aimed at the more "dramatic" and most expensive areas of medicine, such as open heart surgery and organ transplantation, it is logical to conclude that an even greater disproportion of physicians will specialize in these areas, because that is where the most of the money can be found.

Most catastrophic illnesses are treated in hospitals, and the vast majority of the estimated $5 to $7 billion cost of a catastrophic program—which we believe would be a substantial underestimate by 1981—would go to hospitals. This would distort the allocation of national health care resources to hospitals or other institutional treatment and take resources away from prevention, health maintenance, home care, outpatient surgicenters and hospices.

Most medical care is good for people, but too much care can be harmful at worst or superfluous at best. We frankly believe that S. 350 and S. 351 would make it too financially attractive to some unscrupulous doctors and hospitals to provide hospital care, surgery and laboratory work that is not needed. Since the only quality controls in these bills are the inadequate medicare standards, both the taxpayers and the patients could be big losers.

Catastrophic insurance would underwrite the expansion and proliferation of high-cost medical technology. According to the Council on Wage and Price Stability, most of the increase in hospital cost inflation is due to the intensity of care—or, in other words, the use of more and more expensive diagnostic and therapeutic equipment. While the use of this new technology does save lives, its rampant proliferation, inappropriate use and the lack of any assessment of the diagnostic or therapeutic value of this technology versus risk greatly increases costs.

Title I of S. 350 and S. 351 would just pour billions of dollars into this extravagant and wasteful system without providing for more efficient utilization of this high-cost technology.

Mr. Chairman, catastrophic health insurance has had a trial run in the United States, and that experience demonstrates the high-cost factor of such a program. When the end-stage renal disease program under Medicare became operational in July 1973, the Department of Health, Education, and Welfare estimated the cost at $250 million for the first year and close to $1 billion annually by 1978. Actual costs are now over $1 billion and are expected to rise to $2.3 billion by 1982.

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Why costs have increased is symptomatic of the problems associated with gearing programs to the more costly forms of care.

After the law passed, the proportion of patients on home dialysis—which costs between $7,000 and $14,000 a year—declined from 37 percent to 25 percent, while the percentage of patients treated in dialysis centers increased. Treatment in these centers costs about $25,000 a year. The number of dialysis centers has doubled between 1972 and 1977, and there are now more than 860 approved to receive Medicare funds and many are operated on a for-profit basis.

For the poor and many working people, unless catastrophic health insurance is built on top of a foundation of a comprehensive national health insurance program, it would not pay for needed care until after they had incurred initial high expenditures they cannot afford.

The Health Care for All Americans Act, soon to be introduced by Senator Edward Kennedy, will provide for physician and hospitalization without limit and, therefore, includes catastrophic insurance as an integral part of a total health care program. We, therefore, wish to make it clear that we favor catastrophic protection for all Americans, as part of a comprehensive program with a foundation of basic coverage which includes preventive and health maintenance benefits without financial deterrents.

In conclusion, catastrophic insurance standing alone is a program for the rich, hospitals and doctors. For the American people it would be a catastrophe.

Mr. Chairman, what is conspicuously absent from both bills is a rudimentary understanding of the basic economics of the health care industry. The laws of supply and demand are skewed beyond recognition in this industry.

It is the doctor who decides what laboratory tests or diagnostic procedures need to be performed.

It is the doctor who prescribes drugs, either by brand name or less costly but equally effective generic equivalents.

It is the patient's physician who leaves instructions with the house staff or nurse.

Patients know this. When patients go to a physician with symptoms—perhaps for a physical examination—they place themselves under the doctor's direction.

It should be clear, then, if any progress is to be made in controlling health care costs in the public interest, fiscal controls must be placed on the providers of health care and not the patients.

Doctors not only supply the services, but actually create 70 percent of the demand for health services—including their own services.

Doctors—not patients—control the demand for medical services.

It is the doctor who decides whether a patient goes to a hospital or receives much less expensive treatment on an outpatient basis.

It is the doctor who decides when a patient can be transferred to an extended care facility. It is the doctor who decides when the patient can be discharged from a hospital or nursing home.

It is the doctor who decides how often the patient should come to the office for treatment and the number of hospital visits that need to be made by the doctor. 30S. 350 and S. 351 are an attempt to make health care fit into the principles of insurance, rather than adapting financing to the realities of the health care industry. The result is a massive misallocation of resources to acute illness and relatively few resources for prevention and health maintenance.

CONCLUSION

Title I of S. 350 and S. 351, which provides for catastrophic health insurance, would cover less than 1 percent of total expenditures for personal health services. It would accelerate the inflation in health care costs by channeling more dollars into intensive high-cost care, rather than financing prevention and health maintenance to avoid catastrophic illness.

Federalizing Medicaid as provided by Title II of S. 350 would be a major advance, but the $3 co-payment for the first patient-initiated visit should be eliminated. We urge enactment of this Title.

Certification of insurance policies as provided by Title III, and establishment of federal standards for such certification is also a step forward, but the standards should include a requirement of community rating, and copayments should not be allowed if a policy is to be certified. All employers should be required to purchase a certified policy because many small employers would not even be able to afford the minimal benefit package stipulated in Title III.

The AFL-CIO would support Titles II and III, if amended along the lines we have suggested, and if they are totally divorced from Title I.

STATEMENT OF BERT SEIDMAN, DIRECTOR, DEPARTMENT OF SOCIAL SECURITY, AMERICAN FEDERATION OF LABOR AND CONGRESS OF INDUSTRIAL ORGANIZATIONS

The AFL-CIO welcomes this opportunity to present its views with respect to S. 350 and S. 351.

We strongly oppose title I in both bills which would establish a catastrophic health insurance plan.

However, we strongly support the concept behind Title III in the proposals which would establish Federal standards for private health insurance plans. Title III, in our opinion, should be divorced from the catastrophic provisions and the minimum benefits specified provided without deductibles and coinsurance. We also strongly support title II of S. 350, which is not a part of S. 351. We also believe that federalization of medicaid should be separated from catastrophic insurance.

The AFL-CIO does have suggestions to improve both of these sections, but both should be temporary until such time as Congress enacts a comprehensive and universal health insurance program.

While still paying lip service to comprehensive national health insurance, the administration's so-called phase I, for all practical purposes, abandons the President's commitment to that goal.

Although the details of its provisions have not been spelled out, what has been released indicates the administration's proposal will not be very different from S. 350. If this turns out to be the fact, this testimony would be applicable to the administration's plan as well as to this bill.

CATASTROPHIC INSURANCE (TITLE I OF S. 350, S. 351)

Medical care costs continue to escalate at about twice the rate of all goods and services, as measured by the Consumer Price Index, and these costs are nearly doubling every 5 years. The impact of these rising costs on the Federal budget is substantial—more than 40 percent of health expenditures now come from public funds. Federal payments for medicare, medicaid and other health programs total about $57 billion and will rise to $102 billion by 1983. The combination of direct and indirect Federal, State, and local government payments to the health industry makes it one of the most heavily subsidized industries in the country—a $76 billion subsidy in 1978 alone.

We believe that catastrophic insurance would greatly accelerate the already unacceptably high inflation in health care costs. For the American people this means higher taxes, higher insurance premiums and higher out-of-pocket payments if catastrophic insurance is enacted. Indeed, medical care costs could easily double in three years, rather than the current 5 years, if this open-ended catastrophic proposal is enacted—and that, Mr. Chairman, would be the catastrophe of catastrophic insurance.

Catastrophic insurance would only perpetuate the factors most authorities consider responsible for the breakdown in the delivery of health services—that is, the lack of organization of the system, compounded by a distorted specialty and geographic distribution of health professionals, and an inadequate supply and inefficient use of trained personnel in certain allied health professions. There is virtually no teamwork among the many specialties and subspecialties in medicine, except in such organized settings as prepaid group practice plans. In most voluntary hospitals, there is little or no teamwork among attending physicians. This leads to medical care cost inflation, which catastrophic insurance would not correct.

Medical care in the United States is oriented to the unusual, interesting or medically challenging types of treatment. As a result, health care in the United States is notably weak in the area of preventive care and routine medical treatment for commonplace illness. The commonplace sickness of today often becomes the catastrophic illness of tomorrow because of the lack of access to preventive and health maintenance services for millions of Americans. Because catastrophic insurance is aimed at the more "dramatic" and most expensive areas of medicine, such as open heart surgery and organ transplantation, it is logical to conclude that an even greater disproportion of physicians will specialize in these areas, because that is where the more money can be made.

Catastrophic insurance would undermine the efforts now under way to give emphasis to primary care and ambulatory services. The long-time growth in the number of specialists and superspecialists in relation to the number of family and primary physicians has only recently been reversed. This new trend will not last long if catastrophic insurance is enacted.

Most catastrophic illnesses are treated in hospitals, and the vast majority of the estimated $5 to $7 billion cost of a catastrophic program—which we believe would be a substantial underestimate by 1981—would go to hospitals. This would distort

the allocation of national health care resources to hospitals or other institutional treatment and take resources away from prevention, health maintenance, home care, outpatient surgicenters and hospices.

Many areas of the country are already plagued by an excess of hospital beds. By channelling billions more dollars into hospitals, catastrophic insurance would encourage hospitals to keep patients longer than necessary because it would only pay for longer hospital stays. Professional standards review organizations (PSRO's) cannot be relied upon to control utilization in the face of such strong financial incentives to the contrary.

Most medical care is good for people, but too much care can be harmful at worst or superfluous at best. We frankly believe that S. 350 and S. 351, would make it too financially attractive to some unscrupulous doctors and hospitals to provide hospital care surgery and laboratory work that is not needed. Since the only quality controls in these bills are the inadequate medicare standards, both the taxpayers and the patients could be big losers.

Catastrophic insurance would underwrite the expansion and proliferation of high-cost medical technology. According to the Council on Wage and Price Stability, most of the increase in hospital cost inflation is due to the intensity of care—or, in other words, the use of more and more expensive diagnostic and therapeutic equipment. While the use of this new technology does save lives, but the rampant proliferation, of inappropriate use and the lack of any assessment of the diagnostic or therapeutic value of this technology versus risk greatly increases costs.

The efficiency and effectiveness of new medical technology is usually unknown before it is widely diffused into the medical care system. Machines often proliferate so quickly that there are not enough patients to make use of all the available capacity. This has been true of open heart surgery units, autoanalyzers, X-ray machines, patient monitors and CAT (computerized axial tomography) scanners. CAT scans are less painful and risky than the procedures they replaced, but the United States now has the capacity to do nearly 3 million scans a year while the procedures replaced never accounted for more than 400,000 a year. In fact, there are more CAT scanners in Massachusetts than in all of England, where the machine was first invented.

The reasons for the diffusion and overutilization of expensive technology are well known:

Doctors have almost unrestricted controls over decisions to buy and use equipment. Doctors, not patients, are the customers of hospitals, because doctors fill the hospital beds with their patients.

Patients are seldom told about the costs, risks and benefit of various therapies. They simply follow their doctor's instructions, because the doctor is the expert.

Doctors have incentives for more intensive use of technology, because the equipment and medical technicians to operate it are provided to doctors rent free. After all, the patient or the insurance company or the government pays for the "rent" of the equipment. The use of hospital-based procedures are profitable for the doctor, because they do not have to make an investment in the equipment. As a result, medical education emphasizes technological, hospital-oriented specialties.

Professional prestige and rewards are proportional to the intensity and specialization of the technology used by physicians. It is, without doubt, the most glamorous facet of the profession.

Hospitals have similar incentives to buy and use this new technology. Hospitals attract and retain physicians by catering to their professional desires. A hospital's prestige is enhanced by having the best and newest equipment, which in turn attracts the better doctors, who are a hospital's real customers. Again, third-party payers, including medicare and medicaid reimburse hospitals on a cost basis for the technology.

Title I of S. 350 and S. 351 would just pour billions of dollars into this extravagant and wasteful system without providing for better planning or more efficient utilization of this high-cost technology.

Mr. Chairman, catastrophic health insurance has had a trial run in the United States, and that experience demonstrates the high-cost factor of such a program. When the end-stage renal disease programs under medicare became operational in July 1973, the Department of Health, Education, and Welfare estimated the cost at $250 million for the first year and close to $1 billion annually by 1978. Actual costs are now over $1 billion and are expected to rise to $2.3 billion by 1982.

Why costs have increased is symptomatic of the problems associated with gearing programs to the more costly forms of care.

After the law passed, the proportion of patients on home dialysis—which costs between $7,000 and $14,000 a year—declined from 37 percent to 25 percent, while

the percentage of patients treated in dialysis centers increased. Treatment in these centers costs about $25,000 a year. The number of dialysis centers has doubled between 1972 and 1977, and there are now more than 860 approved to receive Medicare funds and many are operated on a for-profit basis.

There is also evidence from other countries that a program like catastrophic insurance increases costs. Japan instituted a catastrophic health insurance program in 1973 to cover dependents of employees and others not covered by employer-employee benefit plans. Japan's health plan was a catastrophic insurance plan similar to what is proposed in these two bills. It reduced the copayment of such persons from 50 to 30 percent and provided a ceiling of 30,000 yen a month or about $1,263 a year on such copayments. Prior to the 1973 law, there was no ceiling on copayments.

As a result, the Japanese discovered that the number of high-cost cases—those costing more than $351—doubled in just 2 years, and the average charge for a high-cost illness case increased 21 percent. Moreover, a shift from low-cost to high-cost illnesses occurred at the cutoff point of $351. Illnesses which previously had been classified as "low-cost" subsequently incurred expenditures that moved them into the "high-cost" category.

Appended to this testimony (appendix A) is a reprint of the article, "Japan's High Cost Illness Insurance Program, A Study of its First Three Years, 1974-76," published in the March-April 1978 issue of Public Health Reports. We respectfully request that it be incorporated into the record as part of our testimony.

Catastrophic insurance would also inhibit the development of prepaid group practice plans which offer the greatest potential for containing health care costs, reversing the perverse incentives of the fee-for-service system and reducing hospitalization. As with medicare, the retrospective reimbursement formulas in title I would not allow health maintenance organizations full reimbursement for the hospital days they save. It would not compensate HMO's 1 penny for the catastrophic illnesses they prevent. And unless HMO's can utilize the funds saved from reduced hospitalization and catastrophic illness in outpatient care, which accounts for about two-thirds of their total budget, HMO's probably cannot survive.

We fear that title I would freeze into place the fragmented, inefficient fee-for-service system for all time, with continuing cost escalation the inevitable result. HMO's have the incentive to control cost because they are paid prospectively. They receive a fixed annual amount for comprehensive services and reimburse their doctors by capitation or by salary. HMO's, therefore, have an incentive to control unnecessary utilization and make more rational use of medical technology.

CATASTROPHIC INSURANCE—PROGRAM FOR THE RICH

Upper middle class and rich people are relatively unconcerned about small bills which they can readily meet out-of-pocket or through insurance. They do, however, desire protection against large medical bills. Middle class people often fear bankruptcy more than becoming ill.

As a matter of fact, for the period 1963-70, total medical expenses of the top 1 percent of the population increased 17.2 percent per year compared with 11.2 percent for the total population.

For the poor and many working people, unless catastrophic health insurance is built on top of a foundation of comprehensive national health insurance program, it would not pay for needed care until after they had incurred initial high expenditures they cannot afford.

The medicare experience points up the need for a comprehensive insurance program as a base. Medicare does not provide benefits for preventive care, and, therefore, discourages early diagnosis and treatment because of its deductibles on physician services. Medicare, therefore, places emphasis on coverage for acute illness, rather than preventing sickness in the first place.

The Health Care for All Americans Act, soon to be introduced by Senator Edward Kennedy, will provide for physician and hospitalization without limit, and, therefore, includes catastrophic insurance as an integral part of a total health care program. We, therefore, wish to make it clear that we favor catastrophic protection for all Americans, part of a comprehensive program with a foundation of basic coverage which includes preventive and health maintenance benefits without financial deterrents. The statement by the AFL-CIO executive council on the "Health Care for All Americans Act of 1979" is also appended to our testimony (appendix B).

In conclusion, catastrophic insurance standing alone is a program for the rich, hospitals and doctors. For the American people, it would be a catastrophe.

TITLE II (S. 350)—FEDERALIZING MEDICARE

The proposed federalization of the medicaid program would provide comprehensive benefits for the very poor (i.e., coverage for a family of four with an income of $5,400 or less), but such benefits would be subject to a copayment of $3 for patient initiated doctor visits up to a maximum of $30.

Experience proves that a $3 charge for the first patient-initiated visit would deter necessary utilization of health care services and would not discourage unnecessary utilization. The State of California received permission from the Department of Health, Education, and Welfare to conduct an experimental study to evaluate the effect on medicaid beneficiaries of a $1 copayment for the first two visits to a doctor and 50 cents for the first two drug prescriptions each month. A matched sample of medicaid beneficiaries received their care without any copayments as a control group.

The study showed that following the start of copayment, utilization of ambulatory visits to doctors office and other outpatient services went down for the copayment group as compared with the control group. However, hospitalization rates for the copayment group rose faster than for the group with no copayment. The study concluded that because of the modest $1 copayment, early medical care was deferred; and due to the neglect of early medical care, usage rates of more costly hospitalization increased. The increased cost of hospitalization for the copayment group studied more than offset the saving to the state of reduced utilization of physician services.

Mr. Chairman, we ask that this study "Copayments for Ambulatory Care: Penny-Wise and Pound-Foolish," be incorporated into the record as Appendix C.

We would also like to cite the experience of the Province of Saskatchewan, Canada. The Canadian national health insurance program forbids deductibles, but does allow copayments. In order to "save" money, the Province instituted a $1.50 copayment for doctors visits, which resulted in an overall reduction in outpatient services to the poor of 18 percent. At the same time, services to the nonpoor increased. There was also an increase in the number of physical examinations provided by the doctors for the nonpoor population.

Dr. R. A. Armstrong, Director General for the Canadian health insurance plan, commented on the copayment experience:

"* * * while these lower income people were hit with utilization decreases, after the first year there was an increase in utilization by young single males and females. In other words, the doctors were not going to sit twiddling their thumbs, particularly when they only got paid if they worked. Presumably, these younger people found it easier to get an appointment when they weren't competing with the elderly or with the lower income people."

Saskatchewan dropped the copayment provision in 1973. The important point is that copayments did not even result in a reduction in the utilization of physician services, because doctors determined the demand for their services.

As written, title II of S. 350 would provide virtually no protection for the working poor. Working poor families can be defined as those with an annual income of less than $10,000. According to 1977 data, there are a total of 15.7 million or 27.5 percent of all families with incomes of less than $10,000. Of this, about 5 million families would be eligible for medicaid. This means that about 10 million poor working families would have incomes too high to be eligible for medicaid, but would not earn enough to meet the out-of-pocket expense of the $2,000 medical deductible or the 60-day hospital deductible under catastrophic insurance. They would also be too poor to afford a basic insurance policy to cover these deductibles.

It should be emphasized that the first $2,000 of medical expenses and the first 60 days of hospitalization plus other health expenditures constitute over 99 percent of total expenses for personal health services. A reasonably comprehensive private insurance policy to cover these deductibles would cost more than $1,300 a year.

The spend-down provision of title II would not, therefore, help the working poor except in exceptional cases.

SPEND-DOWN FOR A FAMILY OF FOUR AT VARIOUS INCOME LEVELS TO MEET ELIGIBILITY REQUIREMENTS FOR MEDICAID

Income	Under S. 350 Income Ceiling for medicaid	Spend-down Required
$10,000	$5,400	$4,600
$9,000	5,400	3,600

SPEND-DOWN FOR A FAMILY OF FOUR AT VARIOUS INCOME LEVELS TO MEET ELIGIBILITY REQUIREMENTS FOR MEDICAID—Continued

Income	Under S. 350 Income Ceiling for medicaid	Spend-down Required
$8,000	5,400	2,600
$7,000	5,400	1,600

For low-income working families, the spend-down required for medicaid eligibility would, in itself, be catastrophic. The cost of an adequate health insurance policy would be beyond their means.

There is also a notch effect. A family of four with an income of $5,300 that receives a $200 raise in wages would become ineligible for medicaid. Such a family is worse off because the potential value of medicaid exceeds the $200 raise.

The cost of applying varying means tests for families of different sizes, plus adding and removing beneficiaries as their income moves up or down, would be a substantial percentage of benefit payouts. The cost of administering the spend-down provision of S. 350 would also be very high.

Moreover, catastrophic insurance with its emphasis on high cost hospital care, plus the incentives to hospitals to purchase expensive equipment whether needed or not, would raise the cost of medical care for everybody. It would affect the poor most adversely.

TITLE III (S. 350 AND S. 351)—PRIVATE BASIC HEALTH INSURANCE PROTECTION

Certification of health insurance companies by government authority is a concept whose time has come.

The AFL-CIO does not believe that the health of the American people is a legitimate area for exploitation by unscrupulous profiteers from either the providers of care or financial interests. Minimum standards that third parties must meet in order to be qualified by the Secretary of HEW would be a major advance in the public interest. However, we are concerned about the adequacy of the standards.

The standards would allow a deductible of $100 for hospital care and coinsurance payments of 20 percent. They would also allow a deductible of $50 for insurance against the cost of medical expense and 20 percent coinsurance. Copayments deter patients from contacting their doctors early to maintain their health and avoid acute illness. Deductibles, in particular, are a serious barrier to early diagnosis and treatment. As a result, they increase total health care costs.

Mr. Chairman, what is conspicuously absent from both bills is a rudimentary understanding of the basic economics of the health care industry. The laws of supply and demand are skewed beyond recognition in this industry.

Doctors—not patients—control the demand for medical services.

It is the doctor who decides whether a patient goes to a hospital or receives much less expensive treatment on an outpatient basis.

It is the doctor who decides when a patient can be transferred to an extended care facility. It is the doctor who decides when the patient can be discharged from a hospital or nursing home.

It is the doctor who decides how often the patient should come to the office for treatment and the number of hospital visits that need to be made by the doctor.

It is the doctor who decides what laboratory tests or diagnostic procedures need to be performed.

It is the doctor who prescribes drugs, either by brand name or less costly but equally effective generic equivalents.

It is the patient's physician who leaves instructions with the house staff or the nurse.

Patients know this. When patients go to a physician with symptoms—perhaps for a physical examination—they place themselves under the doctor's direction.

It should be clear, then, if any progress is to be made in controlling health care costs in the public interest, fiscal controls must be placed on the physician and not the patient.

In other words, doctors not only supply the services, but actually create 70 percent of the demand for health services—including their own services.

Another misconception on which these bills are based is that health insurance follows the principles of casualty insurance. Effective and efficient health services cannot be compared with casualty insurance principles of insuring against low frequency but potentially catastrophic expenses beyond the control of the insured.

S. 350 and S. 351 are an attempt to make health care fit into the principles of insurance, rather than adapting financing to the realities of the health care industry. The result is a massive misallocation of resources to acute illness and relatively few resources for prevention and health maintenance.

One analogy would be if a person never bothered to put oil into the engine or water into the radiator of his or her car, but simply drove the car until it broke down. In this case the person would pay a large repair bill which could have been prevented by the cost of a few quarts of oil.

Health insurance—as presently constructed—can never pay for preventive care, because seeking preventive care is under the control of the insured and a violation of insurance principles. Yet, preventive care is less costly than acute care—as prepaid group practice plans have repeatedly demonstrated.

The copayment provisions of the minimum benefit package of benefits an insurance company must provide for certification under title III would, therefore, increase total health care costs, because it ignores preventive care.

The minimum benefit package outlined in title III would not cover drugs, home health services, extended care, intermediate care services, mental health services, prenatal and well-baby care, family planning or early and periodic screening, diagnosis and treatment of children. Each of which benefits has proven cost effective over concentrating on acute care.

The standards of certification under section 1504 do not include any requirement that insurance policies be community-related. The result would be substantial competition between insurers for low-risk groups, and a competitive waste of marketing dollars.

The bills permit States to establish statewide health insurance facilitation programs, one function would be to encourage and facilitate the marketing of certified private insurance policies. We must, therefore, conclude the primary purpose of title III is the promotion of private health insurance, which we believe is an improper role for government at any level. Lastly, all employers should be required to purchase a certified policy because many small employers would not even be able to afford the minimal benefit package stipulated in this title.

CONCLUSION

Title I of S. 350 and S. 351 would cover less than 1 percent of total expenditures for personal health services. It would accelerate the inflation in health care costs by channeling more dollars into intensive high-cost care, rather than financing prevention and health maintenance to avoid catastrophic illness.

Federalizing medicaid as provided by title II of S. 350 would be a major advance, but the $3 copayment for the first patient-initiated visit should be eliminated.

Certification of insurance policies as provided by title III, and establishment of Federal standards for such certification is also a step forward, but the standards should include a requirement of community rating, and copayments should not be allowed if a policy is to be certified.

The AFL-CIO would support title II and III, as amended along the lines we have suggested, and if they are totally divorced from title I.

APPENDIX A

[From International Health, March-April 1978]

JAPAN'S HIGH-COST ILLNESS INSURANCE PROGRAM—A STUDY OF ITS FIRST THREE YEARS, 1974-76

(Joel H. Broida, Sc.D. and Nobuo Maeda, Dr. Med. Sci.)

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Dr. Broida participated in the research reported here while on a work/study assignment to the Institute of Public Health, Ministry of Health and Welfare.

Tearsheet requests to Dr. Broida.

Japan recently instituted a new, specialized health insurance program in recognition of a need to relieve its citizens of the high costs of health care resulting from serious illness (Health Insurance Law, Japan, 1922 (22), revised 1938, 1958, Amend-

ment 89, September 26, 1973). Japan therefore became one of the few countries in the industrial or postindustrial phase of development that have moved to alleviate this problem. Thus, its experience is a valuable subject for study.

Communicable diseases are no longer the major causes of high mortality and morbidity rates. In Japan today, cerebrovascular disease, cancer, heart disease, and other long-term chronic illnesses are the major causes of disease, disability, and death. These long-term illnesses require complex diagnostic and treatment modalities, potent drugs, specialized facilities, and the use of highly trained medical personnel. Since the introduction of new technologies for these illnesses, annual expenditures for medical care have increased rapidly.

In the past, health (sickness) insurance in Japan covered only a portion of the total charges for care. Recently, the majority of medical care costs have been paid by insurance funds derived from premiums, and the uncovered remainder came from out-of-pocket payment by the patient to the provider or institution.

TABLE 1.—HEALTH INSURANCE PLANS,[1] BENEFICIARIES, AND STUDY POPULATION AT RISK, JAPAN

Plan, year established, and beneficiaries	Study population at risk[2]	Sampling ratio
Employer-employees health insurance:		
1. Seikan Kempo, 1926—Employees of firms having 5–1,000 persons	14,412,000	1:20
2. Kumiai Kempo, 1926—Employees of firms having more than 1,000 persons	14,611,000	[3]1:10,1:15
3. Hiyatoi Kempo, 1953—Day laborers	282,000	1:2
4. Senin Hoken, 1940—Seamen	497,000	1:2
5. Kyosai Kumiai, 1962—National and local government employess; public corporation employees; private school teachers and staff (all cases)	[4]4,193	([5])
National health insurance:		
6. Kokuho, 1938—Employees of firms having fewer than 5 persons; persons who are self-employed, retired, aged, and others not covered by employees' insurance	43,853,000	[3]1:40,1:50

[1] All plans were provided for under the Health Insurance Law of 1922 and as amended in recent years.

[2] Includes the number of dependents in plans 1-4 and all persons in plan 6 eligible for high-cost illness insurance benefit, excludes insured workers.

[3] Sampling ratios were changed to lower rates for 2 plans for second and third study years.

[4] Study population for plan 5 included only 1 segment of a single mutual-aid society; this subgroup represented 0.058 percent of the parent group which has a population of 7,181,000.

[5] All appropriate cases were included.

The 1973 amendment to the Health Insurance Law made medical care benefits, *Kogaku Ryoyohi,* for high-cost illness available to nearly 70 percent of the population not previously covered adequately by their health insurance. Workers enrolled in the employer-employee health insurance plans and all persons age 70 and over already had comprehensive health insurance coverage. However, dependents of insured persons and all beneficiaries in the national health insurance plan (Kokuho) were required to pay 30 percent of all medical care charges out of pocket, with no stated maximum liability. When the new benefit was instituted, dependents were still required to pay the 30 percent co-insurance, but a maximum limit of out-of-pocket liability was stipulated by law (30,000 yen within a calendar month).

High-cost illness expenditures usually stem from illnesses that require in-hospital care. For example, if a patient were hospitalized and the total charges incurred within a calendar month were 150,000 yen ($526 if U.S. $1 = 285 yen), the following would occur: (*a*) the insurance initially would cover 105,000 yen or 70 percent of the charges, (*b*) the patient would have to pay 45,000 yen out of pocket, and (*c*) the patient would be reimbursed 15,000 yen after submitting a high-cost illness claim to the insurer because the maximum personal liability is 30,000 yen. Under the new catastrophic illness coverage, the total charges must exceed 100,000 yen ($350) in a calendar month before reimbursement can be claimed.

It was important to study this new program in Japan for two reasons. First, the early experience of the program could be used for future planning that could benefit Japan's providers, insurers, and consumers. Certain questions could be asked about the initial operational phases of the program. That is, have use patterns, case frequencies, and expenditures for care changed as a result of the institution of this

new insurance benefit? If so, in what ways? And should the program be changed in any way or is it satisfactory to all parties? The early research effort may create more questions than answers. But the questions will be answered eventually, and the answers will help to improve the program. If sufficient and timely information from a series of research projects is made available to planners and administrators for review and consideration, they should be able to make more objective decisions for future programing. Second, the experience in Japan may provide valuable information for the United States or any other nation contemplating the addition of a high-cost illness benefit to its social program (1-3).

STUDY PURPOSE

This study was made to examine the first 3 years' experience of *Kogaku Ryoyohi*, the high-cost illness benefit, and to determine:

Whether the addition of a new benefit changed access to care;

Whether different patterns of use occurred among the six major health insurance plans;

Whether expenditure and length of hospital stay changed significantly over a short time;

The distribution of high-cost illnesses in different insurance plan populations at risk; and

Which illnesses, among 10 selected diagnostic categories, generated high-frequency use, high costs, and longer hospital stays.

The primary objective of the new insurance benefit in Japan was to lighten the financial burden of persons with high-cost illnesses. However, it is difficult to know in advance how much dormant, unmet need exists in a population. Under the new benefit, it was possible that numerous persons previously unknown to have high-cost illnesses would seek hospital care. Only educated guesses, based on bits of historical information, could be made as to the percentage of this population. Therefore, we attempted to obtain answers to at least some of the questions from the early experience of the new program.

STUDY METHODS

The first step of the study was to locate agencies that had information about the populations at risk and use patterns of beneficiaries in each of the insurance plans. Next, visits were made to these agencies to determine the availability and accessibility of, as well as the feasibility of collecting, hospital case information, specifically by diagnosis, insurance plan, expenditure, length of stay, and year of service.

Information and assistance for the conduct of this study was provided by the following sources:

All Japan Federation of National Health Insurance Organization (Kokuho Chuokai).

National Federation of Health Insurance Societies (Kemporan).

Ministry of Health and Welfare (Koseisho): Bureau of Information and Statistics; Bureau of Health Insurance; and Bureau of Medical Affairs.

The Institute of Public Health (Kokuritsu Koshu Eisei In): Department of Public Health Practice; Department of Public Health Demography; and Department of Public Health Statistics.

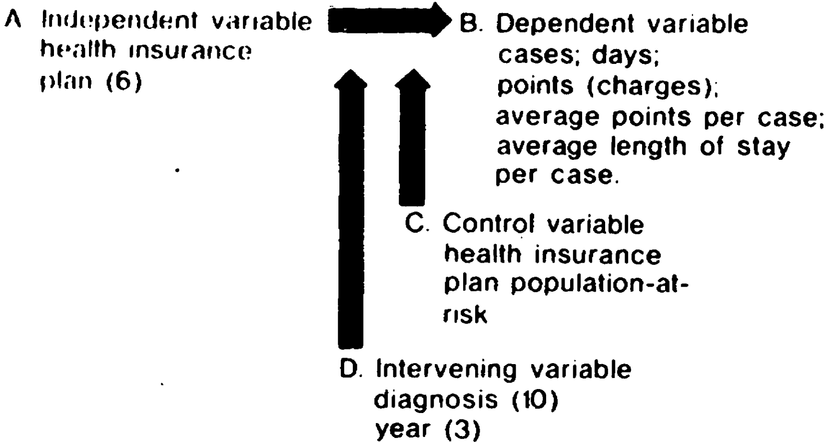
The information acquired for the study consisted of summary frequency distributions only; neither age-specific nor sex-specific data were readily available in the appropriate cross tabulations from all 6 plans (table 1) by 10 selected diagnostic categories (table 2). The time and cost required to gain this additional information was beyond the scope of this project. The information collected is characterized by the following variable sets:

TABLE 2.—*Diagnostic categories selected for study of high-cost illness insurance, by subcategory and index number*[1]

Category	Index number
Tuberculosis:	
Respiratory tuberculosis	4
Other tuberculosis	5
Cancer:	
Malignant neoplasm of the stomach	21
Malignant neoplasm of the mammary glands	22, 23
Other malignant neoplasms	24

Mental illness: Psychosis, mental deficiency, neurosis, abnormal personality, other mental disease	32–34
Nervous system disease: Diseases of the nervous system	40
Hypertension: Hypertensive disease	43
Heart disease:	
Active rheumatic fever and chronic rheumatic heart disease	41, 42
Ischemic heart disease	44
Cerebrovascular disease: Cerebrovascular disease	45
Bronchitis: Bronchitis and pulmonary emphysema	52
Gastric and duodenal ulcer:	
Ulcer of the digestive system	58
Other gastric and colon disease	59
Accidents; poisoning; other:	
Trauma and fracture	84
Intracranial and organic injuries	85
Heat injury	86
Injuries by chemical substances	87
Other injuries or trauma	88

[1] From Eighth Revision, International Classification of Diseases, Adapted for Use in Japan, 1963.



ANALYSIS

Initially, cross tabulations of cases, total charges, and total days were reviewed by insurance plan, diagnosis, and year of service for high-cost cases. In addition, crude (unadjusted) rates of average charges per case and average length of hospital stay were tabulated.

Differences in the means within and between plans were tested by analysis of variance methods for the following variable sets: (*a*) average charge per high-cost case by diagnosis for each study year separately (between insurance plan comparisons), (*b*) average length of hospital stay per high-cost case by diagnosis for each study year separately (between insurance plan comparisons), (*c*) average charge per high-cost case by diagnosis during 3 years (within insurance plan comparisons), and (*d*) average length of hospital stay per high-cost case by diagnosis during 3 years (within insurance plan comparisons).

Projected monthly and annual incidences of high-cost illness cases, by insurance plan and for the total population at risk, were estimated from a 1-month sample of cases from each of five plans. For the sixth plan, Kyosai Kumiai, the estimates were made by use of information from the Kumiai Kempo experience. Case frequencies and information available about the population at risk were considered in calculating the projected incidence. The monthly projections were far more reliable and valid than the annualized rates because they were derived from insurance agency samples for a single month. Annualizing these rates has its hazards; however, they were calculated to obtain at least a crude estimate of the annual incidence of high-cost illness in Japan. More-refined methods should be developed by other researchers in Japan to improve the estimates for future planning.

The following real and potential statistical biases should be kept in mind in evaluating the findings of this study:

Some insurance plans instituted the high-cost illness benefit from the beginning, while others phased this benefit in during 2 years. Information was collected about all cases of high-cost illness as previously defined, regardless of whether or not a particular plan offered the benefit, based on the criterion of expenditure (cases that had total monthly charges of more than 100,000 yen). The case frequencies may have been higher by insurance plan if all the beneficiaries had been entitled to the new benefit from the begining of its availability.

In this study, Kyosai Kumiai cases were represented by only one small group (0.058 percent) of public employees, who may not have been representative of their parent population at risk or may not have reflected the illness experience of Kyosai Kumiai as a whole. The data for this subgroup represent the total experience for each study year, not a sample as for the other five plans.

The samples for the five plans were drawn during different months, four in April and May and one in September, of each year; the climate during these months is similar. Although the different sampling months introduce potential seasonal variation, most of the diagnostic categories in the study represent chronic diseases rather than acute infectious ones that tend to be affected by season.

Kumiai Kempo drew its sample in September, but in August 1976 the maximum liability had been raised from 30,000 to 39,000 yen (Ordinance 201 approved by the Diet, Tokyo, August 1, 1975). The sample was drawn as if the rate were still 30,000 yen, the cutoff for inclusion as high-cost cases. It is possible, but not likely, that persons who could afford 30,000 but not 39,000 yen might have deferred hospital care because of the additional 9,000 out-of-pocket yen now required. But it is more probable that Kumiai Kempo beneficiaries were not yet aware of the change in charges at that early time. Thus, they were expected to have sought hospital care as if the upper limit of out-of-pocket expenditures was still 30,000 yen.

The data available from Kumiai Kempo for this study for 1976 were based on 91 percent of the edited and checked sample cases. The remaining 9 percent of the cases were being checked during the data collection period and were not included in the tabulations presented here. There is little reason to believe that inclusion of this 9 percent would have changed the findings significantly because the available data were consistent with the information collected about the beneficiaries of this plan for 1974 and 1975.

The sampling rates differed between insurance plans and changed in two plans during the study period: Kumiai Kempo went from a 1:10 to a 1:15 sampling rate, and Kokuho changed its sampling rate from 1:40 to 1:50. There is always the potential of sampling error; however, the sampling frames and subsequent sample sizes appear to be of sufficient magnitude that the occurrence of sampling error was considered negligible.

All case information was taken from a special study of selected single calendar months; therefore, the average length of stay could not exceed 31 days.

These potential biases were not expected to have a significant effect on the reported findings.

FINDINGS

The high-cost illness insurance benefit was designed for dependents of insured persons covered by the five employer-employee insurance plans and all persons covered under Kokuho. The eligibility criteria for beneficiaries by insurance plan and the study population at risk are shown in table 1. The enrollee population in Hiyatoi Kempo and Kokuho plans had fewer children in the 0–14 age group and more elderly persons in the 70 and over group than in the other four insurance plans. These are two examples of differences by age groups between insurance plan populations at risk. The age distributions of the other four plans were similar. Unfortunately, age-specific information was not available on the case material used in this study. Therefore, all of the material presented consists of unadjusted frequency distributions and rates.

The frequency distributions of high-cost cases (more than 10,000 points or more than 100,000 yen; 1 point equals 10 yen) for each of the 6 health insurance plans, by year, were as follows:

Plan	1974	1975	1976
Seikan Kempo	1,042	2,029	2,417
Kumiai Kempo	1,645	2,108	2,213
Hiyatoi Kempo	401	749	763
Senin Hoken	381	788	897

Plan	1974	1975	1976
Kyosai Kumiai	151	178	237
Kokuho	2,477	3,478	3,948
Total	6,097	9,330	10,475

Case frequencies increased annually for each of the six plans. As expected, the largest plan, Kokuho, had the most cases. Kyosai Kumiai had the fewest cases because information was available from only one mutual-aid society. The distributions were similar to the proportions they represented of the totals at risk.

A pattern by diagnostic categories for beneficiaries was seen in certain health insurance plans. Hiyatoi Kempo had higher proportions of patients with psychiatric illness, cerebrovascular disease, and heart disease; Senin Hoken, tuberculosis and nervous system disease; a Kyosai Kumiai subgroup, bronchitis and the accident-poisoning-trauma category; and Kokuho, gastric and duodenal ulcer. These were 2- and 3-year trends that require further investigation. The diagnoses for beneficiaries of Seikan Kempo and Kumiai Kempo did not show a noticeable pattern.

Psychiatric illness, cancer, and cerebrovascular disease accounted for approximately 50 percent of the high-cost illnesses. The remaining seven illnesses made up the other half of the cases. The increase in high-cost psychiatric illness demonstrated the most profound change between the first and second year of the program (1974, 12.9 percent and 1975, 25.9 percent of the high-cost cases). Psychiatric illness maintained its same position in 1976, accounting for 26 percent of the cases. No other diagnostic category showed this degree of change. The proportions of high-cost illness cases by diagnostic category and insurance plan varied somewhat, but the observed variation by year within each plan and across plans can not be explained fully on the basis of available information.

Without exception, average charge (points) per high-cost illness case increased by year for all six plans, as shown in the following table:

Plan	Points[1] 1974	1975	1976
Seikan Kempo	15,772.7	16,552.4	18,749.5
Kumiai Kempo	15,648.6	16,391.1	19,154.4
Hiyatoi Kempo	14,464.8	15,308.2	16,981.4
Senin Hoken	15,563.8	15,785.0	18,604.4
Kyosai Kumiai	17,343.4	22,127.5	21,514.6
Kokuho	15,669.2	16,753.4	19,260.7
Overall average	15,637.0	16,532.6	18,949.3

[1] 1 point = 10 yen.

Cancer patients consistently had the highest average charge per case (1974, 21,997.9 points; 1975, 25,725.6 points; and 1976, 30,060.3 points), followed by patients with gastric and duodenal ulcer and cerebrovascular disease. Patients with psychiatric illness had the lowest average charge per case (1974, 11,453.4 points; 1975, 12,476.0 points; and 1976, 13,980.3 points). These diagnostic categories demonstrate the extremes from the grand means (1974, 15,637.0 points; 1975, 16,532.6 points; and 1976, 18,949.3 points). The other diagnoses were spread within these extremes, The diagnostic-specific average charges are not presented in tabular form here; they are available from Broida.

The average length of hospital stay is shown in table 3 by diagnostic category. Patients with psychiatric illness had the longest average stay (1974, 30.2 days; 1975, 30.1 days; and 1976, 30.0 days), while cancer patients had the shortest stays (1974, 25.7 days; 1975, 24.8 days; and 1976, 23.2 days). These same trends were also found across insurance plans by diagnosis. The details documenting these overall cross trends are available, but not presented here. When the data from the preceding text table and table 3 are combined, certain factors emerge. Cancer patients had the highest average charge and at the same time the shortest hospital stays, whereas the opposite was true for persons with psychiatric illness. It must be assumed that cancer patients required the use of specialized personnel and high levels of surgery, medication, and other expensive management over a relatively short time. In con-

trast, psychiatric patients required lengthy stays and less intensive services. The patients in the other eight diagnostic categories required different combinations of these two factors.

Estimates of the incidence of high-cost (catastrophic) illness in the population are shown in table 4. Annualized rates were projected from single-month data derived from each insurance plan. Overall rates were calculated from a summary of the information from all plans. The estimated incidence for Japan (99.4 percent of the population is insured) was as follows: 1974, 2.17 percent; 1975, 3.39 percent; and 1976, 4.44 percent.

TABLE 3.—AVERAGE LENGTH OF HOSPITAL STAY (DAYS) FOR HIGH-COST CASES, BY DIAGNOSTIC CATEGORY AND YEAR

Diagnostic category	1974	1975	1976
Tuberculosis	29.7	29.5	29.4
Cancer	25.7	24.8	23.2
Psychiatric illness	30.2	30.1	30.0
Nervous system disease	29.8	29.1	29.0
Hypertension	28.5	28.3	28.6
Heart disease	28.4	27.9	27.3
Cerebrovascular disease	28.5	28.1	27.8
Bronchitis	27.7	27.4	26.1
Gastric and duodenal ulcer	26.2	25.9	25.2
Accidents, poisoning, other trauma	26.1	26.1	25.0
Overall average	28.0	28.1	27.6

Finally, average monthly and annualized charges per case by study year were estimated in yen and converted to dollar equivalents based on the Japanese experience. If the dollar equivalent is based on the current exchange rate (October 25, 1977, U.S. $1 = 252 yen), the average annual charge per case from the 1976 experience would be equal to $8,594.90. It is interesting that these figures are similar to those projected by some researchers in the United States(2, 3). We recognize that both the estimated annualized incidence and charges per case are crude. However, they are provided as points of reference for future research. In the next section we describe some implications and limitations of the findings from this study for public policy in the United States.

TABLE 4.—NATIONAL ESTIMATES OF THE INCIDENCE (ANNUALIZED) OF HIGH-COST ILLNESS CASES IN JAPAN, BY HEALTH INSURANCE PLAN AND YEAR,[1] IN PERCENTAGES

Insurance plan	1974	1975	1976
Seikan Kempo	1.74	3.38	4.02
Kumiai Kempo	1.35	2.60	2.73
Hiyatoi Kempo	3.41	6.34	6.49
Senin Hoken	1.84	3.81	4.33
Kyosai Kumiai	1.37	2.64	2.77
Kokuho	2.71	4.76	5.40
Overall average	2.17	3.39	4.44

[1] Population at risk as of March 1975, from "Health Insurance and Health Insurance Societies in Japan 1976," National Federation of Health Insurance Societies (Kemporan), Tokyo, 1976

COMMENTS

The findings of this study indicate that high-cost illness increased markedly in frequency and expenditure per case, regardless of diagnostic category, during the first 3 years of Japan's new insurance program. These increases probably can be attributed to a series of interacting factors:

Increased access to care because of the availability of the new insurance benefit,

Unmet need transformed into effective demand,

Physician and patient knowledge of maximum patient financial liability,

Increases in the intensity of services because of the availability of new and improved technology,

Two increases in the rates of reimbursement for physician care during the study period, and

General inflation of medical care costs.

At the same time, there was little change in the average length of hospital stay per high-cost case. For persons with low-cost illness, however, there was a marked reduction in the number of cases, average charge per case, and average length of stay. The low-cost case frequency decreased by more than 50 percent during the 3 years, average charges were reduced 20 percent, and length of stay declined from 17.9 to 8.1 days (detailed data available from Broida).

It appears that a shift from low-cost to high-cost illnesses occurred at the cut point; that is, illnesses formerly classified as low cost subsequently incurred expenditures that were high enough to be classified as high cost. Some evidence to support this hypothesis was observed from documented information provided by Kemporan about the beneficiaries of Kumiai Kempo. The implication is that when a benefit was offered, patients and the medical care system (providers and institutions, for example) took advantage of the benefit. This is not to say that there was wrongdoing by any of the parties, but rather it indicates that when people become aware of a benefit their need turns into an effective demand. In addition, new technology and the introduction of expensive drugs also tended to increase costs and expenditures for medical care and thereby converted low-cost to high-cost illness.

In Japan, particularly since the offering of the new benefit, there was no incentive for the provider or the patient to reduce the intensity of services or the length of hospital stays. The reason for the lack of incentive was that, in the short run, neither party was at risk for the increased expenditures above the maximum liability level. However, the Government has been called upon to provide increasing subsidies to some health insurance plans, and this is causing concern for the future of the program. The only way to make up this deficit was to raise the insurance premiums or raise the maximum liability level, or a combination of both. At present, the combination of increasing both the premium and the maximum liability is being tried. This approach may not completely solve the problem, and it might reduce access to care for those persons in greatest financial need.

In the future, stronger forms of cost containment will be instituted in an attempt to control inflation and some of the other factors that affect the costs of the medical care. At the same time, it will also be necessary to assure adequate levels of access and quality of care, a balance that is difficult to sustain. Many of the same factors that had an impact on the increases in costs, and subsequently expenditures for care incurred by patients in this high-cost illness program in Japan, are currently being discussed as potential problems that could occur in the United States should "catastrophic illness insurance" become available to the U.S. population at large.

REFLECTIONS

What lessons can we learn from this experience in Japan? First, Japan has had a comprehensive, compulsory sickness insurance program in place for many years. Its history and development were complex, but it has been able to meet a societal need—"assure all of our people health and welfare"(4). The insurance was first developed for the working population in 1922 and later included dependents, but with lesser coverage than was offered to workers.

To reduce this inequity between insured persons and dependents, the out-of-pocket payment for dependents was reduced from 50 to 30 percent. Recently, dependents' coverage was expanded to include a high-cost illness insurance benefit with a monthly maximum liability level; that is, the 30 percent deductible remained in effect. However, when the cumulative deductible reaches a specified maximum, 100 percent of the additional expenditures are covered. The maximum liability level has been increased once since the institution of the benefit in 1973 and probably will be raised again soon (Legislative Proposal, Diet Session, Tokyo, spring 1977). The major reasons for these program changes are (*a*) more illnesses have been classified as high cost and (*b*) the cost per case has exceeded the projected estimates for meeting the needs of a particular segment of the population.

The real situation was almost like that postulated by Roemer's law(5). Physicians, hospital beds, and funds for the payment of services were readily available; therefore, they were used. In this situation, the patients and providers expanded the utilization rates, costs, and expenditures to meet the criteria of the benefit. Without appropriate controls in the form of cost containment and without a built-in incentive system for both providers and consumers of care, the program will undoubtedly

continue to be open ended. That is, rising utilization, costs, and financial deficits will become the rule rather than the exception.

It is difficult to anticipate the impact and effects of a new program. The task of changing an operating program is usually more difficult than the initial task of establishing it. Nevertheless, in a crisis situation all parties, regardless of their affiliations, are forced to come to terms with the problems and to make decisions for change. In most cases, they must make compromises and give up some rewards for the good of the majority. After all, the primary purpose of this particular program was to benefit a segment of the population inflicted with serious, expensive, and in many cases, terminal illness.

The Ministry of Health and Welfare of Japan, the Japanese Medical Association, and leaders in the health insurance field have developed this program as a joint venture. We are confident that they will continue to improve the program by reviewing their initial experiences and by instituting appropriate revisions. Planners and policy makers in the United States and other nations can learn from the positive, as well as the negative, experiences of this special program that has been available to a significant segment of the population in Japan since the fall of 1973.

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SYNOPSIS

Broida, Joel H. (National Center for Health Services Research, Hyattsville, Md.) and Maeda, Nobuo: *Japan's high-cost illness insurance program. A study of its first three years,* 1974-76. *Public Health Reports, Vol.* 93, *March-April* 1978, *pp.* 153-160.

In October 1973, Japan's basic Health Insurance Law of 1922 was amended to provide catastrophic illness coverage for dependents of insured workers enrolled in the employer-employee insurance plans and for all persons under the so-called national health insurance plan. Before this time, dependents were required to pay 30 percent of physician, hospital, and related charges out of pocket. Now, although they are still required to pay 30 percent out of pocket, they have a maximum liability level of 30,000 yen (120) during any calendar month. Health insurance covers 100 percent of the excess charges above the personal liability level.

From 1974 to 1976, the first 3 years of the high-cost (catastrophic) illness benefit, an increase of more than 70 percent occurred in the frequency of high-cost cases. This general trend was observed for all of the six major health insurance plans studied. The average expenditure per case increased 5.7 percent from 1974 to 1975 and 14.6 percent from 1975 to 1976, regardless of plan. However, there were marked differences by diagnosis. Although inflation explains part of these increases, the intensity of services certainly played a part. The average length of hospital stay for high-cost cases remained relatively stable, with an overall minimal decrease of 0.6 day—1974, 28.0 days; 1975, 28.1 days; and 1976, 27.6 days. Cancer patients had the highest average charge and the shortest hospital stays, whereas patients with psychiatric illness had the lowest average charge and the longest hospital stays. The authors recommend that micro studies be carried out that include other variables—such as age, sex, severity of illness, education, income, and occupation—for a better understanding of the unexplained variations.

National estimates of the incidence of high-cost illness cases were 2.17 percent in 1974, 3.39 percent in 1975, and 4.44 percent in 1976.

These preliminary findings should be of interest to health planners and administrators in Japan, as well as to those in the United States because of the pending proposals for catastrophic illness insurance.

STATEMENT BY THE AFL-CIO EXECUTIVE COUNCIL ON THE HEALTH CARE FOR ALL AMERICANS ACT OF 1979

Failure to enact a comprehensive national health insurance program has left the Nation and its people paying an ever-higher cost for medical care. And, as costs

continue to escalate, more and more Americans will be denied adequate health care simply because they cannot afford it.

In fiscal year 1977, Americans spent $163 billion for health care or $737 for every man, woman, and child. Americans pay for this in three ways: Taxes, insurance premiums and out-of-pocket payments at the time services are rendered.

Ten years ago, the Nation spent $48 billion or 6.2 percent of the gross national product for health care. For fiscal 1977 that cost was 8.8 percent of the GNP, and by 1985 the United States will be spending $430 billion on health care or about 10 percent of the GNP. The cost to the Federal budget will rise to $98 billion in 1985. This does not include expenditures by State and local governments for health care.

Hospitals, nursing homes and other health care institutions are paid on a cost-plus basis by Blue Cross, commercial insurance, medicare and medicaid. Cost-plus reimbursement rewards inefficiency and waste.

Physicians are paid on the basis of usual and customary fees that are simply an average of fees that the physicians themselves establish. The United States is the only Western country that pays its doctors in this manner. All others negotiate a fee schedule with the medical profession or set capitation rates.

HEALTH CARE FOR ALL AMERICANS ACT

To control these costs and provide quality health care for all Americans, the AFL-CIO has endorsed the Health Care for All Americans proposal which will shortly be introduced by Senator Kennedy. It will phase-in a comprehensive, universal national health insurance program in three steps.

Phase I, beginning as soon as possible after enactment, would establish strong temporary cost controls on hospital costs and physician fees.

Phase II, which would begin two years after enactment, would provide benefits for outpatient and inpatient care, preventive services, home health care and protection against catastrophic costs for the entire population. Drugs would be added as a benefit for the elderly and disabled under Medicare.

As part of phase II, there would be prospective budgeting of institutional costs and physician fees subject to an overall national health spending limit. For the first time there would be effective controls on health care costs.

Phase III would add drugs and nursing home care as benefits for the entire population in 1985.

The program would be administered by a Federal public authority whose members, a majority representing consumers, would be appointed by the President. The public authority would establish and use State authorities to administer the program on a local level.

The plan would be financed by employer-employee health insurance premiums with employees paying a maximum of 25 percent. The premiums would be earnings-related rather than a flat amount per employee, as is now the case with conventional health insurance plans. Unions would be guaranteed the right to negotiate to have the employer pay the employee contribution, thereby protecting noncontributory employee-employer health benefit plans. Also, it is expected that the bill will phase-out the employee contribution. Where the employer premium would be less under the act than it had previously been, there would be a "no-windfall" provision requiring the employer to negotiate with the union regarding distribution of any such cost savings.

Premiums for the unemployed and the poor would be paid from Federal general revenues. Most of the revenue to finance the program would come from insurance premiums, not taxes. Private insurers would be strictly regulated to assure conformity with the basic goals of the program.

HEALTH CARE FOR ALL AMERICANS ACT

Experience in Canada demonstrates that only through national health insurance can there be effective cost control. Canada, which has a health delivery system similar to ours, has contained health care costs more effectively than the United States.

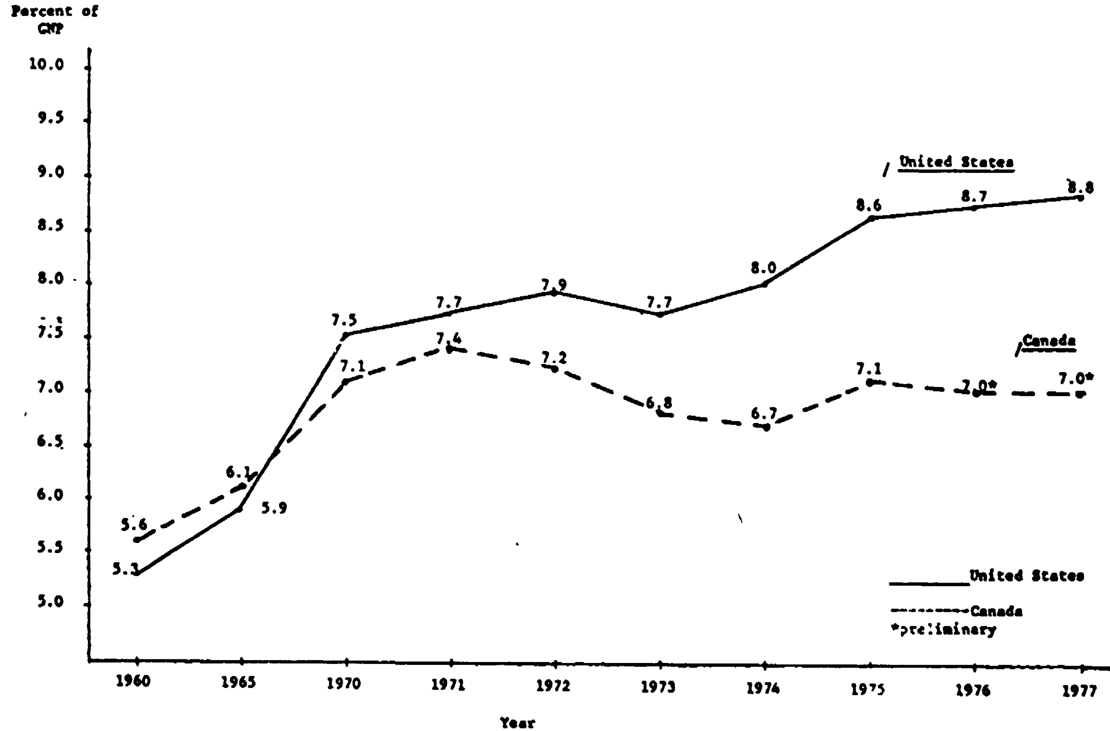
Senator Russell Long has reintroduced a so-called catastrophic health insurance bill that would merely stave off enactment of comprehensive health insurance. Under this bill, there would be no protection against physicians services until after bills of $2000 are paid. Hospitalization bills would not be paid until the patient was in the hospital for 60 days.

For the poor and many working people, catastrophic insurance—unless it is combined with comprehensive health insurance—would provide no needed care until after paying high expenditures which would mean financial disaster. The Long proposal would focus health care expenditures exclusively on the most expensive

kinds of care instead of on preventive care and early diagnosis and treatment. By providing incentives for only the most costly types of health care, catastrophic insurance would accelerate the inflation of health care costs.

In contrast with the Long catastrophic insurance bill, the Health Care for All Americans Act would make quality health care, including catastrophic health services, a basic right of all Americans. The AFL–CIO, therefore, believes this legislation must be enacted at the earliest possible date in the current Congress.

HEALTH EXPENDITURES AS A PERCENT OF
THE GROSS NATIONAL PRODUCT, UNITED STATES AND CANADA



Sources: National Health Expenditures in Canada, Health and Welfare Canada
United States: Department of Health, Education and Welfare

FACT SHEET

Health care for all Americans Act and collective bargaining

Upon enactment and implementation of the Health Care for All Americans Act, collective bargaining with respect to health benefit plans will be affected by the following factors:

The scope of benefits mandated by law will be as broad or broader than the best negotiated health benefit plans in the country. Also, the duration of most of the benefits will be unlimited.

Employers will be required to pay a fixed premium based on a percentage of their payrolls.

In spite of these features, there is a substantial area in which unions will be able to bargain for supplementary benefits over and above the mandated level of benefits. These include:

Negotiating out the 25 percent employee contribution toward the premium cost. Thus no contributions will be required of employees who are now under noncontributory plans.

Supplementing the mandated scope of benefits, which while broad, do not cover all health care services. For example, nursing home care and drugs will not be benefits under the Act until 1985. Initially, it is not expected that dental care for adults will be covered. Custodial nursing home care is not a benefit.Inpatient psychiatric care is limited to 45 days and outpatient psychiatric care is limited to twenty consultations in a benefit year.

There will be a no-windfall provision. In those instances where the employer premium would be less under the Act than it had previously been for the employee-employer health benefit plan in effect prior to the effective date of the Act, the employer would be required to negotiate with the union with respect to the distribution of any such savings through collective bargaining. These savings could be used to increase wages or improve or add to other fringe benefits.

The Health Care for All Americans Act will have strong cost control provisions which will limit future increases in health care costs to a constant percentage of the Gross National Product. This means that by 1985, there will be $31 billion less spent on health care than would have been spent if the Act were not adopted. These savings could be transferred to support other fringe benefit programs such as: Cash sickness benefits, supplementary unemployment benefits (SUB), larger pensions, scholarships for the children of union members, day care centers for children of working mothers, training and apprenticeship programs, group automobile insurance, periodic extended vacations, and prepaid legal services.

Both single and multi-employer collectively bargained health insurance plans would continue to operate in the same way as they do now. That is, they would be insured by Blue Cross, Blue Shield or by a commercial or mutual insurance company. However, all such insurers would be required to be a member of a consortium of Blue Cross-Blue Shield plans, a consortium of indemnity insurance companies or a consortium of Health Maintenance Organizations. Health benefit plans that offer their members "dual choice," whereby each member has the option of joining an HMO or being covered by traditional insurance, would not be changed. Such employee health benefits plans would normally deal with the HMO consortium as well as either the "Blues" or insurance company consortium.

These consortia would be certified and regulated by a Public Authority. The purpose of organizing the Blues, insurance companies and HMO's into consortia is to consolidate the purchasing power of insurers in order to deal more effectively with providers. It would also facilitate regulation by the Public Authority.

Where unions have negotiated benefits or employer contributions beyond those mandated by the Act, the employer or jointly administered trust fund could purchase such additional benefits from any carrier.

The attached brochure published by the Committee for National Health Insurance explains the program in greater detail.

APPENDIX C

COPAYMENTS FOR AMBULATORY CARE: PENNY WISE AND POUND FOOLISH

(By Milton I. Roemer, M.D., Carl I Hopkins, Ph. D., Lockwood Carr, B.S., and Foline Gartside, M.A.)

The California "copayment experiment" imposed a charge of $1 on certain Medicaid beneficiaries for the first two visits to a doctor and 50 cents for the first two drug prescriptions each month, effective January, 1, 1972. Data on utilization rates werer gathered for six months before this date and for 12

months after it. While other administrative requirements, like prior authorization of certain services, doubtless also played a part, it was found that, following the start of copayment, utilization of ambulatory doctor's office visits and other services associated with them showed a decline, relative to that of the non-copayment cohort. After a brief lag, however, hospitalization rates in the copay cohort rose to levels higher than those of the non-copayment cohort—more than offsetting the savings to the state from the reduction of ambulatory service use rates. Due presumably to the neglect of early medical care because of the inhibiting effect of the copayments, these higher use rates of costly hospitalizations suggest that financial deterrents on access to ambulatory service by poor people are penny wise and pound foolish, not to mention their effects on health and well-being.

Notes—The following paper was prepared and submitted before the publication of "California's Medi-Cal Copayment Experiment" by Earl W. Brian and Stephen F. Gibbens as a special Supplement to the December 1974 issue of this journal. Although examining the same medical care program, our study is based on a cohort analysis over time—before and after the imposition of copayment requirements—and applies statistical techniques which adjust for the critical differences in "test" and "control" populations, not done in the previous report. Moreover, it examines hospitilization experience not only because of its costliness but especially because of its value as a reflection of the long-term effects of the demonstrated reduction in ambulatory services. As a result, our conclusions on the ultimate consequences of copayment fees for ambulatory services in a low-income population are very different from those of Brian and Gibbens.

One of the persistent subjects of debate in planning health insurance or other financial support programs for medical care is the effect of copayment or deductible requirements. Applied in many programs, both private and governmental, the general assumption has been that these cost-sharing charges would inhibit "unnecessary" or "frivolous" demands for medical care, and therefore reduce the burden on the fiscal source and available health manpower.(2)

COPAYMENT AS A DETERRENT TO USE OF MEDICAL CARE

Much research has been done on the question of copayment as deterrent, with conflicting findings. Obviously the effects of cost-sharing on utilization or demand depend on the amount of money involved—either in fixed dollars or percentage of charges, on the income level of the insured, on whether the copayment applies to a service ordered by the doctor (like hospitalization) or to one initiated by the patient (like an ambulatory visit), and on other factors. The weight of evidence seems to suggest that for services decided upon by the doctor, if the cost-sharing requirement is small, the effects are transitory or virtually nil.(5) For patient-initiated services, on the other hand, the inhibiting effect of copayments on utilization may be substantial, but especially so for lower income families.(1)

A depressing effect of copayments on consumer demand obviously reduces medical care expenditures in the short run, even if one counts both personal outlays and payments from a social (insurance or revenue-derived) fund. For the social fund, moreover, the saving results from two mechanisms: One, the reduction in numbers of medical claims, and two, the nonpayment by the fund of the copayment amount itself. These fiscal effects, however, tell us nothing about the medical or health consequences of the copayments. It certainly cannot be inferred that a patient's failure to see or delay in seeing a doctor for a symptom means that the ambulatory visit was unnecessary or frivolous. It means only that the copayment obligation effectively inhibited the procurement of care, whether it was medically advisable or not. A recent review paper by researchers from the Rand Corporation, for example, draws the conclusion that copayments reduce ambulatory care demand, thereby saving health insurance funds; it does not consider, however, the possible effects on health.(6) Nor does it consider the later demands for care that these health effects might generate, perhaps more than offsetting any initial savings.

An investigation of the so-called "California Copayment Experiment" (hereafter called COPE) which operated under the Medicaid program from January 1972 until July 1973 provided us with an opportunity to probe this question—that is, the longer term effects on health and costs of a small copayment obligation imposed on Medicaid beneficiaries as a condition for visiting a doctor and for having a prescription filled. Examining the experience of the California COPE program before its start and for 12 months after permitted some inferences on both these matters.

THE CALIFORNIA "EXPERIMENT" AND ITS ASSESSMENT

In brief, the California State Department of Health Care Services imposed a copayment charge of $1 on certain Medicaid beneficiaries for the first two visits to a doctor each month after January 1, 1972. The doctor or his assistant was expected to collect the dollar and, whether he did or not, the State deducted one dollar from the fee payable under the program. Similarly, a 50 cent copayment was imposed for the first two drug prescriptions each month, this amount to be collected by the pharmacist. A survey of providers showed that over 80 percent of the doctors and 90 percent of the pharmacists did, in fact, collect the COPE charges.

Under the original Medicaid law (which barred states from imposing any payment obligations on the indigent beneficiary for statutorily required medical services), this California measure could be approved by the federal Department of Health, Education, and Welfare, only if it was considered an "experiment." Our research group at UCLA, which was called upon by the federal Department to evaluate the results, was not involved in the experimental design. Had we been, we would have much preferred to establish two randomly chosen or matched populations of Medicaid beneficiaries, one of which was required to copay while the other was not. Instead, the State—perhaps in the interests of compassion—decided to impose the copayment obligation only on those Medicaid beneficiaries who had some additional financial resources outside their statutory cash benefits, while not imposing it on the rest of the eligible persons.

Thus the two populations, with respect to "copay" or "no-pay" status, were not basically alike. The copay group, constituting families with some resources, tended to be a decidely older-age population. Even though our evaluative study was confined to AFDC (Aid to Families with Dependent Children) beneficiaries, the children in the copay families tended to be older. Moreover, the very existence of some extra resources in these families meant that their standard of living and perhaps other cultural characteristics were likely to differ from those in the more impoverished no-pay AFDC population. These differing sociodemographic characteristics would inevitably influence tendencies to seek medical care and meant, unfortunately, that our evaluative research could not be based on a simple comparison of the trend lines of the medical care demand rates of the two populations.

Instead, it was necessary to establish two cohorts of copay and no-pay populations, to follow their demand rates for a reasonable length of time both before and after the imposition of the copayment charge, and then to compare not the absolute rates but the relative levels of utilization of various types of medical care by the two populations. This could be achieved by establishing a base period, prior to copayment, at which the actual utilization rates of the two populations were converted to a common index figure of 100. Then one could follow the trend lines for the indices of the two cohorts to determine whether, after the imposition of copayment in one cohort, a difference was observable in the demand or utilization trends followed by each.

COPAYMENTS FOR AMBULATORY CARE

TABLE 1.—*Service data collection quarters*

Time-period and status:	*Quarter*
July-September 1971 (before copayment)	1
October-December 1971 (before copayment)	2
January-March 1972 (copayment started January 1)	3
April-June 1972 (copayment in effect)	4
July-September 1972 (copayment in effect)	5
October-December 1972 (copayment in effect)	6

Since California is a large state, and our research funds were limited, we could not examine the total experience of the State's over 2,000,000 Medicaid beneficiaries. We chose instead the AFDC universe within three counties (San Francisco, Tulare, and Ventura) believed to be fairly representative of the State as a whole, both in urban-rural distribution and in ethnic or racial composition of Medicaid persons.[1]-In these three counties, the copay cohort population throughout the observations numbered 10,687 and the no-pay cohort numbered 29,975, or a ratio of roughly 1:3. This ratio was also characteristic of the Medicaid population in the State as a whole.

[1] Originally, information had been obtained on seven counties, but examination showed so many serious gaps and problems in the claims and eligibility data in four of the counties that we felt compelled to reduce the sample to three counties; in these, the data were satisfactory for analysis.

To establish the basis for these two trend lines, as noted above, a time span was studied beginning six months before the copayment charge was imposed and ending 12 months after. Computerized data were examined for medical and related claims paid for services actually rendered during six quarterly (three-month) periods over this 18-month span. The exact quarters for which service data (from paid claims data tapes) were collected are shown in Table 1.

TABLE 2.—DOCTOR'S OFFICE VISIT RATES FOR AFDC FAMILIES, BY COPAYMENT STATUS IN CALIFORNIA MEDICAID PROGRAM, JULY 1971–DECEMBER 1972.

[Number per 100 eligibles per quarter-year, and indices of rates based on quarter 1=100]

	Doctor's office visits per 100 eligibles		Index of office visit rates (quarter 1 = 100)	
	No-pay	Copay	No-pay	Copay
Quarter:				
1	79.54	75.47	100	100
2	66.79	59.98	84	79
Copayment started:				
3	79.09	69.13	99	92
4	71.24	64.77	90	86
5	67.46	59.55	85	79
6	73.18	66.31	92	88

Note.—Illustrated graphically in figure 1.

FINDINGS

In Table 2 are presented the actual rates of doctor's office visits per 100 eligible AFDC Medicaid beneficiaries over the 18-month study period. Also presented in this table are the same rates, adjusted to an index figure of 100 for the first quarter, as explained above. Graphic presentation of the index figures from Table 2 appear in Figure 1.

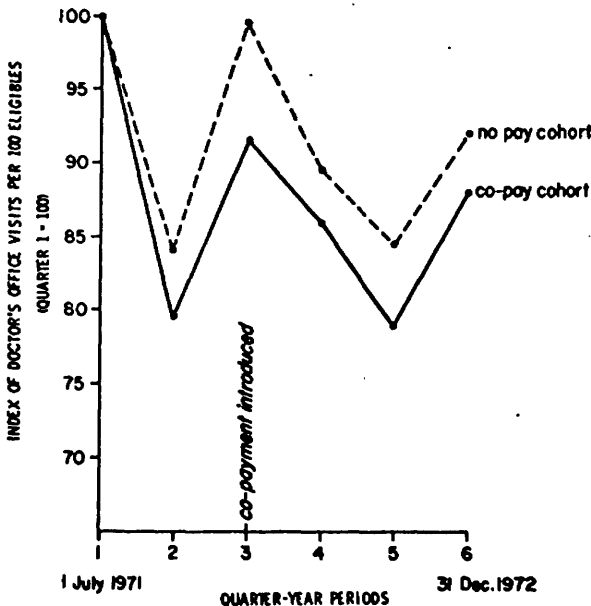


FIG. 1. Doctor's office visit rates for AFDC families, by copayment status in California Medicaid program, July 1971–December 1972; indices of rates based on Quarter 1 = 100.

Interpretation of this table (and subsequent tables and figures) requires further explanation about the course of events in California's Medicaid program over this 18-month period. In October 1971, at the start of Quarter 2, a number of administrative changes were introduced in the program; most important among these was a requirement of prior authorization from a State Medicaid Consultant for more than two ambulatory services or more than two prescriptions in any month. It is evident that this requirement was associated with a sharp decline in utilization rates of *both* the no-pay and copay cohorts for Quarter 2, even before copayment was introduced.(3) Prior authorization for ambulatory services beyond two per month, for nonemergency hospital admissions,[1] and for certain other services was a continuous requirement for both cohorts throughout the remainder of these observations. It is not possible to disentangle the inhibitory effect of this requirement from the copayment obligation in the copay cohort, but its substantial effect may be estimated from the trend line for the no-pay cohort. Probably seasonality also had some effect on both trend curves—for example, the rise in doctor's office visits and drug prescriptions in the sixth quarter for both groups was very likely associated with fall-winter (October-December) respiratory disease.

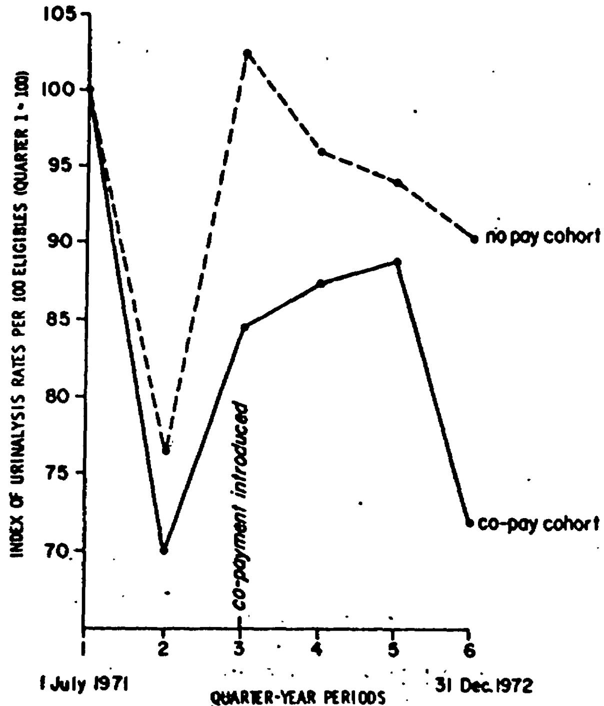


FIG. 2. Urinalysis rates for AFDC families, by copayment status in California Medicaid program, July 1971 – December 1972: Indices of rates based on Quarter 1 = 100.

Keeping in mind the combined effect of the prior authorization requirement, as well as the different sociodemographic composition of the two cohorts, it would appear from these data that the prior authorization requirement, after its introduction at the start of Quarter 2, led to a sharp reduction in the rate of ambulatory doctor visits. Then for subsequent quarters, while seasonality and disease incidence associated with it may have been exerting an influence, the copay cohort had a rate of doctor's office visits—relative to the base period for the index—substantially below that of the no-pay cohort throughout the study span. There would seem to be little doubt that this differential was due to the copayment requirement.

[1] This restriction had, in fact, been operative since April 1968. Such prior authorizations, of course, have been used to restrict medical care use in welfare program for centuries.

Continuing, for the sake of simplicity, with the data simply in graphic form, we can consider a common diagnostic laboratory test, urinalysis, in Figure 2, and a common preventive screening test, the Pap smear, in Figure 3. By both of these trend lines, it is apparent that the copay cohort had substantially lower utilization indices than the no-pay cohort. In Figure 4, the use of prescription drugs, with a 50-cent copay requirement, shows similar relationships. All three of these types of service were associated with ambulatory doctor's visits, for which copayments were usually required.

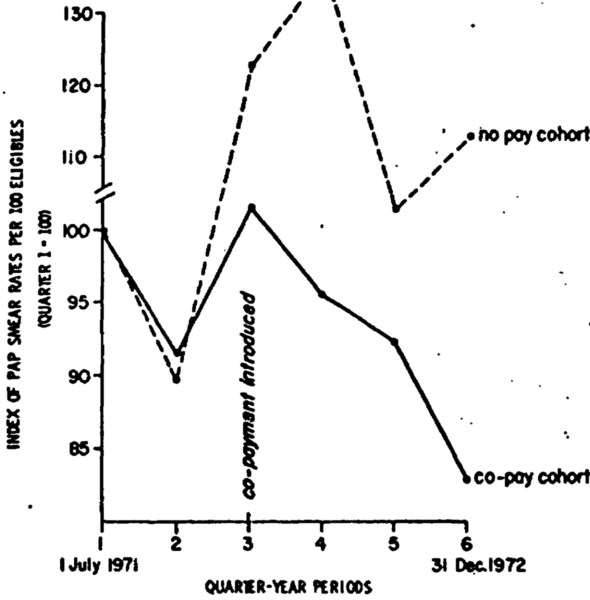


FIG. 3. Pap smear rates for AFDC families, by copayment status in California Medicaid program, July 1971–December 1972: indices of rates based on Quarter 1 = 100.

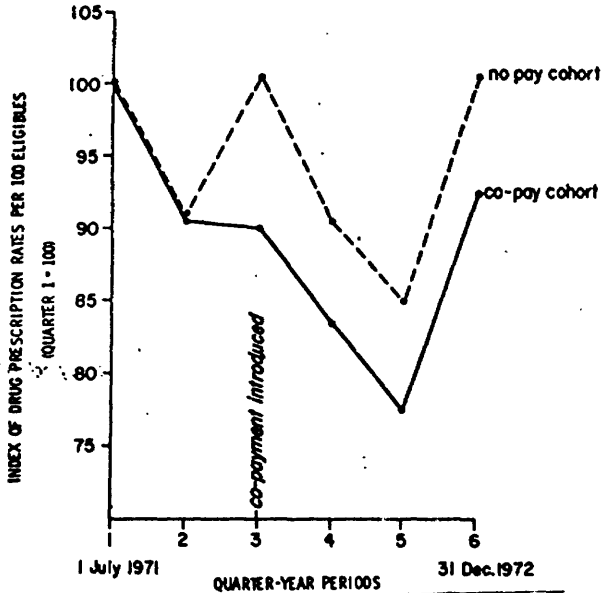


FIG. 4. Drug prescription rates for AFDC families, by copayment status in California Medicaid program, July 1971–December 1972: indices of rates based on Quarter 1 = 100.

Table 3, however, presents data for the two cohorts, with an important distinction. It applies to the hospital patients, and—while showing rates and indices separately for both cohorts—no actual copayment was required from either population, and the decision on hospitalization was made by the doctor. The same data are shown in graphic form in Figure 5. The data in Table 3 and Figure 5, in sharp contrast to trends in all previous tables, show that after introduction of copayment in January 1972 the index figures for the copay cohort leaped up to a *higher* level than those for the no-pay cohort. They remained at a higher level for three of the four copayment quarters. The drop in the final quarter may simply reflect the completion of hospitalizations in the previous three quarters for persons needing such care, as well as the usual overall drop in hospital use around the Christmas holiday season.

TABLE 3.—HOSPITAL PATIENT RATES[1] FOR AFDC FAMILIES, BY COPAYMENT STATUS IN CALIFORNIA MEDICAID PROGRAM, JULY 1971-DECEMBER 1972.

[Number hospitalized per 100 eligibles per quarter-year, and indices of rates based on quarter 1=100]

	Hospital patients per 100 eligibles		Index of hospitalization rates (quarte: 1 = 100)	
	No-pay	Copay	No-pay	Copay
Quarter:				
1	3.56	2.54	100	422
2	3.07	2.09	86	82
Copayment started:				
3	3.12	2.37	88	93
4	2.88	2.14	81	84
5	3.05	2.29	86	90
6	2.70	1.71	76	67

[1] Data are based on an unduplicated count of hospital *patients* during a quarter year, rather than admissions, which may have been more than one for some patients.

Note.—Illustrated graphically in figure 5.

Figure 6 presents the hospitalization rates on another basis. It shows the trend of indices for all diagnoses except those related to pregnancy. The latter may be regarded as "nature-generated" and relatively independent of a doctor's judgment in modern American society. With these cases removed, it is apparent that the differentially higher indices of hospital use for the copay cohort are even greater in three out of the four copayment quarters than for the total of hospital patients shown in Figure 5.

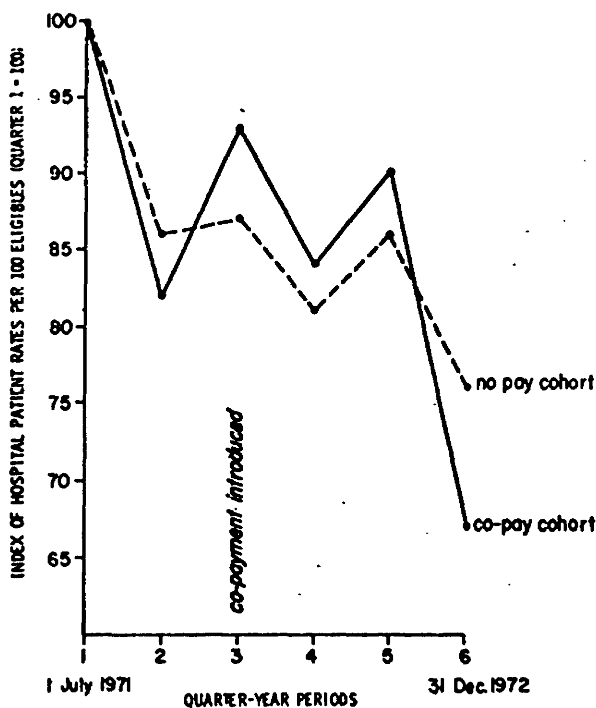


FIG. 5. Hospital patient rates for AFDC families, by copayment status in California Medicaid program, July 1971–December 1972: indices of rates based on Quarter 1 = 100.

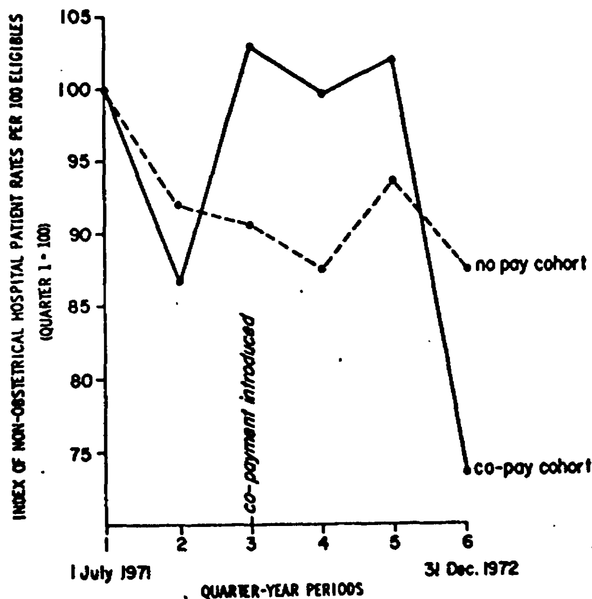


FIG. 6. Hospital patient rates for all non-obstetrical admissions in AFDC families, by copayment status in California Medicaid program, July 1971–December 1972: indices of rates based on Quarter 1 = 100.

DISCUSSION

These findings suggest that the effects of copayment requirements for ambulatory services (and prescriptions) in a medical care program for low-income families were to exert a deterrent effect on demand or utilization. The inhibiting effect applied to office visits—the bedrock of general medical care—and also to typical diagnostic tests (urinalyses), to preventive procedures (Pap smears), and to drug prescriptions. Easy access to and use of general ambulatory doctors' services are widely considered to have preventive value, by permitting prompt diagnosis and treatment of an illness before it becomes more serious.

When such ambulatory services are inhibited, it would seem that a price is paid—namely, a rise in the relative rate of hospitalization. It is likely that this elevated hospitalization rate is due to postponement of ambulatory care, so that when the patient is finally driven to seek assistance, his case is more advanced and requires in-patient care. This interpretation is supported by the general observation in the U.S. National Health Survey of longer hospital stays among low-income persons, even for the same diagnosis, in the nation as a whole.(8) This is likewise associated with lesser rates of ambulatory doctor's care by the poor generally and is usually interpreted along the lines offered above.

A clear-cut reduction in diagnostic tests (urinalyses, Pap smears, and others) as well as ambulatory treatment (doctor visits and prescriptions)—as found in our study—could hardly be expected to benefit health status. This is quite aside from the pain and suffering involved for the low-income patient, who postpones seeking medical care at early stages of his illness.

These findings also have serious financial implications. Hospitalization is by far the costliest sector of medical care. A reduced rate of ambulatory care may yield short-term financial savings, but a subsequent increase in the rate of hospital use could more than outweigh these amounts.

To determine the net financial effect within the copayment cohort, we may estimate an expected cost to the State, based on the rate of office visits in the quarter preceding the initiation of copayment, which was on an annual basis 2,400 visits per 1,000 (much lower, incidentally, than the rate in the general population, and hardly justifying the State government's assertion of "overutilization"). Multiplying this by the cost-per-visit of $8.79 in that quarter yields an "expected" cost of $21,096 per 1,000 eligibles. After copayment was initiated, the actual cost for the year was $21,008 or a theoretical net saving to the state of just $88 per 1,000.[1]

Turning to the hospitalization experience, the "expected" expenditure would be based on the base-period rate of 83.6 patients per 1,000 per year at a cost of $623 per patient (the annual cost per patient in the copayment period) or a total of $52,082 per 1,000. Actually, the expenditure in the copayment period was $53,017 or a net excess of $935 per 1,000. (It should be noted that this excess was due entirely to the increased hospitalization rate; if one took account of actual inflation of hospital costs over the precopayment period, the difference would be much greater.) Subtracting the estimated saving for ambulatory services of $88 per 1,000, the net excess cost to the state was $847 per 1,000 eligibles. Thus, for the approximately 1,450,000 AFDC beneficiaries in California, the overall excess cost to the State was $1,228,150. (It is noteworthy that California discontinued the entire copayment procedure June 30, 1973, even though federal P.L. 92-603, effective January 1, 1973, officially permitted such copayment under certain circumstances.)

In a word, it would appear from this study of the California Copayment Experiment with Medicaid beneficiaries that the State government's strategy was penny-wise and pound-foolish. Short-term savings for lower ambulatory care use were followed by definite increases in costly hospital use. It is of interest to note that this general course of events was predicted in a legal brief submitted in opposition to the copay program before it was instituted. (4) As the experience of many "health maintenance organizations" has repeatedly demonstrated, comprehensive medical care, without cost-sharing deterrents, is probably not only the best way to maintain a person's health, but is also most economical in the long run.(7)

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1. Beck, R. G.: The effects of copayment on the poor. J. Human Resources, publication pending.
2. Brian, Earl W.: The Medi-Cal Reform law. California's Health, April 1972, p. 3.

[1] In spite of the lower indices of office visit rates for the copay cohort, compared with the nopay cohort (shown in Table 2 and Figure 1), it may be noted that the actual rate of visits of both cohorts (for epidemiological or other possible reasons) exceeded the precopayment rate during three out of the four copayment quarters. Thus, despite the $1 saving to the State for most visits, this explains the small differential in total expenditures.

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8. U.S. National Center for Health Statistics: Medical Care, Health Status, and Family Income. Public Health Service, Washington, 1964.

The CHAIRMAN. Next, we will hear from Mr. James W. Walker, senior vice president, INA Corp. and Edward R. Stolman, vice chairman, Hospital Affiliates International, accompanied by Samuel H. Howard, vice president for planning, Hospital Affiliates International.

I am pleased to have you gentlemen.

STATEMENT OF EDWARD R. STOLMAN, VICE CHAIRMAN, HOSPITAL AFFILIATES INTERNATIONAL, ACCOMPANIED BY JAMES W. WALKER, JR., SENIOR VICE PRESIDENT, INA CORP. AND SAMUEL H. HOWARD, VICE PRESIDENT, PLANNING, HOSPITAL AFFILIATES INTERNATIONAL

Mr. STOLMAN. Thank you, Mr. Chairman and members of the committee.

My name is Edward R. Stolman, I am vice president of Hospital Affiliates International of Nashville, Tenn. Accompanying me today are James W. Walker, Jr., senior vice president of the INA Corp. on my right, and on my left, Samuel H. Howard, vice president for planning, Hospital Affiliates International.

We would like to submit our full statement for the record and summarize it with a brief, oral statement.

The CHAIRMAN. Without objection, agreed.

[The prepared statement of Edward R. Stolman follows:]

STATEMENT OF EDWARD R. STOLMAN, VICE-CHAIRMAN, HOSPITAL AFFILIATES INTERNATIONAL

Mr. Chairman and members of the committee, my name is Edward R. Stolman. I am vice chairman of Hospital Affiliates International of Nashville, Tenn. Accompanying me today are James W. Walker, Jr., senior vice president of the INA Corp., and Samuel H. Howard, vice president, planning, Hospital Affiliates International. Hospital Affiliates is a subsidiary of the INA Corp. INA Corp. is one of the Nation's largest diversified financial services companies and among the Nation's oldest commercial organizations. Its history goes back to 1792 with the formation of its principal subsidiary and the nation's first stock insurance company, Insurance Company of North America. The total assets of the corporation are $11.9 billion and in 1978 INA's worldwide operations produced consolidated revenues of $4.2 billion and after-tax income for operations of $211.4 million.

Hospital Affiliates was founded in 1968 by two physicians and two businessmen who sought to apply the efficiencies of professional business management to hospital care and administration. The need for and successful application of this concept has been demonstrated by the fact that today Hospital Affiliates is the world's largest and most experienced hospital management corporation, operating over 135 hospitals with more than 18,000 beds in 34 States and abroad. The hospitals, two-thirds of which are operated under management agreements, are rural and urban, proprietary and nonprofit, foundation-sponsored, community-owned and university-affiliated. What these hospitals provide in common is the highest quality of care at the lowest possible costs.

Because Hospital Affiliates believes in the application of market-oriented incentives to hospital management, we are vitally interested in the effect of existing and proposed federal health care financing programs on incentives to provide efficient

health care service. We firmly believe that if Federal health financing programs are properly structured, hospitals will have positive incentives to provide quality service in a cost-conscious way.

We appreciate the opportunity to comment on S. 350 and related bills establishing a Federal catastrophic health insurance program. We fully recognize the need to ensure access to private insurance to protect our citizens against potential financial ruin which might arise from prolonged or otherwise costly medical treatment. We also acknowledge it is appropriate for the Federal Government to play a well defined role in the financing of insurance coverage for individuals or families to the extent they are not able to pay for it themselves. While others will comment on specific provisions in the bills before this committee, I would like to emphasize two fundamental considerations which, in our judgment, may be substantially more important to the future of our Nation's health care system than catastrophic insurance itself. These issues are:

(1) Whether adding catastrophic insurance coverage to the existing Federal cost-based reimbursement structure will exacerbate the structural inefficiencies inherent in the existing system and, consequently, escalate health care costs; and

(2) Whether catastrophic coverage, as a means toward closing the gap in our Nation's system of health insurance coverage, offers an opportunity to implement a health care system financed through the private insurance sector, and thereby to demonstrate that cost-conscious quality health care can be provided more effectively through greater reliance on marketplace economics.

We believe that both these questions should be answered in the affirmative. Building catastrophic coverage on the cost-reimbursement financing structure that supports the existing system will accelerate spiraling health care costs and place additional strain on the federal budget. At the same time, catastrophic insurance provides a unique opportunity to demonstrate the effectiveness of a better system—one that fosters competition among insurers and providers in the delivery of quality care at reasonable costs, that rewards efficiency and discourages profligacy, that encourages consumers to participate responsibly by making an informed choice among alternative health care plans, and by sharing in the cost, and that reverses rather than accelerates the trend toward intrusive Federal regulation and oversight. Obviously, there is no substitute for complete, immediate reform of the federal health care programs that provide medical care for the poor and elderly. But a new Federal initiative offers the opportunity to set a new course, to innovate, and to demonstrate that marketplace economics can work as effectively in the health care industry as they have in other areas previously dominated by federal regulation.[1]

To demonstrate why such a new course is desirable, I would like to (1) address the problems raised by grafting catastrophic coverage on to the structurally deficient retroactive cost-reimbursement system, (2) discuss how the principles of a market-oriented and consumer-responsive health care financing system may be applied to a program of catastrophic coverage, (3) cite evidence that demonstrates the effectiveness of marketplace incentives in health care delivery systems, and (4) recommend modifications to S. 350 and related bills that would initiate needed structural reforms.

I. PROBLEMS WITH ADDING CATASTROPHIC COVERAGE TO THE EXISTING HEALTH CARE FINANCING SYSTEM

The demand for a federal catastrophic insurance program has been heightened by public awareness that the escalating costs of health care can make prolonged illness financially ruinous for the average American. Nevertheless it is not patient concern about access or catastrophy that dominates the public debate. It is the valid concern about rapidly rising health care costs. Thus, any new federal medical insurance initiative must begin by addressing the structural deficiencies in the Federal reimbursement system that fuels inflation in health care costs.

First, the health care industry operates somewhat differently from other industries. This fact is in part a function of the nature of health care, but it also reflects the distortions of federal legislative and regulatory power. Health care is less sensitive than other industries to the forces of supply and demand because physicians, rather than consumers, generally determine the demand while controlling the supply. Moreover, most health care bills are not paid for by consumers but by "third parties"—Blue Cross/Blue Shield, commercial insurance, or medicare and medicaid.

[1] HAI is encouraged by Congress' recognition of the need for such reform. In a recent discussion of the effect on hospital costs of federal regulation, the Senate Committee on Governmental Affairs concluded: "The principal problem [of spiraling hospital costs] appears to be the existing lack of incentives for cost control, socially productive competition and innovation." Study on Federal Regulation Prepared Pursuant to S. Res. 71, Senate Committee on Governmental Affairs, vol. VI, p. 300, 95th Cong. 2d Sess. (December 1978).

Medicare, medicaid, and private insurance plans with low deductibles and little or no co-insurance, provide little incentive to consumers to seek cost-efficient care. Insurance arrangements of this type encourage consumers to select the "best" and most expensive care available since the consumer gets the benefit of what is perceived to be higher quality but bears little or none of the higher cost. The result is increasing patient volume and, more importantly, the increasing quantity and sophistication of the care each patient receives.

This process of third party coverage which increases the demand for additional and more costly services, and drives up the costs of health care, may even have a spiraling effect. As the costs of health care increases, the pressure for more comprehensive third party coverage increases.

Attempts to hold down health care costs by placing a ceiling on overall costs, paying only a percentage of costs, or narrowing the definition of allowable costs, are remedial only and do nothing to address the basic structural problems in the reimbursement system.

The introduction of a federal catastrophic health insurance program with no co-insurance provisions on top of the current government insurance programs with low deductibles and little or no co-insurance will exacerbate the problem of rapidly rising health care costs. Our appetite for medical care appears to be nearly insatiable when it is fully prepaid.

Moreover, the addition of more medical expense coverage into the existing Federal system of retroactive reimbursement of "reasonable" costs would exacerbate the perverse incentives providers have for controlling health care costs. It is these structural problems that inevitably cause health care costs inflation and create substantial inefficiencies in the use of health care resources. The bills now before this committee offer a unique opportunity to respond to these fundamental concerns. Instead of further encumbering the increasingly complex and inflationary financing structure, this committee—by changing the Federal Government's role in the bills before it—can initiate basic reforms in the incentive systems that operate in the health care industry. These changes would enlist health consumers, providers, and insurers as allies working to fight inflation for reasons of enlightened self-interest. Rather than fighting market forces, a new Federal program can be shaped to use these market forces to achieve the Federal cost-control objectives, while guaranteeing consumers quality health care.

II. PRINCIPLES UNDERLYING A FEDERAL CATASTROPHIC INSURANCE PROGRAM THAT ENCOURAGE HIGH-QUALITY, COST-EFFICIENT HEALTH CARE

Four principles underlying an efficient health care system could be incorporated into the bills being considered by this committee. These principles would create a federal health care program that: (1) fosters competition among alternative health care plans; (2) creates incentives for consumers and providers to utilize health care resources efficiently; (3) ensures consumer participation and informed consumer choice; and (4) guarantees a minimum level of available benefits.

The first principle of reform is that competition among insurers and providers of health care is healthy. In recent years, as frustration with the distortions of government regulation has increased, there has been a resurgence of scholarly support for and political commitment to market-oriented economics in achieving socially important objectives.[2]

In almost every industry other than health care, we have come to recognize that bureaucratic regulators are far from infallible and that properly designed marketplace incentives for consumers and providers may work much more effectively to achieve quality and cost-efficiency than the imposition of layers of regulatory requirements.

It is ironic that the field of health care, in which many have long thought regulation necessary, is in fact less susceptible to effective government regulation than many other industries for which deregulation is now strongly urged. Medical care is subject to so many variables that uniform regulation cannot effectively measure or evaluate its quality. The care of a patient simply cannot be reduced to revenue-passenger-miles or hospital-day-beds.

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[2] See, e.g., Robert B. Helms, Contemporary Health Policy: Dealing with the Cost of Care, in Contemporary Economic Problems 327 (American Enterprise Institute 1978); Alain C. Enthoven, Consumer-Choice Health Plan, 298 New England Journal of Medicine 709 (March 30, 1979); Alain C. Enthoven, Consumer-centered versus job-centered health insurance, 57 Harvard Business Review 141 (January-February 1979); William Hsiao, Public versus Private Administration of Health Insurance: A Study in Relative Economic Efficiency, XV Inquiry 379 (December 1978); Clark C. Havighurst, Health Care Cost-Containment Regulation: Prospects and an Alternative, 3 American Journal of Law & Medicine 309 (1977); P. Ellwood & W. McClure, Health Delivery Reform: Minneapolis, InterStudy (Nov. 17, 1976).

People with a vested interest in the perpetuation of bureaucratic regulatory power raise the spectre of declining quality as the reason why marketplace economics will not work for a particular industry. Opponents of aviation deregulation, for example, argued unsuccessfully that aircraft safety required rigid economic regulation. Just as we learned, however, that safety controls need not be adversely affected by economic deregulation, we should begin to realize that the quality of health care need not be adversely affected by the introduction of competition into the health care financing system. In fact, quality could be enhanced through the encouragement of innovative delivery systems, greater consumer awareness, participation, and choice, and more efficient investment and utilization of medical technology, facilities, and human resources.

President Carter himself has recognized that, "of all our weapons against inflation, competition is the most powerful. Without real competition, prices and wages go up * * * we must therefore work to allow more competition." Yet, by proposing cost controls rather than the introduction of competition into the health care system, the President inconsistently fails to apply this principle to the health care system.

Competition is applicable and it will work for the following reasons. Competition will bring about greater efficiency in the utilization of hospital facilities and services. And because these efficiencies are produced by impersonal market forces, they will not be subject to the often insurmountable political and legal problems created by government attempts to terminate unneeded facilities or programs. Competition will also encourage diversity and innovation in the provision of health care services.

Competition in the health care sector and the benefits derived from it, can be encouraged by government programs that require a variety of available health care plans, give consumers a choice among competing plans, provide equitable financing treatment for alternative plans, and require consumers to share the costs.

A second principle is that any federal health care program should be designed with built-in incentives to encourage more cost-conscious utilization of health care services by both providers and consumers. Instead of a system where the Federal Government reimburses providers retroactively for actual health care costs incurred, the Government should purchase medical expense coverage through the private sector on a fixed premium basis. Some form of consumer participation in the premium payment should be provided to create incentives for consumers to choose plans carefully. In addition, patient co-insurance provisions could provide incentives for consumers to examine costs and benefits when making medical decisions, thus reducing utilization of health care services.

An insurance carrier, operating in a competitive market, recognizes that its premium reflects the cost of providing medical care coverage. Thus such premiums would reflect the results of cost-conscious activity by the private companies. Since private insurers could retain the difference between the premiums received and actual costs incurred, private insurers would have incentives to choose and implement cost-containment programs that are appropriate in specific situations. Such programs would include the greater use of deductibles and co-insurance provisions in health benefit plans, improved claims review programs, and encouragement of the greater use of alternatives to inpatient care.

A third fundamental principle is that of informed consumer choice. Competition and fixed premium financing will work to improve the quality of health care only if consumers make wise choices, have the flexibility to choose from among alternative plans, and have the freedom to change their plans should the service provided not measure up to the standards of competitors. Instead of imposing rigid requirements, Government and employers should encourage consumer awareness by providing for the disclosure of information necessary to a full understanding of the benefits and costs available under each alternative plan.

A fourth principle requires that certain basic minimum levels of benefits be offered in all alternative plans. Where low-income consumers are involved, the Federal Government should pay all or part of the premium to sustain the consumer's coverage at these minimum benefit levels. But the consumer should always have the choice to enlarge the coverage or improve the benefits at additional premium cost. Thus, the Government should establish a basic floor of acceptable benefits but should not impose a ceiling on additional benefits that may be responsive to consumer demand in the marketplace.

If these four principles were applied to a catastrophic health insurance program, each consumer whose catastrophic insurance coverage would be guaranteed by such a program could choose from among competing private medical coverage plans. The Government would subsidize catastrophic coverage for low-income consumers through contributions to private insurance premiums. This Federal subsidy would

be determined on the basis of the average premium costs of the plans with the most enrollees. And Congress would establish the minimum benefits that must be covered in each plan.

Such a program would place substantial reliance on competitive market forces and would allow maximum freedom to consumers and providers to make choices in their own self-interest. Positive incentives to control costs and provide consumer-responsive quality service would be the result of this federal structure. Substantially less government regulation would be required to bring about greater efficiencies and quality of service because the marketplace incentives would be working toward this objective.

Catastrophic insurance offers a unique opportunity to demonstrate the efficacy of these market forces. By structuring a program of catastrophic health insurance according to the principles outlined above, Congress could ensure consumers quality health care in a framework that allows the market to perform those functions for which it is uniquely suited.

III. EXPERIENCE DEMONSTRATES THAT THESE FOUR PRINCIPLES WORK

Experience has demonstrated that health care delivery plans based on the principles ennunciated above can provide high-quality medical care at the lowest possible cost.

Perhaps the best example of a successful plan predicated on these principles is the Federal employees health benefits program (FEHBP), in effect since 1960 and now providing health care services to over 10 million individuals through a system based on principles of competition, multiple choice, equitable subsidization of premiums, and guaranteed minimum benefits. More than 80 different health plans participate in this Program, thus offering employees a wide range of choice among competing health care delivery systems.[3]

Whichever plan the employee chooses, the Government as employer contributes a fixed amount, calculated as the average of the premiums of several of the largest plans. The employee pays the rest. Because the amount of the Government's contribution does not vary with the costs of the plan selected, employees are encouraged to select that plan which provides the greatest benefits at the lowest cost. Carriers offering the plans, in turn, are forced to compete for employees premium dollars, by reducing their own administrative costs and contracting with the most efficient providers of health care services.

Despite initial reservations that a multiple-choice system would result in unacceptably high administrative costs, experience has shown that the expenses of administering the FEHBP are very low. A 1964 report on the program noted,

"The program finally authorized by Congress permits a wide range of choice of plans by all employees and was, in effect, a negotiated compromise among many divergent and highly organized interests. It was the only approach which at any time during the legislative process gained acceptance by all of the principals: the American Medical Association, Blue Cross-Blue Shield, insurance companies, employee unions, group and individual practice prepayment plans, and the Federal Government as the employer. Although there can be no doubt that the 'single plan' approach would have been most desirable from the standpoint of administrative simplicity, now that we have learned to live with the administrative problems which stem from multiple choice, it becomes equally clear that the wide choice of plans has produced a program which is more effective in meeting the needs of Federal employees and their dependents * * *. It was anticipated by many that serious administrative problems would develop that would require continual legislation of a perfecting and remedial nature. This has not been the case."[4]

A more recent study, conducted over 1971-72 by Harvard Professor of Economics William Hsiao, revealed that the average unit cost of administering the FEHBP was ?6 percent lower than the cost of administering Medicare.[5]

[3] Alain C. Enthoven, "Consumer-centered versus job-centered health insurance," 57 Harvard Business Review 141, 150 (January-February 1979).

[4] A. E. Ruddock, Federal Employees Health Benefits Program. I. History and future of the federal program—1964, 56 American Journal of Public Health 50 (1966), cited in Alain C. Enthoven, Consumer-Choice Health Plan, 298 New England Journal of Medicine 709 (March 30, 1978).

[5] William Hsiao, Public versus Private Administration of Health Insurance: A Study in Relative Economic Efficiency, XV Inquiry 379 (December 1978).

The FEHBP requires that each participating plan offer an adequate level of benefits, e.g., benefits for hospital room, board, and other services, surgical care, diagnostic X-ray and laboratory procedures, doctor's hospital visits, maternity care, radiation therapy, psychiatric care, and emergency care. Moreover, plans are prohibited from excluding any employee for reasons of race, sex, health status, or, at the time of enrollment, age. Finally, the Program permits employees to change plans at least once a year, thus enabling them to adjust their coverage to meet changing needs or to switch to a plan with better service or lower costs. This provision also encourages plans to provide adequate service at competitive prices in order to maintain existing enrollees.

The record of the FEHBP is impressive. For more than 18 years it has provided extensive benefits to millions of individuals. In so doing, its rate of increase in the cost of health care and the cost of administration has been significantly lower than other government programs. Thus, the FEHBP demonstrates that comprehensive quality health care can be provided under a system of financing that relies on competition among both insurers and providers of health care services, consumer cost-sharing, informed consumer choice, equitable subsidization of competing plans, and a guaranteed minimum level of benefits.

The FEHBP is not the only example of the effective application of these principles. The California State Public Employees System has been in operation for almost as long as the FEHBP, and now provides benefits for 425,000 people. It has been so successful that non-State public employee groups are now joining it.[6]

Other States have had similar success with highly competitive health care delivery systems. In Hawaii, where most people belong either to the Hawaii Medical Service Association or to the Kaiser-Permanente Medical Care Program, which are intensely competitive, the premiums for comprehensive care are among the lowest in the country.[7] In 1976, hospital expense per Hawaii resident was 68 percent of the national average notwithstanding that consumer prices in Hawaii are among the highest in the nation.[8]

In Minneapolis-St. Paul, health maintenance organizations (HMO's) compete fiercely to provide consumers with coverage at 15 percent to 20 percent less than that available under conventional health insurance, and have survived with smaller rate increases than those posted by conventional insurers.[9]

In areas other than health care, the abandonment of intensive government regulation in favor of greater reliance on market forces has led to increased services at lower costs to consumers, e.g., airline deregulation. Recently, an increasing number of experts and scholars in health care financing have begun to recognize that these principles are workable in health care as well.[10] In fact, two Federal agencies, the Federal Trade Commission and the Justice Department's Antitrust Division, have begun to apply the antitrust laws rigorously to the health care industry, seeking to foster competition.[11]

Thus, learning through experience and continued study, Congress, academic experts, and even federal agencies are becoming increasingly convinced that health care financing need not remain the peculiar preserve of the heavy regulatory hand.

IV. MODIFICATIONS TO S. 350 AND RELATED BILLS WOULD INITIATE IMPORTANT STRUCTURAL REFORMS

S. 350, S. 351 and Senator Dole's catastrophic insurance bill have much to commend them. We especially endorse the concept that every individual should have access to catastrophic insurance coverage, thus preventing serious health problems from destroying a patient's financial security and that of his family, ensuring proper care under the most trying circumstances, and alleviating the economic fears that seriously affect the patient's attitude about recovery. We agree that a federally established minimum level of benefits is a necessary step in closing a significant gap in the Nation's health care system—a gap that has widened with spiraling health

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[6] Alain C. Enthoven, "Consumer-Choice Health Plan," 298 New England Journal of Medicine 709 (Mar. 30, 1978).

[7] Alain C. Enthoven, "Consumer-centered versus job-centered health insurance," 57 Harvard Business Review 141, 144 (January-February 1979).

[8] Jon Christianson, "Do HMO's Stimulate Beneficial Competition?" InterStudy (April 1978), cited in Enthoven, Id.

[9] Edmund Faltermayer, "Where Doctors Scramble for Patients' Dollars," Fortune (November 6, 1978).

[10] See articles cited in footnote page 9, supra.

[11] In a January 19, 1978 speech, Federal Trade Commission Chairman Michael T. Pertschuk, stated: "The FTC, like most other government agencies, has been slow to admit that one possible way to control the seemingly uncontrollable health sector could be to treat it as a business and make it respond to the same marketplace influences as other American Businesses and industries."

care costs. We further support the recognition of the important role of the private sector in providing catastrophic coverage and the utility of first-dollar cost sharing by the consumer, in the form of co-insurance and deductibles.

Our primary concerns with these bills are as follows:

(1) They fail to address the root problem of the present system of federal health care programs—inadequate patient co-insurance and the retroactive cost-reimbursement mechanism. By placing additional pressure on this discredited mechanism, the bills ignore the need for basic reform in the existing system. By rewarding providers of more costly services with greater revenues, they subsidize inefficient providers while denying consumers, insurers, and potentially efficient providers the incentives to make cost-efficient choices. We recognize that the Talmadge-Dole bill, S. 505, represents a positive approach to this problem. It embodies the principle of providing economic incentives for hospitals with below average costs and penalties for hospitals with high costs. However, more fundamental structural changes to the basic cost-reimbursement system need to be undertaken.

(2) They minimize the importance of consumer choice and participation in health care financing. S. 350 gives employers the option of selecting private insurance but ignores employees. Moreover, under neither the public nor private program can employees benefit from the selection of an efficient provider of health care services. The bills would be improved substantially if they provided for responsible consumer participation in choosing among alternative plans and in contributing toward their cost.

(3) They neglect the opportunity to place maximum reliance on the private sector. S. 350 and 351 would create anoth r federal program with the inefficient overhead costs and the open-ended drain on the federal budget which that implies. Unless adequate constraints are enacted initially, the catastrophic program could, like others, veer out of control.[12]

More fundamentally, we are convinced that the principles of a market-oriented health care system, which have been successfully applied in Federal- and State-funded plans for comprehensive health care, can be incorporated into a bill to provide catastrophic insurance coverage to persons not covered under existing plans. Provisions to be incorporated in such a bill would resemble those of the FEHBP which, in addition to providing the high-quality care described above, is a model of legislative brevity.[13]

We recommend including at the beginning of the bill a declaration of policy with respect to both private and publically financed catastrophic insurance programs, making clear that the principles of competition, co-insurance, premium cost-sharing, multiple choice, guaranteed minimum benefits, and equitable subsidization are to be implemented to the fullest extent possible in any plan for catastrophic coverage. Such declaration would help ensure that implementation of the legislative mandates of the bill would be consistent with the principles underlying its enactment.

With respect to a public or residual plan, the legislation should be amended to authorize the Secretary of HEW to contract with qualified insurance carriers offering plans for catastrophic coverage described in the bill, and to specify that any plan which provides a minimum level of acceptable benefits for catastrophic coverage would be eligible for Federal subsidy.

To provide consumers a meaningful choice from among competing plans offering different benefits, the Secretary would be directed to encourage different types of catastrophic coverage plans and would be required to contract with eligible insurers and prepaid health care plans. He also would be required to approve a plan incorporating catastrophic coverage as part of a broader range of services.

By providing every individual the opportunity to select any of the approved plans, the legislation would accomplish two major objectives. First, it would compel qualified plans to compete for consumers premium payments, holding down their premium charge by minimizing administrative costs and by carefully monitoring the efficiency of health care providers with whom they contracted. Second, it would provide consumers with flexibility to select a plan best suited to their individual needs. Consumers desiring a plan which offered benefits in addition to those required by the legislation as a condition to participation in the program could select a plan with more extensive coverage and pay for the costs of such coverage. Consumers requiring less coverage could elect the least costly plan, while being assured that such plan met the minimum standards prescribed by law. Thus, no

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[12] The renal dialysis program, begun in 1974 at a cost of $200 million, is now exceeding $1 billion annually.

[13] It is noteworthy that the law that creates the FEHBP is 8 pages long, while the regulations implementing it fill approximately 16 pages. See Pub. L. 86-382, now codified at 5 U.S.C. 8901-8913; 5 C.F.R. 890. By comparison, the Medicare law (Title XVIII of the Social Security Act) is 102 pages long and is implemented by regulations filling approximately 400 pages.

individual covered by any approved plan would have fewer than those benefits mandated by statute.

To ensure continuing competition and vigilance in monitoring cost effectiveness, consumers would be given the opportunity to change their enrollment periodically. Thus, consumers dissatisfied with rising premium costs under one plan could elect another. Plans which effectively controlled costs would be able to offer greater benefits or reduced premiums. Plans which were inefficient at controlling costs would be compelled to raise premiums and would thus risk losing customers.

For persons earning below a given level of income, the Secretary would establish a federal subsidy to be contributed toward the payment of any approved plan's premium. Some form of co-insurance would be encouraged for all eligible consumers. As in the FEHBP, the subsidy would be computed as an average of the premiums of several of the largest plans.[14] The amount of the subsidy could vary according to the income of the individual, but would be the same for all individuals of similar income regardless of the costs of the plan selected or the health condition of the insured. For example, a family earning $5,000 a year would be entitled to a greater governmental subsidy toward the cost of their plan's premium than a family earning $8,000; but two families of the same size, each earning $8,000 a year, would receive the same subsidy, regardless of the plan chosen by each.

Such a method of subsidization would ensure all consumers the opportunity to obtain at least the minimum benefits required of any plan, while continuing to offer consumers willing to pay the extra cost additional benefits under more comprehensive plans. As in the case of non-subsidized consumers, however, the choice of plan would lie with the individual. Moreover, the Government contribution would not subsidize inefficient plans. Senator Dole envisions this type of financing mechanism for his "residual market" or public catastrophic proposal. We believe this approach is clearly preferable to the establishment of another Federal cost-reimbursement health program.

V. CONCLUSION

My comments today are intended to demonstrate that a program to provide catastrophic health insurance coverage can and should be based on a system which relies on market forces while guaranteeing consumers an acceptable minimum level of benefits. Only by subjecting health plans to economic competition can Congress build in to a system of catastrophic coverage the necessary incentives to provide high-quality health care at reasonable costs.

By requiring each carrier offering a plan under the federal program to provide a minimum level of benefits, the legislation will ensure that all individuals enrolled in the program will be adequately covered. By requiring the Secretary to approve a variety of plans, offering different benefits at varying premiums, the legislation will guarantee consumers the opportunity to choose from among competing plans. By requiring consumers to share in the costs of their plans, the legislation will encourage them to select plans carefully and to seek the best value for their premium dollars. By allowing consumers to change their enrollment periodically from one approved plan to another, the legislation will force plans to compete for consumers premiums and will ensure that cost-efficient plans attract the greatest number of enrollees.

By subsidizing premium payments of low-income individuals, the legislation will guarantee adequate catastrophic coverage to all persons not presently covered by such a plan. At the same time, by establishing a subsidy which remains the same for all individuals of a given income level, the legislation will provide equitable treatment to all plans—insurance or prepaid. If these principles of competition, guaranteed minimum benefits, consumer participation, cost-sharing, multiple choice, and equitable subsidies are incorporated into the proposed catastrophic coverage legislation under consideration today, this new health insurance initiative will not only provide consumers with adequate coverage at affordable costs, but will provide a model of medical expense coverage for the Government to utilize in other programs.

Mr. STOLMAN. Hospital Affiliates International, a subsidiary of INA Corporation, is among the world's largest and most experienced hospital management corporations, operating over 135 hospitals with more than 18,000 beds in 34 states and abroad.

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[14] For example, under the FEHPB, the Government contributes 60 percent of the average of the premiums of six of the largest plans.

Hospital Affiliates beleives in the application of market-oriented incentives to hospital management. Accordingly, we are vitally interested in the effect of existing and proposed Federal health care programs on incentives to provide efficient health care service. We firmly believe that if federal health financing programs are properly structured, hospitals will have incentives to provide quality service in an efficient, cost-conscious manner.

We appreciate the opportunity to comment on S. 350 and related bills establishing a Federal catastrophic health insurance program. We fully recognize the need to insure access to catastrophic insurance to protect our citizens against potential financial ruin arising from prolonged or otherwise costly medical treatment. The Federal Government has an appropriate role in financing health insurance for individuals or families unable to pay for it themselves. We encourage Congress to establish minimum standards for catastrophic coverage for everyone. We particularly endorse the efforts of members of this committee to assign a large area of responsibility for providing adequate health care to the private health insurance industry.

Moreover, we believe that a federal initiative to provide catastrophic coverage offers a unique opportunity to begin to reformulate the Federal role in financing helath care. The bills before this committee can be designed to create a more efficient health financing system and to demonstrate that quality health care can be provided more effectively through greater reliance on marketplace economics.

The following are some of the principles which Hospital Affiliates believes should be followed to achieve such goals.

First, competition among providers and insurers of health care is both necessary and desirable. Congress, the academic community, and the American public recently have come to recognize the importance of reliance on market-oriented economics to achieve socially important objectives. In areas once thought to be the sacred preserve of the regulatory agencies, we are learning that a healthy dose of competition, coupled with a minimum number of regulatory safeguards, can result in service that is both more responsive to consumers and less expensive. As in the case of the recently deregulated airline industry, competition among insurers and providers of health care can bring about greater efficiency in the utilization of hospital facilities and services, encourage diversity and innovation in the provision of such services, and provide consumers the maximum freedom of choice among competing health care delivery plans.

Second, federally financed health care programs should reward providers of health care services who utilize resources wisely and efficiently and penalize those who fail to control costs. Instead of a system where the Federal Government reimburses providers retroactively for actual health care costs incurred, the Government should purchase medical insurance coverage through the private sector on a fixed premium basis. Some form of consumer participation in the premium payment should be provided to create incentives for consumers to choose plans carefully. In addition, patient coinsurance provisions should provide incentives for consumers to

examine costs and benefits when making medical decisions, thus reducing utilization of health care services.

A third principle is that of informed consumer choice. Unless consumers have the opportunity to select from among competing health care plans, there can be no competition and hence no incentives to improve service.

Fourth, the Government should treat competing plans equally. This simply means that where the Federal Government subsidizes various health care plans, the amount of the subsidy should not vary with the cost of the plan. Any difference in the premium costs of competing plans should be borne by the party selecting the plan. Thus, consumers would be encouraged to select the most efficient health care plan and the Government would not favor inefficient health care providers at the expense of the efficient.

Finally, any federally financed program of health care insurance should guarantee a minimum level of benefits under any approved plan. Where low-income consumers are unable to afford the entire premium of a plan offering this minimum level of benefits, the Federal Government should subsidize their premium payments in an amount varying with the income level of the individual. Moreover, like others eligible for catastrophic health insurance, low-income individuals should be allowed to select the plan of their choice, including a more expensive plan, if they are willing to pay the additional premium costs.

These principles are not purely theoretical. They have been applied in Federal and State-financed programs with impressive results. Perhaps the best example of this is the Federal employees health benefits program, a program which has been in operation since 1960 and now provides health care services to over 10 million Federal employees. Under the program, each employee is free to choose from a variety of plans, including health service benefit, indemnity and prepayment plans, which offer different benefits at varying premium rates.

Turning now to the bills under consideration, let me repeat that we are in basic agreement with the principles underlying these legislative proposals. For the reasons I've just noted, however, we find two principal flaws in the bills as presently drafted.

First, their reliance on the cost-reimbursement mechanism builds on the basic weakness of the Federal reimbursement system which rewards the inefficient, penalizes the cost-conscious, and fuels the inflation of health care costs. Even Secretary Califano acknowledged this yesterday before this Committee when he said, "The only way to deal with escalating health costs * * *" must include "fundamental changes in our reimbursement mechanisms."

Second, under neither the public nor private plan for catastrophic coverage are consumers provided an incentives to seek the most efficient provider of health care services, nor are they rewarded for cost-efficient choices. In S. 350 and S. 351, for example, the employer's assumption of the entire cost of the insurance leaves employees with little or no knowledge of or concern over how much their health insurance costs. Moreover, under S. 350 and S. 351's public plan, the fixed percentage payroll tax liability subsidizes efficient and inefficient providers of health care services equally, thus providing no incentives in exchange for lower premiums. Finally, S.

350's public plan, and the private or employer-related plans of both bills, deny consumers the opportunity to select a plan of their choice from among competing plans.

Fortunately, these defects may be corrected. Here are our specific suggestions.

We recommend including at the beginning of the bill a declaration of policy with respect to both private and public programs, making clear that the principles of competition, incentives to provide efficient service, consumer cost-sharing, multiple choice, equitable subsidization of competing plans, and guaranteed minimum benefits are to be implemented to the fullest extent possible in any plan for catastrophic coverage.

To insure adequate minimum benefits for all eligible persons, the Secretary of HEW should be authorized to contract with qualified insurance carriers offering plans for catastrophic coverage which meet minimum standards articulated in the legislation.

As in the Federal employees plan, consumers should be guaranteed a choice from among several different types of approved plans and given the opportunity to change their enrollment periodically. Plans which succeeded in controlling costs would be able to offer greater benefits or reduced premiums, thus attracting new enrollees. Inefficient plans would be forced to raise premiums and thus risk losing enrollees.

For persons earning below a given level of income, the bill could provide for a Federal subsidy, geared to the individual's family income. Low-income individuals should have the same right as others to select from among competing plans, but the Government's subsidy would be applied equitably to all plans.

In these few comments, I have attempted to sketch only briefly what Hospital Affiliates believes to be the fundamental—though remediable—flaws in the legislation being considered by this committee. As I emphasized in my opening remarks, Hospital Affiliates believes in the purpose underlying these bills. We believe with equal fervor, however, that the important goals of this legislation can be accomplished through a system of Federal financing through the private sector which relies on market-oriented incentives to ensure consumers quality health care at affordable costs. If Congress seizes this unique opportunity to implement the principles I have outlined today—principles of proven effectiveness—it will not only accomplish its goal of providing catastrophic health insurance coverage to all Americans, but will fashion a model of medical expense coverage for the government to utilize in its programs.

Thank you very much. We would be happy to answer any questions.

Senator DOLE. In the absence of the chairman, I will proceed.

I thank you for your statement. I think you have pointed out some areas that we can address. You comment specifically on 350 and 351. You mention S. 748. Senator Long now has 760. I am not certain you have had time to fully analyze the latest proposals introduced on Monday.

I do not see anything in what you suggest that could not be accommodated. You do indicate strong support for the principle of cost sharing for both premiums and benefits. We suggest that

maybe the employee pick up 25 percent of the premiums. Is there any magic on how much the co-pay should be, on what level? I guess it depends on income.

Mr. STOLMAN. Yes, it does. It depends on income. There is no magic number. I guess that would have to be worked out. We just feel that it is very important that the individual should have some part of the responsibility in there, should pay some part of the bill, if he is able to afford it. If he cannot afford it, it should be subsidized by the Government.

Senator DOLE. If he is low-income, then you would have total subsidization then?

Mr. STOLMAN. Yes.

Senator DOLE. Do you think consumers can make wise choices? That is another complaint we hear from time to time. We have witnessed a program on "60 Minutes" a few weeks ago where this poor lady was literally covered up with policies. How can we take care of that problem?

Mr. STOLMAN. I think that problem can be taken care of. I give the Americans a lot more credit than many in Government do. I think a major problem today with private health care coverage, a problem which contributes to rising costs, is the average American does not pick his plan. He works for a company. That company has a set program. Typically, he has to accept it if he wants the job. Unfortunately, this situation has contributed to the rising costs in health care.

I think if we would let our American people get educated to the differences in costs and coverage they would be very selective and would have the opportunity and be able to pick from among the plans the one which is best for them. It is going to be an educational process, but one in which, I think, Americans are interested.

One of the big problems today is that the American public does not have much interest in any health care plan because, typically, they are not paying for it directly. They are paying for it indirectly.

I think with the responsibility of choosing and paying directly, they would become very interested and knowledgeable about which plans to select.

Senator DOLE. Do you believe that the insurance companies would cooperate in full disclosure and educational programs?

It is a problem. You can look at the policy and the fine print, whether it is health insurance, life insurance, auto insurance, it is very difficult to understand. We are talking about just making this available across the board to all Americans, maybe some who have had little experience with insurance of any kind, some who have not had any insurance. How do they make the right choice?

Mr. STOLMAN. I believe if it is explained properly, particularly to the employee, he is going to be able to be educated by his employer because he is going to have a choice of selection. I think, again, when you open it up to the marketplace that the insurance companies are going to doa very excellent job in marketing their particular plans and educating the public. They certainly will be spending not only advertising dollars, but educational dollars, because they are going to want to get a piece of the market.

That is how we learn. We learn from exposure to different forms of media advertising and through other personal experiences. We have not had to do that up until now because we have not had the incentives or opportunity to choose.

Once this business is opened up to the public and competition, I do believe people can be educated to the kind of plan they should have and the one they are going to want to use for their particular family.

Senator DOLE. Senator Heinz?

Senator HEINZ. I would like to ask from what you know of Senator Long's proposal and what you know of Senator Dole's proposal, you may not know enough about it, and do not feel compelled to answer, but what do you see as the principal merits and demerits between the two?

Mr. STOLMAN. Mr. Howard?

Mr. HOWARD. Just to comment briefly.

Senator DOLE. Since Senator Long is not here, you can talk about all of the merits of mine.

Mr. HOWARD. Basically, Senator Long's proposal, 350, is building on the current cost-based reimbursement system, in terms of the public program. We see that Senator Dole's proposal, from the knowledge we currently have, is going through the private insurance system. We think that is more appropriate.

We are only suggesting perhaps changes in Senator Dole's proposal to include consumer choice. That is the principal change in the Senator's catastrophic proposal we would advocate.

Senator HEINZ. Are there any additional changes to the 3-D proposal, the Dole proposal, that you would like to see?

Mr. STOLMAN. I do not think we have had a chance to review it enough to make a statement. We would be happy to review it and submit comments.

Senator HEINZ. I think that would be very helpful.

Mr. STOLMAN. We will do that.

[The following was subsequently supplied for the record:]

HOSPITAL AFFILIATES INTERNATIONAL, INC.,
Nashville, Tenn., April 10, 1979.

Hon. H. JOHN HEINZ III,
U.S. Senate, Washington, D.C.

DEAR SENATOR HEINZ: We appreciated very much the opportunity to testify before the Senate Finance Committee at the hearings on catastrophic health insurance legislation March 28. We especially appreciate the interest you showed in the principles we articulated and the thought-provoking questions you asked.

Pursuant to your request at the hearings, we have now reviewed S. 748 in greater detail and are providing our comments and certain suggested modifications that would help achieve the objectives we outlined during our testimony.

We firmly believe that Title II of S. 748—catastrophic illness insurance—is a substantial improvement over the other catastrophic bills which have been introduced. The emphasis in Title II on reliance on the private insurance industry, on consumer participation and cost-sharing, on open enrollment, on guaranteed minimum benefits, and on federal subsidies indexed to the income needs of the poor, is fully consistent with the reforms we are advocating.

With certain further modifications, we believe that S. 748, if enacted, would not only provide catastrophic coverage for all Americans but would initiate important basic reforms in the Federal Government's role of providing and financing health care.

The modifications we are suggesting would simply strengthen the emphasis in S. 748 on consumer choice and participation, the encouragement of competition among alternative plans, and equitable Federal premium financing of alternative plans

that would create incentives to control costs and to deliver quality health care efficiently.

Our suggested modificatons to S. 748 are as follows:

I. Amendments to part A—Employer plans

Since our primary objective is to provide employees a choice of competing plans and to require some employee cost-sharing of premiums, we suggest the following amendment to Section 2104 (additions underscored):

"SEC. 2104. (a) Every employer shall make available to each of his full-time employees who has been such an employee for more than 30 days, the option to participate in a catastrophic health insurance plan meeting the requirements of section 2105 (hereafter in this part referred to as the 'plan') subject to the plans (sic) open enrollment requirements.

"*Each employer which is required during any calendar quarter to pay its employees the minimum wage specified by Section 6 of the Fair Labor Standards Act of 1938 (or would be required to pay its employees such wage but for section 13(a) of such Act), and which during such calendar quarter employed an average of not fewer than twenty-five employees, shall make available at least two health insurance plans, including but not limited to service, indemnity, prepaid health plans, or employee association plans, which include catastrophic coverage meeting the requirements of section 2105, and which are subject to open enrollment requirements, unless there is not a second catastrophic plan available in the community.*

"(b) *Each employee shall be required to pay at least 10 percent but not more than 25 percent* of the cost of participating in the plan, and the employee shall have the option of paying his share of the cost through a payroll deduction system."

II. Amendments to part B—Residual plan

Since Part B's Residual Plan envisages making coverage available to otherwise uninsured individuals through policies offered by a variety of carriers, there should be a choice of plans. However, to ensure that plans providing more than mere catastrophic coverage would be eligible for approval by the Secretary, we suggest adding the following language to Section 2153 (additions underscored):

"SEC. 2153. (a)(1) The Secretary shall enter into agreements with private carriers that are willing and able to do so, whereby such carriers shall make available catastrophic health insurance policies *or shall include catastrophic coverage in more comprehensive health insurance policies,* which *catastrophic coverage* the Secretary determines *meets* the requirements of this part * * *"

These additions would make clear that carriers offering more than catastrophic coverage could also have their plans approved.

We also recommend that Section 2153 subsection (c), concerning premiums, be modified in order to make clear that the legislation contemplates premiums differing not only according to the region of the country, but according to the benefits offered in the policy. Thus the amended subsection would read:

"(c) The amount of the premium which may be charged by an entity having an agreement under this section for approved policies for which the Secretary may make subsidy payments, may vary by region according to reasonable cost differences *and the benefits offered in the particular plan,* but may not vary according to the health status of the individual (or his family) purchasing the policy (or on whose behalf the policy is purchased)."

Finally, we suggest a modification to Section 2156 which establishes a government subsidy to be paid on behalf of low-income individuals, according to a sliding scale based on income. We suggest subsection (b)(2) of Section 2156 be amended as follows:

An individual with a family income of less than the amount determined under paragraph (1) shall be eligible for a subsidy, determined on a sliding scale basis, which takes into account the following factors:

"(A) The amount of the premium.

"(B) The family income.

"(C) The family size.

["(D) Coverage provided by the policy which goes beyond the minimum coverge required of an approved policy."]

"*Provided, however, that the dollar amount of the subsidy shall not vary according to the cost of the plan selected or the benefits provided therein.*"

The principle of equitable subsidization among alternative plans requires that the government subsidy not vary according to the benefits provided by the particular policy. Subsection (D) is inconsistent with this principle. If the government subsidy remains the same for all competing insurers and plans, then insurers and providers compete on equal footing, and each has the incentive to control costs and provide care efficiently. Insurers and providers also may offer additional benefits to the

consumer at a premium cost to be borne by the consumer. To ensure adherence to this principle we have suggested that the dollar amount of the subsidy not vary according to the cost of the plan.

III. Elaboration of statement of purpose—Parts A and B

While the above changes represent minor structural modifications which will enhance competition, consumer choice, and incentives toward efficiency, we believe there is also merit in amending Section 2101 to incorporate in the statement of purpose the basic principles which should govern the new catastrophic illness insurance program. Section 2101 should read as follows:

"Purpose of Title

"SEC. 2101. It is the purpose of this title to make available to all citizens and permanent residents of the United States insurance against high-cost catastrophic illness under an employer plan required under Part A of this title or under an individual policy approved under Part B of this title.

"The following policies shall govern any program to provide catastrophic health insurance under this title:

"(a) *The assurance of quality health care at affordable costs, through maximum reliance on competition among providers and insurers of health care services in the private sector;*

"(b) *The development of incentives to providers of health care services to use resources wisely and efficiently;*

"(c) *The encouragement of consumer awareness and cost-conscious behavior through co-insurance and sharing our premium costs;*

"(d) *The assurance of informed consumer choice among competing health insurance plans;*

"(e) *The guarantee of minimum benefit levels to consumers covered under any approved plan;*

"(f) *The guarantee of equitable treatment of providers and recipients of health care services, through fixed government contributions, computed independent of any individual plan's costs or benefits."*

IV. Expansion in medicare coverage

With respect to Title I of S. 748, we recognize that there is probably no group that needs catastrophic coverage more than Medicare beneficiaries and that involvement of the private sector in providing this coverage directly is more difficult than the inclusion of catastrophic coverage in broader based plans for the population as a whole. Presently, a Medicare patient pays an initial inpatient deductible of $160. Medicare then pays for the first 60 days of hospital services in full. Medicare continues to pay for these services from the 61th through the 90th day except, for a 25 percent coinsurance payment. After the 90th day, the coinsurance requirement is increased to 50 percent.

S. 748 deletes the limitation on the number of days covered by inpatient hospital services and eliminates all coinsurance requirements after the 60th day. We are concerned about the efficacy of modifying the present Medicare cost-sharing provisions in the manner suggested. We believe that reliance solely on the nomimal initial inpatient deductible is an insufficient incentive to encourage cost-conscious utilization of hospital services by both providers and consumers.

While we would agree with the principle of uniformly starting catastrophic hospital coverage after the 60th day, we believe that concurrent changes should be made in the coinsurance requirements for the first 60 days. We suggest replacing the current deductible and coinsurance requirements with a 25 percent coinsurance requirement for the first 60 days of a hospital stay.

In addition, for similar reasons, we believe that the daily copayment for skilled nursing care should be continued. We do support your changes that would ease the restrictions on reentry into a skilled nursing facility after discharge from such a facility.

We also remain convinced that some form of cost-sharing—particularly at the time of premium payments—is desirable from the standpoint of cost-incentives and consumer participation. We thus recommend that the consumer be asked to pay a part of the premium for catastrophic coverage as he or she is presently asked to do for Part B coverage. This could be accomplished by providing that a part of the additional costs of catastrophic health care coverage be reflected in Medicare beneficiary contributions to the premiums payable under Part B.

We also are seriously concerned that Medicare catastrophic coverage rests on the defective federal retrospective cost-reimbursement financing structure, which has

exacerbated incentives for providers and consumers to spend excessively. We recognize that the Committee may not wish to address such basic structural reforms. However, too often additional programs have been added onto this shaky structure while postponing consideration of the basic problems. We urge the Committee to give careful consideration to reform of the federal Medicare financing mechanism in its consideration of S. 748. Ultimately, we believe that the cost-reimbursement method must be replaced by a fixed premium method, where insurers and providers are encouraged to hold down unnecessary costs and to maximize efficiency. We would be delighted to provide the Committee and its staff our recommendations as to how such a system might work, and we recommend that the financing structure contained in the Federal Employees Health Benefits Program and its record of cost efficiency be reviewed by the Committee in this context.

We appreciate your interest in the principles we have outlined and your invitation to provide comments and suggested modifications to S. 748. We look forward to working with you and your staff in the months ahead as you continue to address the complex problems presented by the Government's role in financing health care.

Sincerely,

EDWARD R. STOLMAN,
Vice Chairman.

SAMUEL H. HOWARD,
Vice President, Planning.

Mr. WALKER. I might add, the first goal that we have included in the statment, the goal of articulating at the beginning of the bill certain objectives, I think would be a very desirable step. I have not seen S. 748, so I do not know whether it is there or not. It may very well be.

Of course, there is a second goal that we have been commenting on that has to do with consumer choice in the selection of insurance. Perhaps some attention could be given there.

Senator HEINZ. One of the examples given about consumer choice was the Federal employees benefits choices, the high option and the low option plans, and these plans do, although they do provide various coverage levels and premium levels, thereby offer a choice to the consumer, but do not necessarily reflect what you might call a difference, do not necessarily make it possible for a consumer to choose between a more efficient more cost-conscious kind of approach and a less cost-conscious approach.

I do not know whether my high-option plan or my low-option plan is more cost-conscious. I know which one costs me less money; I do not know which one is better run, assuming they are run by different companies.

How is the consumer ever going to find out if they want a low option plan which company is doing a better job? Are you suggesting, in other words, that we mandate no more and no less than a particular benefit package?

Mr. STOLMAN. Yes, Senator. We are recommending a basic minimum package. Every company must offer that minimum benefit package to all Americans. However, the more comprehensive the package gets, the more things there are in that package, the more the consumer will pay for it.

We believe that through coinsurance, with the consumer directly paying some part of his bill, that he will soon begin to recognize whether the plan he has opted for in a particular year is a plan that offers him what he wants. If he feels he is paying too much, he would have an option to switch to another plan in the following year.

That market orientation is going to make both the provider and insurer look carefully at what they are offering to the public to make sure the public is getting the best buy for the dollar.

Senator HEINZ. So your thinking is that the consumer can make some kind of risk benefit judgment, that the benefit to having a lower premium per unit is served provision provided with that copayment is going to be a greater benefit to him than the risk of having to pay the copayment.

Should he need some kind of health care under the policy?

I have got to say I think, first of all, it is a very abstract concept to work with. It is certainly in theory correct, but when you put yourself in the position of the person actually choosing which is better, a lower premium or should I get stuck having to pay Lord knows how much, 20 to 25 percent copayments, it becomes a difficult decision for individuals to wrestle with.

If they say gee, I do not know. Where do I get actuarily? Let's assume that they know there are such things as actuaries, where do they go to get actuarial advice?

Do you?

Mr. STOLMAN. Let's just take the Federal employees health benefit plan which I understand offers about 80 different health care options to Government employees, whether it be HMO's, or private insurance companies. The cost to the employee is based on the plan and the amount of coverage he is going to get.

He can opt for a very expensive plan or a less expensive one. The U.S. Government is paying a flat premium of 60 percent of the premiums of the largest six sets of plans and that is what the Government contribution is for the employee; the employee picks up the rest. Now, he does have to think for himself.

He may go to a plan one year that may not offer him a full range of benefits. The following year his condition may change. He may have more children in his family or he may have different options that he might need, or he feels it is better for him. He therefore has that option. He can either pay for it or not. Because he has a direct financial stake in the cost of the coverage, he will learn to be a better consumer.

Mr. HOWARD. One comment. There are two decisions. The first decision is a decision to buy the policy. That decision is going to be based on the amount of premium he would have to pay for the health care benefits desired. Second, we would encourage the basic policy to have coinsurance provisions. This provision would relate to the decision that one needs to make when medical care is needed. We also want the providers themselves to be aware of the 25 percent coinsurance provision. So it is two decisions: The decision to buy the policy which is based upon how much money I am going to put out of my pocket for the premium and the decision on how much I must pay when the health care services are specifically needed.

We think that coinsurance would help control the utilization and facilitate, at least encourage, the consumer to make a wise choice in the latter case.

Senator HEINZ. So that I understand your proposal accurately, are you suggesting that we mandate a specific co-insurance schedule, a copayment?

Mr. STOLMAN. We would simply recommend that any legislation would require some coinsurance or cost-sharing, but at this point we are not prepared to specify exactly what that level should be. It depends a lot on the economic position of the person involved. For the very low-income person, of course, the cost will be completely subsidized. For others with more income, they should share in some of these costs and understand that they have a responsibility for their own health care.

Senator HEINZ. I understand that principle. What I am asking you, are you saying, though, that essentially in the legislation we develop a schedule which, for the sake of discussion, starts at zero for $5,000, and works its way up 25 percent at some unknown level and could that be mandated for all of the plans that essentially qualify? Is that what you are saying.

Mr. STOLMAN. Yes.

Senator HEINZ. Therefore, we would not allow any plan to qualify for, I guess our Good Housekeeping approval, or whatever it is you get, a 3-D stamp, or whatever. We would not allow any plan, really, to participate that did not have a copayment.

Mr. STOLMAN. Yes.

Senator HEINZ. All right.

Thank you very much. It has been very helpful.

Senator DOLE. Thank you.

The CHAIRMAN. The next witness is John B. O'Day, president and managing director, Insurance Economics Society of America.

Mr. O'DAY. Thank you, Mr. Chairman.

STATEMENT OF JOHN B. O'DAY, PRESIDENT AND MANAGING DIRECTOR, INSURANCE ECONOMICS SOCIETY OF AMERICA

Mr. O'DAY. Mr. Chairman, my name is John B. O'Day and I am president and managing director of the Insurance Economics Society of America. The society, founded in 1917, is an organization engaged in the continuous study of social and private insurance systems. Members of the society consist of a select group of insurance companies who are among the pioneers in the development of America's unique and unprecedented health insurance system and over 7,000 insurance agents who are engaged in marketing and servicing health insurance to individuals as well as employers.

The society has been privileged to appear as a witness before committees of the Senate and House of Representatives to testify on all major health insurance bills dating back to 1943.

Since 1943, the society has urged Congress not to expand the social security tax mechanism to include mandatory health insurance coverage for the American people. We, therefore, must oppose S. 350 because it proposes a new payroll tax similar to the social security tax as a funding source.

The society realizes that this Senate committee is well aware of the vast burdens of the social security tax on most Americans, employers, and on the entire economy.

However, one illustration should be called to your attention: When today's 50-year-old worker began to work, his maximum social security tax was $30 a year. By the time he reaches age 57, his maximum social security tax will have grown to $3,000 a year. That represents a 100 times increase in less than a working life-

time. His employer must pay an equal amount which will make the social security tax on a single job as much as $6,000 in 1986.

The society has argued in a countrywide no health tax campaign that any health insurance tax, no matter how modest at its inception, will experience a growth similar to that of the current social security tax.

The society is concerned that if S. 350 should be enacted, future Congresses will be subjected to formidable social and economic pressures to expand the program toward a comprehensive national health insurance law funded by taxes and directed by the Federal Government.

A review of the society's testimony before congressional hearings since 1943 discloses the many social and economic problems western European countries experienced with government health insurance laws through the recent decades. Because they have been so well-publicized, the time will not be taken to repeat them. However, the world was reminded of these problems February 11, when the Archibishop of Canterbury condemned, from the pulpit, the sheer pitilessness of British ambulance drivers who, during a strike for higher wages, left the dead unburied and turned their backs on the sick and dying.

In Sweden, government health insurance is a major component leading to very high taxes. On the average, the Swedish workers now pay 53 percent of their income in taxes. Their taxes have been so high that it is reported that Sweden's economy is seriously affected by emigration, tax cheating and lower productivity as the incentive to work is reduced significantly by taxes.

The society believes that these recent events in other countries are instructive and must be brought to the attention of Congress and the American people.

The society is concerned about part B of S. 350, described as "the private insurance option." Under this section, an employer could elect to have all of his employees and their dependents covered under a qualified private catastrophic insurance plan as an alternative to coverage under the government plan. This section would place the government in direct competition with private insurance companies for the mandated coverage.

The society has sound reason to believe, that under this arrangement private health insurance companies would be driven from the marketplace by government regulatory bodies as well as by many aspects of unfair competition. This has happened under competitive health and disability insurance laws in California and New Jersey.

In 1946, the California State Unemployment Compensation Disability Fund was established which permitted private health and disability insurers to compete with the State fund for the State's mandatory disability insurance coverage. Private plans insured over 50 percent of the workers during the early 1950's just as the law was expanded to include a hospital room benefit.

Because the State fund experienced perennial deficits in the late 1950's and early 1960's, the State's employment security director issues a regulation which made it unfeasible for private insurers to compete with the state fund. In 1963, the State declared thousands of existing private insured plans to be no longer qualified under

the law, and this action was upheld by the California Supreme Court.

Today, although the statute still contains language permitting a private insurance option, the private plans are a miniscule factor in this program where the State collects $½ billion in disability insurance taxes annually.

New Jersey, in 1948, enacted a similar mandatory disability insurance law which permitted competition between a State fund and private insurers. In its initial stage, two-thirds of the employees elected a private insurance option.

When the law was expanded to include a pregnancy benefit without a proper increase in the state disability tax to fund it, private plans eroded into the state fund. Ironically, the state fund experienced perennial deficits during the almost total erosion of private insurance option plans.

Mr. Chairman, the society urges this Senate committee to study the California and New Jersey experience to see the unfortunate results suffered by the private insurance industry when government enters the competitive marketplace.

In conclusion, the insurance economics society wishes to congratulate those members of this Senate committee who have proposed tax incentives for individuals, as well as employers, to purchase catastrophic health coverage. The society particularly emphasizes the need for a form of income tax credits for the purchasers of individual and family policies. In addition to thousands of nonmembers, over 7,000 members of the Society throughout the nation can offer catastrophic health insurance coverage paying benefits over $100,000. Policies offering up to a quarter of a million dollars of coverage are readily available.

The society urges Congress to study the practicability of giving prospective individual purchasers of catastrophic health insurance a tax incentive effective this year in 1979.

Mr. Chairman, this concludes our statement and we deeply appreciate the right to be here to present it.

Senator DOLE. Thank you very much, Mr. O'Day.

Senator Long had to leave a moment ago. He read your statement and he indicated, as I have indicated, we are moving away from the payroll tax in S. 748 or in 760, which takes care of your suggestion and I believe that the administration—I am not sure about Senator Kennedy, but I think even there you will see some movement away from a payroll tax because, as you pointed out, we have about reached the limit on adding more and more to the social security burden.

In reference to tax credits and tax incentives, I do not quarrel with that, except what do you do about those who pay no taxes, the poor people?

Mr. O'DAY. We do believe, Senator, that the poor people should be subsidized by Government, that the programs—and I think I have seen some of the programs which indicate that the poor, and even the near-poor, will receive quite a subsidy from the Government so that they can purchase also voluntary health insurance.

Senator DOLE. Do you think the consumer can make the right choice if given all the options?

Mr. O'DAY. In a free country, yes, Senator. We make free choices all day long. We should be given the right to make free choices in this area.

I sure would not want the government to tell me which care to buy, or what bread to eat. Why should the Government insist on telling me what type of coverage?

Senator DOLE. It is not a question of insisting, but a question of protecting some very vulnerable groups, those with less education, and the elderly. I am not talking about whether you can make a choice or I can make a choice—we may not make a choice, but we certainly can make a choice but there are some in society who may not be able to make the choice unless we have an educational effort.

Mr. O'DAY. I agree with you. I think it is the Government's responsibility and the responsibility of all professionals in the health care system to root out those who do not provide the best in this type of coverage. We in the private insurance industry detest any type of coverage that is not fully and return for the dollar premium an adequate service to the policyholder. We will work with government on that score, and have worked with regulatory bodies on that score through educational programs and other types of programs.

Senator DOLE. I think that will be one of the arguments. If we want to put our trust in the private sector, which most of us do, we are faced with the argument it is better to have the government participate—if we are going to pay them, we ought to have some discretion in what we pay for.

Mr. O'DAY. Senator, I believe we do. I think the advertising policies of the companies, for example, who explain their coverage on the media and on the TV, that is going to be subject to analytical review of people like Sylvia Porter, for example, other columnists, that journalists must take a part in saying we think that this type of coverage is good for this purpose and this type is good for that purpose, and I think it is a media responsible as well as a government and insurance responsibility.

Senator DOLE. We appreciate your testimony, and the hearings will recess until 10 tomorrow morning.

Mr. O'DAY. Thank you very much.

[Whereupon, at 12:35 p.m. the committee recessed to reconvene at 10 a.m. on Thursday, March 29, 1979.]

CATASTROPHIC HEALTH INSURANCE AND MEDICAL ASSISTANCE REFORM

THURSDAY, MARCH 29, 1979

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, D.C.

The committee met, pursuant to notice, at 10 a.m., in room 2221, Dirksen Senate Office Building, Hon. Russell B. Long (chairman of the committee) presiding.

Present: Senators Long, Talmadge, Ribicoff, Baucus, Bradley, Dole, and Danforth.

Senator TALMADGE. The committee will come to order.

The first witness this morning is the Honorable Joseph F. Boyle, medical doctor, board of trustees, American Medical Association, accompanied by Alan R. Nelson, M.D., council on legislation.

We are delighted to have you, Dr. Boyle. You may insert your statement in the record in full and summarize it in any manner that you see fit, taking not more than 10 minutes. We have a long witness list this morning.

Dr. BOYLE. Thank you, Mr. Chairman. With us also are Harry Peterson and Ross Reuben of our legislative department.

STATEMENT OF JOSEPH BOYLE, M.D., BOARD OF TRUSTEES, AMERICAN MEDICAL ASSOCIATION, ACCOMPANIED BY DR. ALAN R. NELSON, COUNCIL ON LEGISLATION; HARRY PETERSON, LEGISLATIVE DEPARTMENT AND ROSS RUBIN, LEGISLATIVE DEPARTMENT

Dr. BOYLE. Our association is pleased to present its views on the legislative proposals for catastrophic insurance, modifications of Medicaid, and insurance certification embodied in S. 350 and S. 351.

Mr. Chairman, the extended discussion on national health insurance which has taken place during the past years has been beneficial in many respects in analyzing the issues and in evaluating the impact of national health insurance upon society. The thrust and scope of national health insurance proposals have altered with changing circumstances.

During this extended period of NHI debate—but particularly during this last decade—we have seen a number of significant changes take place in our health system. To name a few: Marked increases in numbers of medical schools; significant expansion in number of medical graduates, with emphasis in primary care training; substantial increase in training of allied personnel; proliferation of medical facilities, affording easier access; development of

sophisticated technology; wider distribution of medical personnel; expansion of government supported health programs; increased access to care by the disadvantaged; and wider coverage of private health insurance, including catastrophic coverage. Thus, while the debate has waxed and waned, our health delivery system has shown steady improvements. This has been accomplished through the cooperative efforts of many, including both government and the private sector.

The American Medical Association is concerned about the problems that remain in the country that inhibit the availability of needed health care services to all the American people. There is a need to provide adequate care for all the poor. There are a number of individuals who do not have adequate health insurance coverage. There is a problem for individuals who cannot receive insurance because of pre-existing medical conditions. There needs to be wider availability of adequate coverage to protect families from the staggering costs that a catastrophic illness can bring.

At the same time, Mr. Chairman, we must keep in mind that the vast majority of our population is currently covered, or has available, coverage for both basic and catastrophic health expenses. Therefore, the limited problem areas that do exist should not be made to overshadow the beneficial aspects of our system, and certainly they do not justify complete restructuring of the private health care delivery system, as it exists in this country, into a direct instrumentality of federal policy.

Rather, these deficiencies indicate a need for specifically-targeted and designed initiatives to further alleviate the problems while allowing the health care delivery system to develop and to operate as it has over the years—providing high quality care to the American public.

It is against this background, Mr. Chairman, that our house of delegates adopted principles at its meeting in December 1978, for guiding modifications to our present health care system. These principles are found on pages 3 and 4 of our written statement.

At this time, I want to emphasize our concurrence with the objectives stated by both Senator Long and Senator Dole in seeking solutions to the limited problems which exist without which, as Senator Long has stated, "the potentially disruptive and bankrupting effects involved in proposals which would radically alter and scrap existing structures and mechanisms." The labor approach "the Corman bill," and the Kennedy outline, as well as the HEW program currently under consideration for national health insurance, all would provide for the radical restructuring which you, as well as the medical profession, seek to prevent as being destructive of our system. If the American health system becomes an instrument of Federal policy, controlled and dominated by the Federal bureaucracy, we can only expect a deterioration in our health system. Chairman Long has said it well, although in what we believe is an overly mild and reserved tone:

> To those of us who have worked with medicare, medicaid, and other Federal health care financing programs, it has become quite clear that there are limits to the Government's administrative capacity. It seemed to us rather foolhardy to pile upon that limited capacity further responsibility which could not be met effectively.

We agree also with Senator Dole and appreciate and endorse his comments when introducing S. 748 where he has said:

What we need is an approach which builds on the private marketplace and recognizes the importance of incentives and competition, one that supports the private sector, and one that does not encourage the development of yet another inefficient, costly, oppressive Federal bureaucracy.

Mr. Chairman, Dr. Nelson will continue with the remainder of our statement.

Dr. NELSON. Mr. Chairman and members of the committee, S. 350 is a three-part program providing for a plan for catastrophic health insurance, a federalized medicaid with standardized eligibility and benefits for the poor, and a system of Federal certification of private health insurance policies designed to encourage minimum standards in health plans and facilititative the availability of adequate coverage for the general population.

S. 351 is identical with S. 350 in its proposals for catastrophic health insurance and certification of private insurance policies. Unlike S. 350, it does not seek to change the present medicaid system.

We concur with you, Mr. Chairman, that there is a need to encourage and facilitate the expansion of catastrophic health insurance coverage to reach persons who are not now so protected. We are acutely aware of the severe impact that a family might experience from a costly illness for which they can ill-afford to pay, or even the psychological effects of the threats of such illness.

We question the need, however, for the addition of another public plan of insurance with yet an additional payroll tax.

We recognize the need to provide assistance for all those individuals who cannot afford to purchase catastrophic coverage as well as to assure availability for all those who want such coverage. However, we question the need for universal coverage through the public plan. We believe that your objective can be met through the private sector, with governmental financial assistance for low income individuals.

Mr. Chairman, some 40 million Americans are now covered by medicare and medicaid, and S. 350 and S. 351 before this committee would add to the numbers who would be receiving their health care in the public sector. Each such increment brings us closer to a Government-operated and controlled system of health care for the American people. Such steps should be avoided, by expanding coverage in the private sector. We believe that we should not now be overextending the direct involvement of the Federal Government in the delivery of care by providing catastrophic insurance to those able to obtain such insurance for themselves. For the medicare group who rely on that program for their care, a removal of limitation on hospital care would provide substantial protection. For the medicaid group, an expanded program of adequate coverage, including catastrophic coverage, could meet basic and catastrophic needs.

The American Medical Association supports the modification of Federal health care programs to provide for uniform benefits for those who cannot provide for their own medical care.

S. 350 would approach this objective by replacing medicaid. Under the bill's medical assistance plan, low-income families and

individuals would be provided a standard package of benefits comprised of hospital and medical services that are now covered in the medicare program. The MAP would be administered primarily by the Federal Government.

Mr. Chairman, we recognize advantages and improvements contained in your program modifying medicaid. We are concerned, however, with further fostering a two-class system of care. We are currently examining alternative methods to bring all our citizens into the mainstream of medical care. Rather than burden the already overburdened Federal and State governments with the direct administration of more health care programs, it could prove more practical and beneficial to provide coverage through the private insurance system with governmental financial support for those in need of assistance.

Both S. 350 and S. 351 incorporate a system of federal certification of policies issued by private insurers. The commendable intent of this program is to provide individuals with information that a policy carrying the seal of approval will provide, at least, a minimum standard.

The program also contains provisions designed to assure the availability of coverage for those individuals who are currently uninsured due to preexisting conditions.

In reviewing the legislation, we find several aspects that go significantly beyond those stated objectives. First, the program would authorize the Government to become an issuer of policies. This appears to us unnecessary and inappropriate.

Second, it also carries the potential for Government control of the health care industry through the establishment of rigid and inflexible insurance standards. As an example, language inappropriately ties charges for all health services to the levels allowable under medicare and medicaid.

The detail in the prescribed standards of coverage outlined in the bill is more in keeping with Federal control over administration and payment mechanisms, rather than assuring availability of adequate policies. The certification program as outlined in the bills is too broad.

The American Medical Association believes that the solutions to the problems that have been identified and addressed in S. 350 and S. 351 should be concentrated in the main in the private sector, building upon a system that is providing the highest quality of health care in the world.

The private sector can meet the need of insurance coverage for all Americans. The success of the private sector in supplying coverage is well documented by the tremendous growth of private health insurance coverage, both basic and catastrophic, over the past 25 years. This success must be compared with the problems that large scale governmental programs engender, including excess rigidity, redtape, waste, and abuse. We believe that governmental support should be provided to finance, as necessary, adequate levels of insurance protection for those unable to afford coverage.

Mr. Chairman, there is a need to fill gaps in health insurance coverage. We agree that expansion of the availability of catastrophic coverage is necessary. Low-income individuals should be brought into the mainstream of health care. We believe that the public

should have available and be informed of policies that meet minimum standards. However, it is our belief that these matters can be adequately addressed in the private sector with proper Federal encouragement. We urge this committee to accept these principles and not adopt S. 350 and S. 351.

Within the past few days, Senator Long and Senator Dole have introduced new approaches—changes from S. 350 and S. 351 that move catastrophic insurance coverage generally from the public sector to the private sector. We applaud these changes.

We have just received these new bills and have not finished our analysis. With your permission, Mr. Chairman, we will submit additional comments shortly to the committee with respect to the new legislation.[1]

Senator TALMADGE. Thank you, gentlemen. We would be happy to have your additional comments, whenever they are available. I think this question is probably for Dr. Boyle. What is the official position of the AMA as to the PSRO program?

Dr. BOYLE. With respect to the PSRO program?

Senator TALMADGE. Yes.

Dr. BOYLE. The policy of our association has and is support for the PSRO program. Since its enactment, we have developed constructive amendments to this program to change certain of the thrust of the PSRO and its application at the local level. These amendments have been introduced in the 93rd, 94th, and 95th Congresses and we intend to submit them again very shortly.

Senator TALMADGE. I understand your position to be supportive with amendments?

Dr. BOYLE. That is correct.

Senator TALMADGE. You have had a lot of experience with PSRO's. Are the PSRO's serving as a means of denying necessary and proper care?

Dr. BOYLE. Are they a means of denying necessary care?

Senator TALMADGE. Do they serve as a means of denying necessary and proper care?

Dr. BOYLE. I believe that if misapplied that such a result could certainly occur, Mr. Chairman. At the present time, I am not aware of instances in which that has occurred. However, this program is still relatively new. I do not believe there has been an opportunity for that kind of experience to develop.

Senator TALMADGE. Has your experience to date been that the PSRO's save the Government money?

Dr. BOYLE. As far as I know, in a few areas of the country, there have been some savings, but as far as the general savings of the Government is concerned, I do not believe that large amounts have been realized.

Senator TALMADGE. Dr. Nelson, would you like to comment on that?

Mr. PETERSON. Mr. Chairman, may I offer a comment on that? There is a recent report from HEW—HCFA. They identified within the recent activities of the PSRO that there were savings to the Government over the expenses involved in connection with the program.

[1] At presstime, June 18, 1979, the material referred to had not been received by the committee.

Senator TALMADGE. That was the thrust of Senator Bennett's amendment, as you know, at the time that this committee adopted that amendment. Two things, really. It was to give the medical profession a means of policing itself and, in addition to that, it was hoped that any areas where there was fraud, abuse or unnecessary hospitalization or unnecessary surgery that the doctors themselves were the best qualified to pinpoint those areas and not the Government.

You share that point of view, do you not?

Mr. Peterson. I believe the intent was to examine the quality and to look at potential overutilization as such.

The principle thrust of PSRO was to determine the appropriateness and the quality and necessity of the care.

Senator TALMADGE. Dr. Nelson, do you want to comment?

Dr. NELSON. Not on that point, Senator, but I would point out in addition to Dr. Boyle's comments regarding your first question, at the last meeting of the AMA House of Delegates, the association endorsed a strong, positive statement urging physician participation in PSRO's. Over the past year, it certainly seems that the AMA official policy set by the AMA House is very supportive, particularly in so far as urging that the physicians become involved in making the law work.

Senator TALMADGE. Thank you.

Senator Ribicoff?

Senator RIBICOFF. No questions.

[The prepared statement of Dr. Boyle and Dr. Nelson follows:]

STATEMENTS BY JOSEPH BOYLE, M.D., AND ALAN R. NELSON, M.D., FOR THE AMERICAN MEDICAL ASSOCIATION

Mr. Chairman and members of the committee, I am Joseph Boyle, M.D., a physician in the practice of medicine in Los Angeles, Calif. and a member of the board of trustees of the American Medical Association. Participating with me in the presentation of this statement is Alan R. Nelson, M.D., a practicing physician from Salt Lake City, Utah and a member of AMA's Council on Legislation. With us is Harry N. Peterson, Director of our Department of Legislation.

The AMA is pleased to have this opportunity to present its views on the legislative proposals for catastrophic insurance, modifications of medicaid, and insurance certification embodied in S. 350 and S. 351, which are the subject of the hearings before this committee.

Mr. Chairman, the extended discussion on national health insurance which has taken place during the past years has been beneficial in many respects in analyzing the issues and in evaluating the impact of national health insurance upon society. The thrust and scope of national health insurance proposals have altered with changing circumstances.

During the long period of NHI debate—but particularly during this last decade—we have seen a number of significant changes take place in our health system. To name a few: Marked increase in numbers of medical schools; significant expansion in number of medical graduates, with emphasis in primary care training; substantial increase in training of allied personnel; proliferation of medical facilities, affording easier access; development of sophisticated technology; wider distribution of medical personnel; expansion of government supported health programs; increased access to care by the disadvantaged; and wider coverage of private health insurance, including catastrophic coverage. Thus while the debate has waxed and waned, our health delivery system has shown steady improvements. This has been accomplished through the cooperative efforts of many, including both government and the private sector.

The American Medical Association is concerned about the problems that remain in the country that inhibit the availability of needed health care services to all the American people. There is a need to provide adequate care for all the poor. There are a number of individuals who do not have adequate health insurance coverage.

There is the problem for individuals who cannot receive insurance because of pre-existing medical conditions. There needs to be wider availability of adequate coverage to protect families from the staggering costs that a catastrophic illness can bring.

At the same time, Mr. Chairman, we must keep in mind that the vast majority of our population is currently covered, or has available, coverage for both basic and catastrophic health expenses. Therefore the limited problem areas that do exist should not be made to overshadow the beneficial aspects of our system, and certainly they do not justify complete restructuring of the private health care delivery system, as it exists in this country, into a direct instrumentality of Federal policy. Rather, these deficiencies indicate a need for specifically targeted and designed initiatives to further alleviate the problems while allowing the health care delivery system to develop and to operate as it has over the years—providing high quality care to the American public.

It is against this background, Mr. Chairman, that our House of Delegates adopted the following principles at its meeting in December, 1978, for guiding modifications to our present health care system:

(1) Requiring minimum standards of adequate benefits in all health insurance policies sold in the United States with appropriate deductible and co-insurance.

(2) Providing for a simple system of uniform benefits provided by the Federal, State and local governments for those individuals who are unfortunate enough (through no fault of their own, i.e., age, disability, financial hardship, etc.) not to be able to provide for their own medical care.

(3) Formulating a nationwide program by the private insurance industry of America (and government if necessary for reinsurance) to make available catastrophic insurance coverage for those illnesses and individuals where the economic impact of a catastrophic illness could be tragic. All catastrophic coverage should have an appropriate deductible and co-insurance to make it economically feasible and to avoid abuse.

(4) Recognizing that a program developed pursuant to these principles should be administered at the state level with national standardization through federal guidelines.

This was followed by a statement by our Board of Trustees, as follows:

"The American Medical Association believes that everyone should have health insurance, at adequate benefit levels, and that the gaps in the present system that affect some segments of the population need to be filled. Nearly 190 million individuals have private or "public" insurance coverage, and the benefits provided under much of the coverage are broad and comprehensive. Approximately 20 million people do not have access to coverage for varying reasons, and the Association supports the extension of appropriate insurance coverage to these segments of the population.

"The Association is cognizant of the growing problems facing other nations with government controlled health programs; the rising costs of health care and the effect that a massive federal program would have on an already overheated segment of the economy; and the priority that the nation needs to give to controlling inflation and eliminating waste and inefficiency."

Mr. Chairman, at this point I want to emphasize our concurrence with your objectives in seeking solutions to the limited problems which exist, without, as you stated, "the potentially disruptive and bankrupting effects involved in proposals which would radically alter and scrap existing structures and mechanisms." The labor approach (the Corman bill), and the Kennedy outline, as well as the HEW program currently under consideration for national health insurance, all would provide for the radical restructuring which you, as well as the medical profession, seek to prevent as being destructive of our system. If the American health system becomes an instrument of federal policy, controlled and dominated by the Federal bureaucracy, we can only expect a deterioration in our health system. The Chairman has said it well, although in what we believe is an overly mild and reserved tone:

"To those of us who have worked with medicare, medicaid, and other Federal health care financing programs, it has become quite clear that there are limits to the Government's administrative capacity. It seemed to us rather foolhardy to pile upon that limited capacity further responsibility which could not be met effectively."

Dr. Nelson will continue with the remainder of our statement.

STATEMENT BY ALAN R. NELSON, M.D.

Mr. Chairman and members of the committee, S. 350 is a three-part program providing for a plan for catastrophic health insurance, a federalized medicaid with standardized eligibility and benefits for the poor, and a system of federal certification of private health insurance policies designed to encourage minimum standards in health plans and facilitate the availability of adequate coverage for the general population.

S. 351 is identical with S. 350 in its proposals for catastrophic health insurance and certification of private insurance policies. Unlike S. 350 it does not seek to change the present medicaid system.

CATASTROPHIC INSURANCE

To protect against possible high costs of extended or catastrophic illness and the threat of bankruptcy that might accompany such illness, S. 350 and S. 351 would place a maximum limit on the amount that any individual would have to pay in any year toward the cost of his health care. The benefits covered under the program would be the same as those covered under medicare with no upper limits on hospital days. Medical benefits would trigger when a family had incurred $2,000 of medical services. Hospital benefits would be payable for hospital services as to an individual following 60 days of hospitalization for that individual. There would be no coinsurance on catastrophic insurance benefits.

The total population would be covered. Catastrophic insurance would be provided for much of the population under a public plan administered by the federal government (HCFA) through fiscal intermediaries and financed by a payroll tax. An employer (or self-employed individual) might opt out of the public plan on behalf of his employees by furnishing the employees with private insurance, specifically approved by the Secretary of HEW, that would assure coverage at least equal to that available under the public plan.

For persons eligible for and covered by medicaid under the federalized medicaid to be established in S. 350, the catastrophic insurance benefits would be coordinated with the basic benefits provided in medicaid. Under S. 351, however, some gaps could remain in States that have limited benefit packages.

We concur with you, Mr. Chairman, that there is a need to encourage and facilitate the expansion of catastrophic health insurance coverage to reach persons who are not now so protected. We are acutely aware of the severe impact that a family might experience from a costly illness for which they can ill-afford to pay, or even the psychological effects of the threats of such illness. We question the need, however, for the addition of another public plan of insurance with yet an additional payroll tax. We recognize the need to provide assistance for all those individuals who cannot afford to purchase catastrophic coverage as well as to assure availability for all those who want such coverage. However, we question the need for universal coverage through the public plan. We believe that your objective can be met through the private sector, with governmental financial assistance for low income individuals.

While we understand the need for the availability of free standing catastrophic insurance, we should keep in mind that problems would remain for those who may be uninsured or inadequately insured since catastrophic insurance would mean protection against a catastrophic contingency without accommodating basic health care needs.

Mr. Chairman, some 40 million Americans are now covered by medicare and medicaid, and S. 350 and S. 351 before this committee would add to the numbers who would be receiving their health care in the public sector. Each such increment brings us closer to a government-operated and controlled system of health care for the American people. Such steps should be avoided, by expanding coverage in the private sector. We believe that we should not now be overextending the direct involvement of the Federal Government in the delivery of care by providing catastrophic insurance to those able to obtain such insurance for themselves. For the medicare group who rely on that program for their care. A removal of limitation on hospital care would provide substantial protection. For the Medicaid group, an expanded program of adequate coverage, including catastrophic coverage, could meet basic and catastrophic needs.

MEDICAL ASSISTANCE PLAN (S. 350 ONLY)

The American Medical Association supports the modification of Federal health care programs to provide for uniform benefits for those who cannot provide for their own medical care.

S. 350 would approach this objective by replacing medicaid. Under the bill's medical assistance plan (MAP), low-income individuals and families would be provided a standard package of benefits comprised of hospital and medical services that are now covered in the medicare program. The MAP would be administered primarily by the Federal Government.

Mr. Chairman, we recognize advantages and improvements contained in your program modifying medicaid. We are concerned, however, with further fostering a two-class system of care. We are currently examining alternative methods to bring all our citizens into the mainstream of medical care. Rather than burden the already overburdened Federal and State Governments with the direct administration of more health care programs, it could prove more practical and beneficial to provide coverage through the private insurance system with governmental financial support for those in need of assistance.

CERTIFICATION OF PRIVATE INSURANCE

Both S. 350 and S. 351 incorporate a system of Federal certification of policies issued by private insurers. The commendable intent of this program is to provide individuals with information that a policy carrying the "seal of approval" will provide, at least, a minimum standard.

The program also contains provisions designed to assure the availability of coverage for those individuals who are currently uninsured due to pre-existing conditions.

An insurer wishing to have a health insurance policy certified would, on a voluntary basis, offer it to the Secretary for examination; and the policy would be certified if the secretary found that specified criteria had been met. Such certification would entitle the insurer to imprint an official emblem of certification on the approved policy form and to make appropriate reference to such approval in advertising.

Mr. Chairman, the private insurance industry has been very progressive and has taken the initiative over the years in designing insurance policies to provide health insurance protection. Attesting to this is the wide variety of excellent insurance policies available on the market today, covering basic and catastrophic health needs, within a wide range of insurance limits. This vast selection of available policies could now, or with some tailoring of terms to meet special requirements within a definition of "adequate coverage" and "reasonable conditions," meet the desired coverage of the American public and advise the public as to those policies that do not provide the suggested minimum standards of coverage.

From an industry standpoint, offering desired insurance is not only good service, it is good business. It does not appear that extensive legislation is necessary to create the insurance availability contemplated in the legislation.

In reviewing the legislation, we find several aspects that go significantly beyond those stated objectives. First, the program would authorize the government to become an issuer of policies. This appears to us unnecessary and inappropriate. Second, it also carries the potential for government control of the health care industry through the establishment of rigid and inflexible insurance standards. As an example, language inappropriately ties charges for all health services to the levels allowable under medicare and medicaid.

The detail in the prescribed standards of coverage outlined in the bill is more in keeping with Federal control over administration and payment mechanisms, rather then assuring availability of adequate policies. The certification program as outlined in the bills is too broad.

CONCLUSION

The American Medical Association believes that the solutions to the problems that have been identified and addressed in S. 350 and S. 351 should be concentrated in the main in the private sector, building upon a system that is providing the highest quality of health care in the world.

The private sector can meet the need of insurance coverage for all Americans. The success of the private sector in supplying coverage is well documented by the tremendous growth of private health insurance coverage, both basic and catastrophic, over the past 25 years. This success must be compared with the problems that large scale governmental programs engender, including excess rigidity, red tape, waste and abuse. We believe that governmental support should be provided to finance, as necessary, adequate levels of insurance protection for those unable to afford coverage.

Mr. Chairman, there is a need to fill gaps in health insurance coverage. We agree that expansion of the availability of catastrophic coverage is necessary. Low-income individuals should be brought into the mainstream of health care. We believe that

the public should have available and be informed of policies that meet minimum standards. However, it is our belief that these matters can be adequately addressed in the private sector with proper Federal encouragement. We urge this committee to accept these principles and not adopt S. 350 and S. 351.

Within the past few days, Senator Long and Senator Dole have introduced new approaches—changes from S. 350 and S. 351 that move catastrophic insurance coverage generally from the public sector to the private sector. We applaud these changes.

We just received these new bills and have not finished our analysis. With your permission, Mr. Chairman, we will submit additional comments shortly to the committee with respect to the new legislation.

Senator TALMADGE. The next witness is Mr. John A. McMahon, president of the American Hospital Association.

Is Mr. McMahon here? We will call him when he arrives.

The next witness is Mr. Melvin Glasser, director, social security department, international union, United Automobile, Aerospace and Agricultural Implement Workers of America-UAW.

You may insert your full statement into the record and summarize it, not to exceed 10 minutes.

STATEMENT OF MELVIN GLASSER, DIRECTOR, SOCIAL SECURITY DEPARTMENT, INTERNATIONAL UNION UAW, ACCOMPANIED BY PATRICK F. KILLEEN, SOCIAL SECURITY DEPARTMENT, UAW

Mr. GLASSER. Thank you, Mr. Chairman.

If I may, I would also like to insert into the record a brief statement by UAW President Douglas Fraser on the same subject. He regrets that he cannot be here. I thank you for the kind introduction.

Senator TALMADGE. Without objection, that will be done.

[The material referred to follows:]

UAW PRESIDENT FRASER CALLS FOR A RATIONAL POLICY TO DEAL WITH AMERICA'S HEALTH CARE PROBLEMS

BEVERLY HILLS, CALIF.—Asserting that discussions of health care concentrate too much "on dollars and cents" instead of sense, UAW President Douglas A. Fraser today (Saturday) decried the absence of a national health policy.

He was speaking at the Beverly Hilton Hotel here before a Conference on Proposals for a National Health Policy sponsored by the University of California at Los Angeles.

"Cost containment should not be a national goal," he declared. "Cost containment is a means to achieve the goal of a rational health care system. To me, that makes sense."

He cautioned against "a piecemeal health policy," citing "so-called catastrophic health insurance" as an example. He said it was "aptly named" because its passage "would be a catastrophe for health care in our country.

"It is based upon the cruel myth that people already have good basic health care coverage and require protection only against very expensive bills * * * Catastrophic health insurance would do nothing to bring relief to most people. Its intolerable deductibles—the first 60 days in a hospital plus the first $2,000 in doctors bills—would force most people into bankruptcy long before financial aid becomes available," Fraser charged.

"Because of the high deductibles and overwhelming emphasis on major illness, it would create greater inflation in the health care system. It would invite providers to raise their prices. And it would result in longer hospital stays on the excuse that the family or individual would thereby become eligible for catastrophic benefits. The net result would be a price rise in all aspects of health care.

"It would create greater imbalance in the health care system by adding incentives for expensive care and disincentives for health maintenance and preventive care, early diagnosis of disease, and other neglected aspects of the system," he asserted.

Fraser outlined nine principles on which a rational policy might be built. They include:

The removal of all economic barriers.

"We must provide for a single universal national health insurance program covering the entire population regardless of age, race, income, employment, or unemployment status," he noted.

Fully paid health benefits "to cover the entire range of personal health services, including the prevention and early detection of disease." Good health care is much more than just "the treatment of acute episodic illnesses," Fraser pointed out.

Built-in incentives to make the delivery of "more efficient, high quality health services" possible. Fraser cited "substantial evidence" that nonprofit health maintenance organizations (HMO's) provide "better care at less cost." Health professionals should be encouraged to practice team-work health care delivery, he said.

The savings of billions of dollars through "better use of existing resources," and a reduction of waste and excessive profits by means of "effective health planning and allocation of resources," such as consolidation of hospital services and high-cost medical technologies.

Elimination of unnecessary surgery and laboratory tests through the monitoring of the quality of health care.

A role for the consumer-patient "at every administrative and decisionmaking level," Fraser said. "There must be provider risk-sharing. Presently, the consumer takes all the risks."

Several measures to make the financing of health services "simple and equitable."

Incentives to overcome the shortages and maldistribution of health personnel.

A "carefully structured national health plan with regional administration" to replace "the present chaos of federal, state and local programs and private insurance companies selling different policies and administering them with thousands of different and often conflicting benefit packages," Fraser said.

"These are the principles upon which to base a national health policy. The list is by no means all-inclusive. But * * * to make real gains, those principles must be tied to a comprehensive national health insurance program," the UAW president declared.

The absence of a national health policy at the present time is reflected in "runaway health care costs," in a lack of access to decent health care by "significant portions of our population," in the "fragmented organization" of health services, the inadequate quality of care and the "failure of the private insurance industry," Fraser asserted.

He noted that "we spent $182 billion on health care last year," of which the consumer paid $48 billion "out of his own pocket," and that "the elderly who rely on medicare are now paying more out-of-pocket today * * * than they did before we had a medicare program."

He pointed out that "nearly 51 million Americans * * * live in areas without sufficient health services" and that it is difficult for many people to get to see a doctor because we have a surplus of specialists and a shortage of general practitioners, and doctors "concentrated in the wrong places."

He compared the solo practice, fee-for-service system to the "cottage industries before the industrial revolution" and charged it was "a major factor in fragmentation." He said "waste and record profits have become endemic" while the quality of health care ranges "from superb to horrid."

And he charged that most health insurance policies "provide Swiss cheese coverage" because the many gaps and loopholes create "more illusion than reality of coverage."

Mr. GLASSER. I thank you for your kind introduction. By the time you finished reading the name of my union, my time is almost up.

Senator TALMADGE. We will omit my preliminary introduction.

Mr. GLASSER. I am accompanied this morning by Mr. Patrick Killeen on my right, a member of the staff of the Social Security Department.

Mr. Chairman, we have chosen primarily to address Title I of S. 351 which would establish a catastrophic national health insurance program. We are prepared to discuss other sections of the total bill at a later point.

Our principal thesis, Mr. Chairman, is that the problems of American health care relate to cost, quality, fragmentation of serv-

ice, maldistribution of resources and providers. Our viewpoint, which we will illustrate, is that the catastrophic illness proposal before your committee in fact addresses none of those proposals and will exacerbate the problem of health care in America.

We think it is the wrong proposal at the wrong time and it goes in the wrong direction. Catastrophic health insurance legislation would do nothing to restrain health care costs. The fact is that it would greatly increase the current inflation in health care by adding incentives for very expensive care and for price increases and disincentives for prevention.

If basic economic theory and common sense do not convince us of this, we should learn from the experience of others.

The Japanese national health insurance program, for example, requires dependents of workers to pay 30 percent of their medical costs out of pocket. In 1973, the program was amended to put a ceiling on that. After the individual spends the equivalent of about $120 in a month, the catastrophic insurance covers 100 percent of subsequent charges.

In the first three years of the program, the number of cases eligible for catastrophic coverage jumped 70 percent. The average cost per case increased 21 percent. There was a corresponding decrease in low-cost cases. The result has been a dramatic increase in health care costs, which observers in that country and in the United States attribute to the shift to more high cost illnesses resulting from provider reaction to the availability of catastrophic insurance.

By fueling the fires of health care inflation, catastrophic coverage actually would increase the cost of medicare, medicaid, and other Government programs at a time when the Congress and the administration are concerned with holding down expenditures in the Federal budget.

Catastrophic insurance is based on the myth that most people have good basic coverage. That is the key to this.

However, 22 percent of those under age 65—some 41 million persons—have no hospital or surgical insurance. In addition, it is estimated that 12 to 13 percent of those under 65 have no economic protection against the cost of illness at all—not even inadequate welfare medicine under the medicaid program.

And when we look at the many exclusions, loopholes, copayments, deductibles, and other limitations common in private health insurance plans, we find that tens of millions of more persons are denied adequate protection. The protection they have is more illusion than reality.

Increasing costs and the fragmentation of health care were a principal factor in a major strike at Ford Motor Co. with the UAW a few years ago, and a major factor in the strike of the United Mineworkers 1½ years ago.

I suggest to you that the passage of a program like this which will exacerbate the problems, will also increase the problems in collective bargaining in a very difficult time.

Furthermore, this bill will do nothing to bring an end to the two-class system of medical care. It does nothing for the 1 out of 3 black mothers who do not receive prenatal care, nor for the babies

in poor families who are twice as likely to die before their first birthday than infants in middle-income families.

In fact, the catastrophic program would discriminate against low-income workers. Their employers will pay the required 1 percent of wages for catastrophic coverage. Yet because so many of them have inadequate basic coverage they will never get beyond the barrier represented by the huge deductibles in S. 351. The bill has separate deductibles of 60 hospital days and $2,000 in physician fees and medical expenses. This will amount to a bill with a deductible close to $19,000 in 1981.

We are talking about insurance with a $19,000 deductible. Those with higher incomes will be more likely to have the good basic insurance protection and other financial means to surpass the deductibles and get catastrophic benefits. Lower income workers will just pay and pay and rarely receive benefits. They would be bankrupt long before they exceeded the deductible barrier.

A catastrophic program would not help fill the need for more health education, illness prevention, and early detection of disease. It will do the exact opposite by creating incentives for longer hospital stays, use of more costly medical technology, and curing rather than preventing illness.

Catastrophic insurance does nothing for the 51 million Americans who live in areas without sufficient health care services. Indeed, it would further draw doctors away from rural and small town areas by increasing funds available to pay lucrative medical specialties in urban areas.

By providing incentives for physicians to become specialists in order to receive higher fees, catastrophic coverage would tend to decrease the number of already scarce general practitioners and family doctors and increase the already abundant supply of specialists and superspecialists. At the present time, only 35 percent of all physicians are general practitioners or primary care specialists.

By making more funds available for more frequent and longer hospital stays, catastrophic illness insurance creates greater incentives for filling hospital beds and for increasing hospital capacity and facility construction. This clearly runs counter to the national efforts to hold down and, in certain areas, reduce costly excess hospital capacity.

A catastrophic plan would do nothing to bring innovation and reform to the delivery of health care but only would help to perpetuate the status quo. It would do nothing to encourage the growth of health maintenance organizations.

Catastrophic coverage would not reduce the fragmentation and complexity of payment for health care services. It would serve to increase the complexity by adding another layer of financing. The recordkeeping required to administer the deductible requirements would be a bureaucratic nightmare. Already, nearly 14 cents out of every premium dollar paid to private insurers for benefits is creamed off the top for administrative expenses, reserves, and profits. The experience of the private insurance industry with this kind of program convinces us that the present administrative costs will only be increased.

Nothing in S. 351 would increase the responsiveness of the health care system to consumer needs. All the economic risks

would stay with the consumer while the provider would be further protected through finances from any such risk. It would totally ignore, Mr. Chairman, the quality of medical care in the United States.

You have heard, and other committees have heard, any number of reports on high rates of excess surgery, inaccurate laboratory tests, avoidable surgical deaths, and complications and preventable drug reactions. Catastrophic coverage would make more money available for excess surgery and for doctors in hospitals to raise their charges in order to cover their rising malpractice insurance rates. That is certainly not the intent of this committee, I am sure.

The plan would be very expensive. Supporters of the bill have pegged its annual cost at $5 billion to $7 billion, but in 1976, the Trapnell Associates report for HEW on cost projections of various proposals priced the catastrophic insurance part of the Long-Ribicoff bill in new dollars at $13.5 billion, $6.8 billion of which would be on the Federal budget. And they projected then a 1.2 percent payroll tax would be needed.

There are other estimates that show that even a $13.5 billion estimate would probably be low. But perhaps the most serious danger of this bill is that it gives the illusion of coverage when there is not any, and there is a need, indeed, to deal with the serious problems in our health care system. There are some alternative measures which are in the Congress and which will be in the next weeks. We urge this committee to give most serious attention to a bill that would deal with the problems in a more comprehensive way and would not give the appearance of national health insurance when, in fact, it does not happen.

Thank you, sir.

Senator TALMADGE. Thank you, Mr. Glasser.

Does the UAW contract with the auto industry require the manufacturers to assume any taxes or premiums required for a national health insurance plan that may be adopted by Congress?

Mr. GLASSER. Yes, sir.

It requires that if the total cost of any new program passed by the Congress do not exceed the premiums paid in any given year for health insurance, the workers' portion of that would be assumed by the employer in return for which the employer would be relieved of the responsibility for providing such benefits under the private insurance scheme.

Senator TALMADGE. The auto workers have excellent health insurance coverage. Which expensive and high cost kinds of care are denied to your members?

Mr. GLASSER. Our members, through having good primary care, in fact have catastrophic illness insurance. The only area not covered is out-of-hospital physicians' services.

The distinction I wish to make is a good program that provides primary care benefits covers catastrophic illness. A catastrophic illness program does not cover good primary care.

Senator TALMADGE. Is it not true that apart from nursing home care costs that the bulk of catastrophic illness expense not presently met by insurance is for medical rather than hospital charges?

Mr. GLASSER. I am really sorry.

Senator TALMADGE. Is it not true that apart from nursing home care cost that the bulk of catastrophic illness expense not presently met by insurance is for medical rather than for hospital charges?

Mr. GLASSER. We have recently, within the last 4 weeks, done a study of major medical as it might affect our members, which is not the same, but roughly is in the same ballpark. I can answer it in those terms. Specifically the way in which major medical would affect our program is that it would cover primarily certain mental health treatment expenses which are excluded from our basic mental health program by design because we do not consider them appropriate, and it would cover a part of physician out-of-hospital expenses.

The answer to you, sir, as far as the study we have made of its effect on our own members, the answer to you would be "No" on nursing home care.

Senator TALMADGE. Could you comment on it nationally without reference to the UAW contract?

Mr. GLASSER. I do not have data on the national incidence or the national impact. I am not aware, sir, of any studies. I have no reason to believe that it would be significantly different, except that we know that under medicaid, the largest part of their expenses are indeed to pick up for nursing home care. I would suggest this is a fundamental problem in the organization and delivery of care and not a problem of payment. The problem in this country is that we have millions and millions of the long-term ill for which we have no sound solution. The solution to them, I would suggest, to their problem is not to build more nursing homes and not to pay for more nursing home benefits but to provide for more effective ways of taking care of them.

Senator TALMADGE. Try to keep them out of nursing homes, if you can.

Mr. GLASSER. I would love to, and I think we can.

Senator TALMADGE. Senator Ribicoff?

Senator RIBICOFF. Mr. Glasser, has your organization been involved in formulating the new Kennedy proposal?

Mr. GLASSER. We have been consultants and participants, yes, sir.

Senator RIBICOFF. Has your organization approved that?

Mr. GLASSER. We have not approved anything. We have nothing to approve, sir, at this moment. Through our participation in the Committee for National Health Insurance, of which, as you know, UAW President Douglas Fraser is chairman, we have approved the principles that are being developed and we are active participants in drafting the proposal which I hope your committee will hear in the near future.

Senator RIBICOFF. But the Kennedy approach is such a far departure from the Kennedy-Corman approach which you have been advocating all these years that it does present an entirely different picture of your union's and your organization's concept of where health insurance should go.

Mr. GLASSER. Our union has certainly departed from the original health security plan. I am most reluctant, as you can gather, to discuss the details of the new proposal because they are not completed.

Senator RIBICOFF. When you say they are not completed, last week Senator Kennedy showed them to me in full detail. Has he showed them to you?

Mr. GLASSER. Yes, sir. I am aware of what he showed you.

Senator RIBICOFF. They are fairly well complete. In looking at them, as I told Senator Kennedy and Secretary Califano and Senator Long, it would seem to me that Senator Kennedy is going toward the Long-Ribicoff approach and so is the administration, so that you certainly have an opportunity of getting all the forces involved in health insurance coming together in a common concept.

Mr. GLASSER. Mr. Ribicoff, if one were to conclude that the proposal being developed by the Committee for National Health Insurance with Mr. Kennedy were going in the direction of this Long-Ribicoff approach, I can say here and I am prepared to say that is categorically not correct.

If one were to conclude that the proposal being worked on is a major compromise which keeps most of the principles of the health security bill but makes it economically viable in the present climate of the Congress, I would say that is correct.

But, sir, the difference between a comprehensive plan which provides primary benefits and a catastrophic plan is a difference of about 179 degrees.

Senator RIBICOFF. Yes, but generally, the new Kennedy approach is an incremental approach to health insurance, is it not?

Mr. Glasser. It is a comprehensive approach in phases. It is not an incremental approach that says, let us do something that will divert the system from meeting the problems, as S. 350 would do. Nor it is not one that says, let's get a piece before the Congress now and every couple of years we will go back for other pieces.

That is the difference. An incremental approach that passes the comprehensive plan and has phasing in it is quite different, sir, than the approach you are indicating.

Senator RIBICOFF. Does Senator Kennedy start off with catastrophic as the first phase?

Mr. GLASSER. No, sir.

Senator RIBICOFF. What is his first phase?

Mr. GLASSER. I am sorry. I have to delay that discussion before there is a formal proposal before the committee.

Senator RIBICOFF. What always intrigues me, Mr. Glasser, in your criticism of the Long-Ribicoff approach—I am a cosponsor of 350 but I am not a cosponsor of 351—is your failure to ever address title II and title III of the bill. I do not know how intellectually you can address title I and condemn the Long-Ribicoff approach without taking into account title II which provides for coverage of lower income individuals and the poor; and title III which provides for private insurance to pick up the first $2,000 of medical costs and the first 60 days of hospitalization.

From a union standpoint, if all you had to bargain with your employer about was the coverage of the first $2,000 in medical costs and the first 60 days of hospitalization, I think that your union membership would be in a pretty good position to bargain with their employers on the differential for wages and other fringe benefits.

And I am at a loss to understand why you never talk about title II and title III. Constantly representatives of your union and other unions come to my office with fire in their eyes over the fact that I am for Long-Ribicoff. When I sit down and explain title II and title III, there is not a single person who has ever been informed that Long-Ribicoff has a title II and title III.

When title II and title III are explained to them, they are puzzled why the union leadership has never said Long-Ribicoff has title II and title III.

Now, you come here today and condemn the bill and you avoid talking about title II and title III. I would like to know what is wrong with title II and title III of 350 and why are you against title II and title III?

Mr. Glasser. Mr. Ribicoff, I would be very glad to respond. I would point out to you, sir, that in 8 minutes it is hardly possible to analyze three titles to a bill. I would point out further, sir, that we were informed that it was the intention of the chairman to give precedence to title I and to address title I. However, I am prepared to respond to you at this moment.

Senator RIBICOFF. But your cost estimates include the cost of titles II and III.

Mr. GLASSER. No, sir.

Senator RIBICOFF. I think this is important and I hope the Chair will allow Mr. Glasser to explain what he does not like about title II and title III.

Senator TALMADGE. Certainly.

Mr. GLASSER. The problems with title II and title III are essentially the same as the problems we have with title I. The approach in all three titles is to deal with the health care system as though the problem were in payments. The problem, sir, in our view, is not in payments. The problem is in organization, delivery of service, cost containment, proper distribution of resources, none of which are addressed by any of the three titles.

Senator RIBICOFF. May I interrupt?

But we are concerned about cost containment. I support the President and Senator Nelson and the chairman of the subcommittee is interested in cost containment. We are interested.

Mr. GLASSER. There are no references to those aspects.

Senator RIBICOFF. I know, but there are correlative bills moving in Congress and you will have cost containment before you will have any health insurance program. Of that, I am sure.

Mr. GLASSER. Mr. Ribicoff, I will be very glad to discuss the cost containment legislation which our union supports, which the administration has introduced.

You asked for comments on titles II and III. Titles II and III ignore those aspects. Titles II and III, as well as title I, have built in them inflation factors that inflate far more than hospital costs.

When we increase the rate of surgeries, we not only provide poor care, but we inflate the costs of the health care system.

We have had a 31 percent or 32 percent increase in surgery in the last 5 years and a 4 percent increase in population. Titles I, II, and III do nothing about that. They are essentially payment mechanisms and because they do not deal with the problems of the

health care system, we suggest that the committee is going off in the wrong direction.

Senator Ribicoff. In title II, it refers to "all other phases."

Suppose we put a title IV, cost containment?

Mr. Glasser. Then I would like to see the nature of that cost containment and I would like to see it for 100 percent of the cost of health care. Should the administration hospital cost containment bill pass and should it achieve its objective, it will deal with 40 percent of the cost. What about the other 60 percent?

I think you understand our concern, sir—we have had close relations with you over the years. We represent neither doctors nor hospitals nor nursing homes. We have insurance programs that are good for our members. We are interested in the total society. We are interested in the consumers of health care, and we do not see S. 350 or S. 351 as addressing the health care problems. It is addressing payment problems.

Senator Ribicoff. Mr. Glasser, we have a basic problem here. Your union is up against the situation in every negotiation you have where you have to determine time and time again, is 50 percent of something better than 100 percent of nothing. That is the problem we are faced with here. I have no better friend and closer associate than Senator Kennedy. I have told him constantly that his approach means that you will not have any health insurance at all. The incremental approach can work if you start to try solving these problems one step at a time and take a complicated system and make that system work, without shattering what is good in our system at the present time. You must realize that the overwhelming cost of the original Kennedy approach would never be accepted by the Congress and the American people.

Let us start incrementally. Let us try to build this up one step at a time. As our system absorbs it, as we are able to afford it, go to the next step and the next step, and eventually you can come out where you want to come out. But to try to put it in in one fell swoop, you deprive a major segment of the population from any coverage whatsoever.

Of course, those who are against health insurance just love that kind of opposition, because that opposition means you are not going to have anything. So the AMA likes that kind of opposition, the insurance companies like that kind of opposition, the hospitals like that kind of opposition, the Manufacturers' Association likes that kind of opposition, because in that type of opposition, you divide all those people who want to do something and you get nothing and years go by.

For the past 6 years we could have passed the catastrophic. Now we are still struggling to get the first step going and there is great difficulty. you realize If you just count noses in the House and the Senate, you will realize how much support there is for the Kennedy-Corman proposal.

There was so little support for it that you were forced to look for an alternative to get around it. The new Kennedy proposal costs are way down, way beyond or below what your original objectives were.

Now the question becomes, are you going to be realistic? My feeling is that Senator Kennedy today is willing to be realistic. I do

not know whether you are yet, because if you are realistic and try to work this out, my feeling is that between Senator Long, Senator Kennedy, the President and Joe Califano, we can work out a plan. But if there is going to be a situation of all or nothing, there will be nothing. This is a decision that has to be made by those who have been in back of Kennedy-Corman.

Do we want to start on the road of health insurance, or are we going to have another 20 years in which nothing is achieved?

Mr. GLASSER. Mr. Ribicoff, may I briefly respond in three ways?

In the 19th century, British social historian said, "It is impossible to leap across a chasm in two jumps." This has something to do with my second comment.

My second comment is that, indeed, we in the UAW are prepared to make major changes in our approach, although not our principles, of how one gets the comprehensive health insurance plan. Based on our experience and based on the fact that we have $2 billion a year in negotiated health premiums at stake, we are not casual observers, we are victims of the system.

It is our conviction that it is possible to develop and propose a phased system which, in fact, would cost less and would be less inflationary than the two bills before this committee.

No. 3, it is our absolute conviction that this is the wrong step, these two bills are at the wrong time, in the wrong direction, and it is not incremental, it is retrogressive.

Senator RIBICOFF. I am convinced that there could be worked out a Long-Kennedy bill.

Mr. GLASSER. I would hope so.

Senator RIBICOFF. Yes. I am not sure that you think so. I am not sure that you understand that. And I am willing to try to work for it. It can be done, but not when there is absolute condemnation of what is trying to be worked out. The realities in this present day and age include our budget problems and the proposition 13 mentality which I reject and oppose vehemently.

Mr. GLASSER. I would hope we could have a Long-Ribicoff-Kennedy bill.

Senator RIBICOFF. I will say this: I will have a hand in it. I do not care whether my name is on it or not. I want a bill passed.

I have said to Senator Kennedy, let's get a Long-Kennedy. Forget Ribicoff. I will work for it.

You see, I do not care whether my name is on it or not. That does not mean so much to me.

I would like to achieve it. I think it can be achieved, because there is a very big problem. Unless we bring every segment in here, we are going to have these pitched battles, Congress after Congress, election campaign after election campaign, and the basic needs for health insurance for the people in this country will go by the boards. That is what I am talking about.

Mr. GLASSER. I think we are in agreement on that. I am hoping to find a common ground. I am suggesting for our union, sir, that the common ground could not begin with catastrophic illness proposal for the reasons I have indicated.

We certainly would seek a common ground. We certainly would like to see a way of dealing with the problem.

Senator RIBICOFF. That is not the case. Senator Long and myself, not in S. 351 but in S. 350, were very, very concerned about doing something for low-income individuals. That is why I refused to go on Senator Long's S. 351—because it deletes the low-income title. My feeling is that you just cannot take care of catastrophic, you must take care of the lower income individuals as well. I would hope that we can try to put this thing through.

Senator Long will see why you cannot do S. 350 in a different formula, because it takes care of a different segment of the population. But you cannot reject what we are driving at in title III to pick up that first $2,000 and the first 60 days. That becomes important. And only if we are going to be able to view this in a realistic sense and in light of our ultimate objectives will you have a bill.

Senator Long would like to phase this in beginning in 1981. Secretary Califano wants to phase this in in 1983. I think Senator Kennedy wants to start phasing his in in 1981 as well.

But this is doable. It is doable because you have people who want to do it; but if there are going to be cutoffs at the pass from every section, people will throw up their hands and wait for another Congress. There is a mood here to try to work something out, and it becomes very important in this present mood for those who would be leading the fight for one phase of health insurance or another to work together. It becomes important to have cooperation from you and Senator Kennedy, because my feeling is that it can be done in this session.

Mr. GLASSER. Our union is completely prepared to go the route of cooperation in attempting to get something worked out. I would suggest to you, sir, that when we have our Health Care for Americans Act ready for introduction, which I am told will be in the next few weeks, we may find that we are not that far apart, because the issue of cost is not one to which we are blind.

We are pragmatists. We understand the society. I think you will find that it is possible to address the total problems of the system, to address the issues which, in my view, are neglected in the two bills before the committee at this time, and to do it at no greater and probably lesser cost over the first years than the proposals now before this committee.

Senator RIBICOFF. I think you are right. That is why we are reaching a situation today where, by necessity, we are being realistic and can start on a health insurance system that can work.

Senator TALMADGE. Senator Danforth?

Senator DANFORTH. No questions.

Senator TALMADGE. I have one final question. I know you say the only way to get a handle on health care costs is with comprehensive national health insurance for all. You cite as an example of cost control that hospitals would be paid prospectively, everyone knowing in advance how much will be paid out and how much will be received. That sounds good, but how does that work, when you do not know how much will be passed through in wage increases of nonsupervisory hospital employees during the year?

How do you budget for a blank check?

Mr. GLASSER. There are very good bases, sir, on which this can be estimated; the increases that are expected are taken into account.

Hospitals budget that way every single year and have done so for many, many years. They do not come far off in their knowledge.

I am a trustee of two hospitals. I know from personal experience; we do it.

I should add one other thing. We have very substantial evidence that this is workable. If one looks at the situation in Canada where there has been prospective budgeting of hospitals for 21 years, where they have a much larger percentage of their hospital employees unionized than we have in the United States, they have taken this into account in their prospective budgeting and their annual increases in hospital costs in no way are comparable to those in the United States.

So my answer is that we have experience. We have knowledge from the Canadian experience. We believe that it is a sound and reasonable way to do it.

Senator TALMADGE. Thank you, sir. I appreciate your contribution.

[The prepared statement of Mr. Glasser follows:]

STATEMENT BY MELVIN A. GLASSER, DIRECTOR, SOCIAL SECURITY DEPARTMENT, INTERNATIONAL UNION, UAW

Mr. Chairman, members of the Committee on Finance. My name is Melvin A. Glasser. I am Director of the Social Security Department of the International Union UAW. Accompanying me is Patrick F. Killeen, my associate from the UAW Social Security Department. We appreciate the opportunity to present testimony regarding S. 351, the "Catastrophic Health Insurance Act," sponsored by you, Senator Talmadge and other distinguished members of the Senate. We appear on behalf of more than 1,600,000 UAW members who, together with their families constitute over 5 million Americans covered under UAW negotiated health care benefit programs.

Mr. Chairman, we have chosen principally to address Title I of S. 351[1] which would establish a Catastrophic National Health Insurance Program. We are prepared at a subsequent time, should the committee wish, to discuss title II of S. 350 which would establish a uniform medicaid program administered by the Federal Government. Today we are primarily addressing title I which appears to have generated the most serious attention.

Mr. Chairman, leaders of our Union long have recognized your continuing interest in health care and your sincere concern for the difficulties faced by many Americans in obtaining and paying for health care services. We are well aware of your recognition of the need to remove barriers to access to needed care, to restrain rising health care costs, and to reduce waste, fraud, and abuse in our health care system. This committee, under your leadership, Mr. Chairman, has made many significant contributions, benefiting millions of Americans, through the development of major health legislation.

Mr. Chairman, the American health care system is beset by a number of severe and fundamental problems. In fact, for the past decade or more, crisis has become a continuing fact of life for those of us who have been attempting to deal with these problems. This crisis also in a very personal way has touched the lives of millions of Americans who face obstacles in getting the health care services they need at a price they can afford.

These very serious and nearly overwhelming problems call for comprehensive and fundamental reform of our health care system—its financing, organization, and delivery. They will not disappear by ignoring them. And, we believe, these problems are not addressed by and, therefore, will not be solved by S. 351. In fact, enactment of a catastrophic health insurance program might well deepen the crisis in American health care.

Health care costs continue to soar completely out of control. They are nearly doubling every 5 years. National health expenditures will surpass $200 billion this year and increase to $323 billion in 1983, and to $1 trillion by the year 2000, according to the National Institutes of Health. That will amount to about 12 percent

[1] This is identical to Title I of S. 350, the "Catastrophic Health Insurance and Medical Assistance Act."

of our gross national product compared to about 9 percent now—already the highest among modern nations.

One out of every $12 spent from our own family budgets now pays for hospital and medical costs and for private health insurance premiums and uncovered gaps in the insurance. So frightening to Americans is the fear of medical costs that controlling them is the fourth highest priority of Americans surveyed last fall by Louis Harris. Among 21 national priorities listed, only general inflation, government spending and unemployment were selected as higher priorities.

In each of the past two major rounds of negotiations in our Union the escalating costs of health care and the insistence of the employers on passing these costs on to our members has been a major factor in causing strikes. Unfortunately, indications are that rising health insurance premiums again will present obstácles at the bargaining tables in the auto and agricultural implement negotiations later this year. The same problem is being experienced by other unions across the country. Today the family health insurance premiums for a Chrysler worker in Michigan amount to $234 a month—equivalent to about 8 weeks pay. Our members have to forgo additional wages and benefit improvements merely to maintain present benefits. This situation cries for correction.

But our primary concern, Mr. Chairman, is providing adequate health care for those who need it. Cost containment must be seen as a means to reaching this objective. We in the UAW—and, we know, you and the members of this committee—would want to examine any legislative proposal in terms of its provisions for dealing with the problems of our sick health care system.

The problems confronting us have been well documented and are well known by this committee. In addition to the problem of costs, we are concerned about the lack of adequate basic protection against the cost of health services for tens of millions of Americans. We are concerned about the two-class system of health care in which the poor often receive substandard care and the health of minorities is a national disgrace. There is an overemphasis on acute, episodic care and a lack of health education, disease prevention, and primary medical care. Facilities and doctors are poorly distributed geographically in relation to population needs. The quality of medical care has been demonstrated to range from superb to horrid. The plethora of fragmented third-party payers is burying physicians and consumers in red tape.

Mr. Chairman, these problems are severe, in many ways they are intertwined, and they go to the root of the way in which health care is financed and organized in our country.

We believe that S. 351 does not begin to deal with these problems. We fear that it would serve to perpetuate and worsen much of the present disarray.

Catastrophic health insurance legislation would do nothing to restrain skyrocketing health care costs. The fact is that it would greatly increase the current inflation in health care by adding incentives for very expensive care and for price increases and disincentives for prevention. If basic economic theory and common sense do not convince us of this, we at least should learn from the experience of others.

The Japanese national health insurance program, for example, requires dependents of workers to pay 30 percent of their medical costs out-of-pocket. In 1973 the program was amended to put a ceiling on these out-of-pocket expenses. After an individual spends the equivalent of about $120 in a month, the catastrophic insurance covers 100 percent of subsequent charges. From 1974 to 1976, the first 3 years of the program, the number of cases eligible for catastrophic coverage jumped 70 percent. At the same time, the average cost per case rose 21 percent. There was a corresponding decrease in the number of low cost cases, those which did not qualify for catastrophic coverage, and in the average charge per low cost case. The result has been a dramatic increase in health care costs. Observers in Japan and in the United States attribute the shift to more high cost illnesses as resulting from provider reaction to the availability of catastrophic insurance. They had every incentive to increase the intensity of acute hospital services and to increase the length of hospital stays in order to qualify for the catastrophic funds.[3]

By fueling the fires of health care inflation, catastrophic coverage actually would increase the cost of medicare, medicaid and other government programs at a time when the Congress and the administration are concerned with holding down expenditures in the Federal budget.

Catastrophic insurance is based on the myth that most people have good basic coverage. However, 22 percent of those under age 65—some 41 million persons—have no hospital or surgical insurance. In addition, it is estimated that 12 to 13

[3] Joel H. Broida and Nobuo Maeda, "Japan's High Cost Illness Insurance Program: A Study of Its First Three Years, 1974-76," Public Health Reports, DHEW, March-April 1978, Vol. 93, No. 2.

percent of those under 65 have no economic protection against the cost of illness at all—not even inadequate welfare medicine under the medicaid program.[3]

And when we look at the many exclusions, loopholes, copayments, deductibles, and other limitations common in private health insurance plans, we find that tens of millions of more persons are denied adequate protection. The protection they have is more illusion than reality.

A voluntary certification program for private insurance policies, as provided in title II of S. 351, will not help those with no coverage or poor coverage. It will not provide financial means for the purchase of policies certified as adequate for millions who currently are outside of the mainstream of health care.

Catastrophic coverage does nothing to bring an end to the two-class system of health care. It does nothing for the one-out-of-three black mothers who do not receive prenatal care; nor for the babies in poor families who are twice as likely to die before their first birthday than infants in middle-income families.

In fact, the catastrophic program would discriminate against low-income workers. They will pay the required 1 percent of wages for catastrophic coverage. Yet because so many of them have inadequate basic coverage they will never get beyond the barrier represented by the huge deductibles in S. 351. The bill has separate deductibles of 60 hospital days and $2,000 in physician fees and medical expenses. This will amount to a bill with a deductible close to $19,000 in 1981.[4] Those with higher incomes will be more likely to have the good basic insurance protection and other financial means to surpass the deductibles and get catastrophic benefits. Lower income workers will just pay and pay and rarely receive benefits. They would be bankrupt long before they exceeded the deductibles.

A catastrophic program would not help fill the need for more health education, illness prevention and early detection of disease. It will do the exact opposite by creating incentives for longer hospital stays, use of more costly medical technology, and curing rather than preventing illness.

Catastrophic insurance does nothing for the 51 million Americans who live in areas without sufficient health care services. Indeed, it would further draw doctors away from rural and small town areas by increasing funds available to pay lucrative medical specialties in urban areas.

By providing incentives for physicians to become specialists in order to receive higher fees, catastrophic coverage would tend to decrease the number of already scarce general practitioners and family doctors and increase the already abundant supply of specialists and super-specialists. At the present time only 35 percent of all physicians are general practitioners or primary care specialists.

By making more funds available for more frequent and longer hospital stays, catastrophic illness insurance creates greater incentives for filling hospital beds and for increasing hospital capacity and facility construction. This clearly runs counter to the national efforts to hold down and in certain areas reduce costly excess hospital capacity.

A catastrophic plan would do nothing to bring innovation and reform to the delivery of health care but only would help to perpetuate the status quo. It would do nothing to encourage the growth of health maintenance organizations.

Catastrophic coverage would not reduce the fragmentation and complexity of payment for health care services. It would serve to increase the complexity by adding another layer of financing. The recordkeeping required to administer the deductible requirements would be a bureaucratic nightmare. Already nearly 14 cents out of every premium dollar paid to private insurers for benefits is creamed off the top for administrative expenses, reserves and profits. The experience of the private insurance industry with this kind of program convinces us that the present administrative costs will only be increased.

Nothing in S. 351 would increase the responsiveness of the health care system to consumer needs. Services would continue to be arranged largely for the convenience of those who provide services rather than those who use them. Consumers and the public would continue to assume all the economic risks while providers would be isolated further from such risks.

A catastrophic plan would ignore totally the problem of uneven quality of medical care rendered in the United States. Any number of studies have revealed high rates of excess surgery, inaccurate laboratory results, avoidable surgical deaths and complications, and preventable adverse drug reactions. Catastrophic coverage would

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[3] Marjorie Smith Carroll, "Private Health Insurance Plans in 1976: An Evaluation," Social Security Bulletin, DHEW, September 1978, Vol. 4, No. 9.

[4] This is based on projected $280 per day hospital costs in 1981 and on the reasoning that it is only in the rare situation that a patient would incur $2,000 in doctor fees in a year without a period of hospitalization.

make more money available for excess surgery and for doctors and hospitals to raise their charges in order to cover their rising malpractice insurance rates.

The catastrophic insurance plan will be expensive, especially in relation to the almost nonexistent benefits. Precise cost estimates are difficult to make and are always subject to challenge. Supporters of S. 351 have pegged its annual cost at $5 to $7 billion. But in 1976 Trapnell Associates prepared for the Department of HEW cost projections of various national health insurance proposals. Although we would not completely agree with all of their assumptions, they predicted that the cost in new dollars for the catastrophic part of the Long-Ribicoff bill in 1980 would be $13.5 billion: $6.8 billion in the Federal budget and $6.8 in the private sector. The Trapnell report also projected that a tax of 1.2 percent of payroll would be needed, rather than the 1 percent specified in the bill.

In 1977 the Congressional Budget Office costed out a catastrophic plan with a 150 day hospital deductible and $2,000 medical deductible—a much skimpier program than even S. 351. The CBO estimated that such a program would cost $13 to $14 billion in 1978, with the Federal portion amounting to $12 to $13 billion. And in return for such expenditures, most Americans would receive nothing in benefits.

Perhaps the most serious danger resulting from a catastrophic insurance program is that the Congress and the American people might be persuaded that with this legislation they would be getting national health insurance at bargain basement prices. The members of this committee and of the Senate realize that this is not true. But the promises held out for this bill are such that it would detract attention from solving the fundamental problems of the American health care system. What is needed is a program which provides for universal coverage, comprehensive first dollar benefits, equitable financing, and effective consumer participation in policy-making. Soaring costs must be contained by annual budgets with ceilings. If the program is to serve its objectives, it should deal with protection of quality of care, reform of the organization and delivery of services, and accountability of providers of care and of the insurance industry to public and consumer interests.

For the reasons indicated, we urge the committee not to recommend S. 351 or any similar proposal, to the Senate. There are more desirable alternatives which we hope this committee and the Congress will review and consider in the immediate future.

Senator TALMADGE. I see now that Mr. McMahon has arrived, president of the American Hospital Association. We will be happy to hear from you, Mr. McMahon. You may insert your full statement in the record, sir, and summarize it not to exceed 10 minutes.

STATEMENT OF JOHN A. McMAHON, PRESIDENT, AMERICAN HOSPITAL ASSOCIATION, ACCOMPANIED BY LEO J. GEHRIG, M.D.

Mr. MCMAHON. Thank you, Mr. Chairman and members of the committee. I am John Alexander McMahon, president of the American Hospital Association, accompanied by Dr. Leo J. Gehrig, and we appreciate this opportunity to testify on a number of bills before the committee.

Mr. Chairman, our analysis of these bills is not yet complete, which I trust is understandable, particularly in light of the fact that a couple of the bills have been so recently introduced. So I am not thoroughly familiar with all of the details of the four bills on which I will comment, but I will do my best.

If there are questions you wish to raise or that come up, we would be glad to continue our analysis and provide further information.

Mr. Chairman, I think this committee from past testimony is somewhat familiar with the position of the American Hospital Association. We have, for many years, endorsed the idea of comprehensive health insurance coverage with preventive benefits and catastrophic benefits—dealing with the existing gaps in coverage but emphasizing the need to build on the present system of plural-

istic financing and providing assurance of access. And, in the past, we have opposed separate, catastrophic coverage.

But as you know, Mr. Chairman, and as the committee knows, and I suspect as the Congress knows, the world has changed. We are confronted today with marked problems of inflation in the economy as a whole and with a Federal deficit that must be dealt with. So that movement in the direction and the way we had envisioned before probably is no longer appropriate and we understand very clearly the thrust of the present bills that step in the direction of incremental change—in the direction of picking out things that ought to be done first.

We agree completely with the idea of providing better coverage for poor people and low-income people. Certainly, we understand the need for catastrophic coverage for the large bulk of employed people because there is no question in our mind, Mr. Chairman and members of the committee, that concern about the impact of catastrophic illness is a real one in our society today.

We deal in the testimony, Mr. Chairman, with S. 760. We make brief comments about S. 350 and S. 351 and wind up with S. 748 and I would like to make a comment about each.

The committee is thoroughly aware, of course, of the fact that in S. 760 there is a mandated approach to catastrophic coverage by employers for full-time employees and incentives and financial assistance is provided for small employers and for coverage of governmental employees and employees of nonprofit organizations. Then there is a provision for the certification program for basic coverage.

We think that this approach, the mandated approach, Mr. Chairman, is preferable to the payroll tax base approach of S. 350 and S. 351 and we prefer the mandated approach.

We have included in the testimony several comments, several caveats that we had. I would like to mention two in particular that we think might be worth exploring.

The idea of a commission. Instead of granting to the Secretary an oversight responsibility for existing plans, including the determination of their actuarial appropriateness, and where an acceptable private plan does not exist, authority to establish a Federal plan, we think that a commission would have certain advantages.

In addition, we will provide specific details on this, Mr. Chairman. We think that probably the medicare reimbursement system designed for people over 65, particularly on the institutional side, would not be appropriate. If you broaden that reimbursement mechanism to cover care for other kinds of people, particularly a large number of poor people and those who might be covered by a Federal plan in the absence of an appropriate private plan, we foresee problems, and we will submit further specifics on that.

With respect to S. 748, Mr. Chairman, the advantage that we see in this particular bill is the improvement of medicare benefits and we think, in the light of consideration of 60 days of coverage as the dividing line between basic and catastrophic, that perhaps the $5,000 level before the catastrophic coverage cuts in, would be appropriate. Obviously in S. 748, there is a possibility of more gaps and fewer people being provided coverage, but I think, Mr. Chairman, that is probably an issue that the committee itself can deal with.

I frankly do not know which is the more appropriate way to go, the S. 748 approach of mandating the offering of coverage, versus the S. 760 approach of mandating coverage with full employer participation.

Thank you, Mr. Chairman and members of the committee, for the opportunity to make these brief summary comments on our testimony. I shall, of course, be glad, along with Dr. Gehrig, answer any questions you may have.

Senator TALMADGE. Thank you very much, Mr. McMahon. We appreciate your contribution.

The bulk of the testimony we have heard thus far suggests that we should not provide additional health insurance without, at the same time, adopting some form of health cost containment program. Would you please comment on these suggestions?

Mr. MCMAHON. Yes, Mr. Chairman. I would be happy and pleased to do so.

As I testified before your subcommittee, Mr. Chairman, we understand the problem that we have faced, both the Government and the public at large, with increases in the rate of health care costs in general and hospital costs in particular—an increase, however, that we thought was responding to demands for more and better care for more people.

As you know, we have mounted a voluntary effort, a coalition of providers, of carriers, of business and labor and the public, to deal with that issue. We think we can deal with the issue voluntarily and that there is no reason to enact some kind of hospital cost containment legislation as a precursor to any further movement in the health insurance benefit area.

We do not see, Mr. Chairman, that the bills before this committee would escalate costs to such an extent as to bring on the necessity for legislation on cost containment in the hospital world, and we have testified on all of the problems that exist in some of the existing across-the-board proposals. We understand, of course, your own approach to cost containment in the medicare setting. It does not have those implications. As for the suggestion that has been made to the committee for an across-the-board hospital cost containment legislation as a precursor to further health insurance, we do not think that is necessary.

Senator TALMADGE. Senator Ribicoff?

Senator RIBICOFF. No questions.

Senator TALMADGE. Senator Danforth?

Senator DANFORTH. No questions.

Senator TALMADGE. Senator Baucus?

Senator BAUCUS. No questions.

Senator TALMADGE. Thank you very much for your contribution,

[The prepared statement of Mr. McMahon follows:]

STATEMENT BY JOHN A. MCMAHON, PRESIDENT, AMERICAN HOSPITAL ASSOCIATION

Mr. Chairman, I am John Alexander McMahon, President of the American Hospital Association. With me is Leo J. Gehrig, M.D., Senior Vice President of the Association.

Our Association represents some 6,400 health care institutions, including most of the Nation's hospitals, long-term care institutions, mental health facilities, hospital schools of nursing, and over 27,000 personal members. We appreciate this opportunity to testify before your committee on the important issues of modifications of the

medicaid program, health insurance coverage for the catastrophic costs of illness and injuries, and other proposals. Mr. Chairman, as you know, a number of these important legislative proposals have only recently been available. Consequently, our testimony is based on a limited review of these bills. We are proceeding with further analysis and will appreciate the opportunity to continue these discussions with the committee and staff as this legislation is developed.

Initially, I would like to summarize the specific views of our Association on national health insurance coverage, briefly describe current problems in the cost of health care as they relate to goals for expanded health insurance benefits, and comment on documented gaps in health insurance coverage in our country.

AHA POSITION ON HEALTH INSURANCE PROTECTION

It has long been the policy of the American Hospital Association that all Americans should have access to comprehensive health benefit coverage, including protection against the catastrophic expenses of some illnesses and injuries. While there has been a dramatic growth in health insurance, many Americans, specifically among the aged, the poor, the near-poor, and the self-employed either have health insurance protection that is inadequate or have no protection whatever. As I have indicated, I will cite recent statistics to document the need for more adequate coverage later in my testimony.

We feel that national health insurance is an important goal for the Nation. It is our firm contention, moreover, that the development of such insurance protection, along with continuing improvements in the delivery of health care services, must be built on the existing pluralistic system of financing and delivery of health care. The method of financing the system, we believe, should include the use of such sources of financing as private premium payments, general tax revenues, and payroll taxes, thus allowing for maximum flexibility, innovation, and recognition of differences in local conditions. For these same reasons, we believe a centralized administrative and fiscal control structure for the health care system would be detrimental to the quality of health care and result in a costly, top-heavy bureaucratic system. I feel that it is necessary to state this fundamental policy of our Association in relation both to the extension of a specific category of health insurance benefits and to the eventual development of a program of comprehensive national health insurance.

Finally, in recognizing the need for comprehensive coverage as a goal for the Nation, the Association believes that the attainment of such coverage is and should be an incremental process, consonant with the continuing development of health care and economic resources. Above all—particularly at this time of stress in our Nation's economy—it would be irresponsible and misleading to the public to promise expansion of health insurance benefits and extension of services that the economy presently cannot afford or that the health care system, as a result of economic constraints, would be unable to deliver. This is not to say, however, that we feel nothing can be done in the near future.

CURRENT PROBLEMS IN THE COST OF HEALTH CARE

I would like to comment only briefly on cost issues, having recently outlined in greater detail the problems of health care costs, and most particularly hospital costs, in testimony before your Health Subcommittee in relation to S. 505, the Medicare and Medicaid Administrative and Reimbursement Reform Act of 1979, as well as other cost containment proposals being considered by that subcommittee.

Additional benefits, we believe, must not be developed in isolation, but in relation to the general economy. Indices developed by the AHA have shown that almost two-thirds of last year's 12.8 percent rate of increase in hospital expenses were due to price inflation in the goods and services which hospitals must purchase to provide patient care. It is erroneous, then, to suggest that such rates are solely due to inflation in hospital costs. Rather, they are a combination of inflation in the prices of goods or services we must purchase, costs related to caring for a larger and an older population, and modernization and improvement in the technology and services provided.

The growing demand for health care services is one of the major factors influencing the growth in hospital expenses. It is significantly affected by a growing and an aging population who require more care. Demand also has been stimulated by our deliberate decision to remove financial barriers to health care for many of our economically disadvantaged citizens. And numerous other factors stimulate demand, including advances in medical technology, dramatic expansion of health manpower, and increased public awareness and expectation of the potentials of medical science.

Germane to the extension of health insurance benefits to cover the catastrophic costs of some illnesses and injuries is the intensity of services—both in terms of

frequency of use and the sophistication of technology—with inevitable cost consequences. A leading example, as cited in HEW's annual report released last month, "Health, United States, 1978," is cancer—the second leading cause of death in the Nation (after circulatory diseases)—identified as one of the most costly of disease categories. It has risen in frequency in the last two decades among the elderly, who as a population group are growing more rapidly than any other, and who require more health services of greater intensity than do younger members of the population.

Added to these are the costs to hospitals of complying with a cascade of regulations from all levels of government, a factor which must be given serious consideration as we contemplate new dimensions of health insurance coverage. Government has been remiss in meeting its responsibility to assess the cost impact, effectiveness, and benefits of many of the regulations it has imposed on hospitals.

GAPS IN HEALTH INSURANCE COVERAGE

There has been dramatic progress in health insurance coverage in the United States since World War II; nonetheless, gaps in coverage still leave many individuals and families financially vulnerable in time of serious illness. More than 90 percent of all Americans either have private health insurance coverage or are eligible for assistance through public programs, a fact corroborated by numerous sources. In its "Profile of Health Care Coverage: The Haves and Have-Nots," however, the Congressional Budget Office (CBO) recently reported that approximately 5 to 8 percent of all Americans—or a range of 11 million to 18 million individuals—did not have health insurance protection last year. Those not covered by health insurance are largely members of low-income families (with incomes under $10,000 a year) and are young or unemployed. Many persons with low incomes are not eligible for Medicaid because they do not have dependent children, are not blind or disabled, or have incomes that exceed eligibility limits in their states. Many do not work for employers who provide group health insurance coverage and are not able to afford such coverage on their own. Finally, CBO reported that at least 15 percent of the insured are not protected against catastrophic costs of serious or long-term illness. Clearly, while we are faced with a variety of population groups which have inadequate health insurance coverage, among the more important are the poor, near-poor, and those with inadequate catastrophic coverage.

THE CATASTROPHIC HEALTH INSURANCE AND MEDICAL ASSISTANCE REFORM ACT, S. 760

I would now like to comment on some specific elements of this proposal, which you introduced on Monday of this week.

Title I—Catastrophic illness insurance

While insurance coverage for catastrophic costs has expanded substantially in recent years, there are still significant gaps. The provision of catastrophic health insurance for all Americans is a good and needed incremental step toward the goal of comprehensive coverage for all.

We believe that the extension of catastrophic coverage should rely on the private sector as much as possible. Therefore, incentives for the future use of catastrophic insurance available through the private sector should be strengthened. A federal program should serve only as a back-up to private programs, enabling any who cannot otherwise afford insurance to be covered.

We are pleased that the approach of S. 760 builds on private health insurance coverage among the employed population by mandating employer coverage for all full-time employees. It further provides tax incentives to purchase such coverage for individuals who are not covered under an employer-sponsored plan. The bill also provides special assistance to small employers and to State and local governments and nonprofit organizations in meeting the cost of such insurance.

We are concerned that the provisions for Federal approval of private plans and carriers and Federal sponsorship of a public plan may impair or discourage private efforts unnecessarily. The Government should not create for itself an unfair competitive advantage over private insurers. To the maximum extent feasible, the business of insurance should remain decentralized and competitive. To address these issues, we would recommend consideration by your Committee of approval of private insurance carriers and plans by a commission, similar to the proposed Federal Actuarial Committee. That same commission should also be required to review and make periodic reports to Congress on the administration and financing of the public plan and the newly established insurance revolving fund.

The levels and methods of reimbursement for the public plan under title I would parallel those of title XVIII. Our membership continues to be concerned about the

adequacy of the medicare reimbursement system and we believe that, before that system is expanded, these concerns should be addressed further. As you know, we are working with the Committee in considering improvements in these payment methodologies.

S. 760 does not ensure that all individuals will have protection against catastrophic costs of health care—for example, individuals who do not meet medicaid eligibility requirements, are unemployed and, because of limited resources, are unable to purchase such coverage. Finally, although it may merely be a drafting oversight, catastrophic coverage of Medicare beneficiaries is not included in this proposal.

Title II—Medical assistance for low-income people

Mr. Chairman, the AHA believes that title II of S. 760, which provides for the "federalization" of the medicaid program, is an important move toward the goals which we have identified. It is a desirable step toward assuring comprehensive health care coverage for all Americans because it would close many of the existing gaps in coverage for the indigent and medically needy. These gaps have created barriers to access to needed health care and have placed significant financial burdens on hospitals and the patients they serve.

It is appropriate for the Federal Government to strengthen its continuing obligation to provide assistance for economically disadvantaged persons and in so doing to expand health insurance coverage in an equitable manner. S. 760, in our opinion, would make a significant change in the medicaid program by improving and standardizing the conditions for determining eligibility across the country and by expanding the scope of minimum benefits. More specifically, there have been a number of limitations on the title XIX program since its inception which have frustrated its original goal of making adequate health care services available to the economically disadvantaged. Many of these frustrations would be rectified by the provisions of S. 760. The advantages to be realized by these modifications include:

Eliminating the categorical approach to eligibility and substituting an income-level determination;

Providing that income-level determination and other mechanisms for ascertaining eligibility would be consistent;

Improving the minimum benefits under title XIX providing more adequate coverage of basic health services; and

Recognizing more adequately those costs associated with the provision of needed quality health services under the program.

However, Mr. Chairman, the AHA has some specific reservations about the program outlined in S.760. Some of our concerns are:

The need to recognize regional standard of living variances. A single national income standard, if not adjusted for such variances, creates unequal income tests for persons in similar economic circumstances who reside in areas with different standards of living. We believe that a procedure for regional adjustments to the national income standard based on cost of living data is necessary.

The need to evaluate the adequacy of payment for institutional services. This is necessary to avoid the inequitable cross-subsidization by other hospital patients and payers of the costs of the care of medicaid beneficiaries.

The nature of a "spend-down" provision. These requirements have been the source of considerable controversy in certain states that have employed this device for the purpose of determining eligibility. This is due, in part, to the open-ended eligibility such a provision establishes and, in part, to the disincentives it creates against the purchase of private health insurance. The AHA recommends that the committee consider a system of graduated premium subsidies for the low-income employed group in place of the spend down provisions related to medicaid eligibility. Such a system would establish greater coverage by private health insurance and reduce the financial obligations of Federal, State, and local governments.

The AHA believes that attention to these recommendations would improve health care coverage for the poor and near-poor.

Title III—Private basic health insurance certification program

In our review of title III, we have identified a number of points that deserve further consideration:

(1) Section 1502(b)(1), requires that basic private health insurance policies that meet the minimum standards may only be used in States that have in operation a basic health insurance facilitation program. This requirement could result in unnecessary and undesirable expansion of the direct federal insurance programs. Private companies should be strongly encouraged to offer certified policies on the broadest possible basis. The Federal Government should be only an insurer of last resort.

(2) Under section 1504, there is a requirement that not less than the first $2,000 of incurred medical expenses should be covered. While probably a drafting oversight, an adjustment for inflation similar to that in section 2104(c)(4) should be included in this provision.

(3) Private insurers should have a prescribed right of appeal from negative decisions by the Secretary under section 1502 with respect to proposed policies. States should have a similar right under section 1510 with respect to proposed basic health insurance facilitation programs.

(4) An advisory council with professional expertise in health insurance administration should be established. The council should advise on the review of proposed private health insurance policies and state facilitation programs. It should evaluate conditions under which private health insurance policies are not actually available, identify the circumstances and causes of such failings, and recommend ways of alleviating them. It should approve in advance the offering of Federal health insurance policies in any state or local area. It should recommend for congressional consideration changes it deems appropriate for this title.

Title IV—Other amendments

This title will extend benefits under medicare in sections 401 and 402 to cover appropriate immunizations and additional mental health services. Further, section 403 reduces the amount of premiums for medicare hospital insurance coverage for individuals who "buy into" the program. Finally, we strongly endorse section 406 which encourages philanthropic support for health care programs and is necessary to protect the use of such resources that are so critical in facilitating desirable experimentation and innovation in the delivery and improvement of health services in this country.

While we have indicated some of our concerns with respect to S. 760, we believe its approach is preferable to the provisions of S. 350 and S. 351. For example, those proposals would rely largely on a mandatory payroll tax for financing catastrophic coverage. Further, S. 351 does not address critical needs for the improvement of health care coverage for the poor and the near-poor.

THE CATASTROPHIC HEALTH INSURANCE PROGRAM AND MEDICARE AMENDMENTS OF 1979, S.748

The catastrophic health insurance proposal (S. 748), also introduced this week, by Senators Dole, Danforth, and Domenici, is intended to make available health insurance to cover the catastrophic costs of certain illnesses and injuries. The bill would accomplish this purpose in three ways.

First, the portion of the population covered by the medicare program would be automatically protected for such catastrophic expenses by the removal of the current limitation on hospital days, modification of the skilled nursing home and home health benefits, and unlimited coverage for medicare part B services after incurred medical expenses exceeded $5,000 annually or out-of-pocket expenditures exceeded $1,000 annually, whichever came first. This medicare catastrophic coverage would also include certain prescription drugs for life-threatening or chronic diseases being treated on an outpatient basis. State medicaid programs would be required to provide catastrophic insurance coverage equivalent to the private plans or purchase private insurance policies providing such coverage for their beneficiaries.

Second, this bill would mandate all employers to offer group health insurance that at least provided protection against the catastrophic costs of illnesses or injuries. The benefit would include coverage for all necessary hospital days beyond 60 per year and coverage for the services provided under medicare part B after the insured has incurred medical expenses of $5,000 for such services. No employed individual or self-employed individual is required to purchase catastrophic health insurance, although the deductibility of health insurance premiums for such persons on income tax returns would not be permitted unless the health insurance contained at least coverage for the catastrophic expenses of medical care.

Finally, this bill would make approved catastrophic health insurance policies available for purchase by self-employed individuals and those not covered under medicare, medicaid, or employment-based plans. A premium subsidy for persons with low incomes would be provided from Federal general tax revenues.

While we have not had an adequate opportunity to review this legislation, we commend its approach which would build on the present private health insurance mechanism. It would provide opportunities for catastrophic health insurance for many individuals not now covered. We support the provision which would subsidize for low-income individuals the purchase of private catastrophic health insurance. However, the income ceiling for this subsidy is so low that it may not be financially feasible for some individuals to purchase such coverage.

There is also a potential for continuing gaps in both basic and catastrophic health insurance arising from the failure of individuals to take advantage of the opportunities afforded them under this bill. Further, our previously identified concerns with the basic eligibility and benefit levels under title XIX are not addressed by this bill. We will continue our review of this legislation and provide our further recommendations to Senator Dole, the cosponsors, and the other members of the Committee.

Mr. Chairman, we will continue our review of these bills. We commend you and other members of this committee, who, through these proposals, have placed before Congress and the public issues of critical importance in the consideration of expanding health insurance coverage for all Americans.

Senator TALMADGE. The next witness is Dr. N. Thomas Connally, chairman, Task Force on National Health Insurance and member, Board of Trustees, American Society of Internal Medicine, accompanied by Mr. Mark Leasure, director, government relations.

You may insert your full statement in the record, Dr. Connally, and summarize it in not more than 10 minutes.

STATEMENT OF THOMAS CONNALLY, M.D., CHAIRMAN, TASK FORCE ON NATIONAL HEALTH INSURANCE AND MEMBER, BOARD OF TRUSTEES, AMERICAN SOCIETY OF INTERNAL MEDICINE, ACCOMPANIED BY MARK LEASURE, DIRECTOR, GOVERNMENT RELATIONS

Dr. CONNALLY. Thank you. I am Tom Connally, member of the board of trustees of the American Society of Internal Medicine. For the past 2 years, I have been chairman of our task force on national health insurance. With me is Mark Leasure, our director.

We appreciate the opportunity to testify. Most of our comments will be directed toward the Catastrophic Health Insurance and Medical Assistance Reform Act, S. 350, but with some references to S. 748.

The American Society of Internal Medicine is the largest national specialists society, devoted predominantly to the social and economic aspects of health care and health care delivery. For several years we have been studying the gaps and good points in our mix of public and private health insurance.

We have come to the conclusion that there are two basic gaps in our current insurance program, one being the lack of coverage for catastrophic expense of illness that covers a large group of the population and the other is a lack of proper first dollar coverage, or an equitable and appropriate coverage, for the poor.

ASIM believes that S. 350 is the best major proposal yet devised to eliminate these gaps. I would like now to address more specifically the three major titles of S. 350. I believe the committee has our statement, and they might follow along.

Title XXI, the catastrophic health insurance program, we think, is the most important part of the bill. In 1975, our house of delegates went on record for 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 pro-

gram 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 increases 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. Section 2104(f) (1) 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.

The decisions on what is appropriate in spending on the bill should be delegated specifically written into the law to the PSRO program and an extension of the Government's health program into catastrophic illness will make health planning and the PSRO program even more important.

Since the inception of these programs, we have urged our members to participate in them and we urge Congress to continue their support of the programs.

Our major concern is the 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.

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 spenddown 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 incomes. 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 should be required to recommend to Congress adjustments in the copayment level based on program experience.

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.

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.

Second, 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. 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.

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.

Senator TALMADGE. Thank you, Dr. Connally.

I refer you to page 3 of your statement beginning with line 4 and ending with line 9, and I quote.

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.

Why do you say that?

Dr. CONNALLY. Well, I think if you look, there is a limit on outpatient psychiatric services. Those of us who deal as primary physicians realize that a great deal of the illness which we see is perhaps not pure physical illness; it is psychological, social illness, loneliness.

It may be that if free psychiatric care or psychoanalysis were available to everybody that we would have half our citizens sitting on the couch and the other half—and the Government would be paying everybody. I think you can go too far with that. I think we certainly can overdo a psychiatric benefit on an outpatient basis.

I think with regard to institutional care, we had in mind the long term nursing home benefits. Obviously, there is a gray zone as to what should be medical care benefits, or health care benefits, and what are simply the social benefits that a compassionate society would give to its frail, elderly citizens.

We think this should be done in some other way. We know there are a lot of lonely, feeble older people who perhaps would not qualify for health care under this catastrophic program, but if we included an open-ended program for these benefits, I think that it would be very difficult to have any sort of actuarial understanding of the program and to do an effective cost accounting.

I do not think that a catastrophic health care program is the way to pay for these problems.

Senator TALMADGE. Thank you, Dr. Connally.

Senator Ribicoff?

Senator RIBICOFF. No questions.

Senator TALMADGE. Senator Danforth?

Senator DANFORTH. Doctor, what is the American Society of Internal Medicine? How many members would it have?

I take it these are practitioners of internal medicine. Is this a large group? Does it represent most practicing internists?

Dr. CONNALLY. We have 16,000 members, all of whom are internists. The vast majority of our members are practicing. We have component societies in all 50 States and Puerto Rico.

I think we are probably the largest society that is strictly formed to try to look at the social and economic aspects of health care. We have for many years, our home office has been, in San Francisco. Just this past December we moved to Washington feeling that we could better serve our members and our patients by being here.

Senator DANFORTH. Would 16,000 be a good cross-section of internists throughout America, or is it a small number?

Dr. CONNALLY. I think clearly it is a most representative group of internists with regard to social and economic issues.

Senator DANFORTH. I do not know what that means. When I think of an internist, I think of my doctor in Missouri. Would you speak for him?

Dr. CONNALLY. If he is a member, we would speak for him. We would probably help him whether he is a member or not.

Senator DANFORTH. Is the average internist a member of your Society, or are these people just internists who have particular social or political objectives?

Dr. CONNALLY. I think the average internist is a member of our society.

Senator DANFORTH. 16,000. How many internists are there in the country? Dr. CONNALLY.

Dr. CONNALLY. 40,000 in all, counting residents and others.

Senator DANFORTH. Are you pretty confident that the positions you have expressed today have spoken for—is this the mood of practitioners of internal medicine throughout the country, in your view?

Dr. CONNALLY. In an organization this large, as you know, there is a large diversion in diversity of view. However, several of the points of view we have expressed have come up through our house of delegates and voted on through each of the States.

Others are more specific points of view, and have been approved by our board of trustees, which is constitutionally the way we do things in the organization.

We only get together once a year representatives from the whole organization, but the board of trustees meets more frequently. They have approved this statement.

Senator DANFORTH. You think the thrust of what you have been saying is basically agreed on by most internists?

Dr. CONNALLY. I think as far as we can follow due process within our organization, I think this represents the point of view of internal medicine in the United States now.

Senator DANFORTH. Senate bills 748 and 760 have just been introduced in the past few days. Do you feel that you have had an opportunity to give them the same careful and considered analysis that you gave 350?

Dr. CONNALLY. No; we have not been able to read the entire bill. We have had a very brief summary of 748, which was supplied by Senator Dole's office, and all I have had the opportunity to do is read Senator Long's introductory remarks about 760. As I understand it, 760 is basically 750 with a change in the financing mechanism which is similar to what we would suggest.

I really do not know exactly the small print of the financing changes of 748 and 760 to comment specifically on those. Basically, I think they would incorporate the major changes which we would like to see in this legislation.

Senator DANFORTH. If you have any further comments down the road on 748 or 760 or any other of the various alternative proposals, I am sure the committee would be interested in receiving any written comment that you, or anybody else who is interested would care to make on it. I think that it is fairly clear that we are moving toward a consensus on the committee that some form of catastrophic coverage is called for and probably will be reported out of the Senate Finance Committee and therefore, it would be

more of a question at looking at the various alternatives and looking at some of the fine print of the proposals than the broader concepts on which there is general agreement.

So if you, or any other group who is interested, would care to consider some of the other proposals, specifically the more recent ones, I think that would be welcome by the committee.

Dr. CONNALLY. We are here and I am here in Washington. We would be delighted to help you in any way. That is why we are here.

Senator TALMADGE. Thank you very much, gentlemen. We appreciate your contribution.

[The prepared statement of Dr. Connally follows:]

STATEMENT OF THOMAS CONNALLY, M.D., FOR THE AMERICAN SOCIETY OF INTERNAL MEDICINE

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) (1) 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.

Second, 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 substract 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 should 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 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 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.

Senator TALMADGE. The next witness is Dr. Donald Siehl, president, American Osteopathic Organization.

Incidentally, Senator Long, the chairman of our committee, is at the White House. He will be back as soon as he can.

You may insert your full statement in the record, Doctor, and summarize it, not to exceed 10 minutes.

STATEMENT OF DONALD SIEHL, D.O., PRESIDENT, AMERICAN OSTEOPATHIC ASSOCIATION, ACCOMPANIED BY JOHN P. PERRIN, ESQ., DIRECTOR, WASHINGTON OFFICE, AMERICAN OSTEOPATHIC ASSOCIATION

Dr. SIEHL. Thank you, Mr. Chairman and members of the subcommittee. I am Donald Siehl, D.O., president of the American Osteopathic Association; with me is Mr. John P. Perrin, director of the association's Washington office. We are most pleased to appear before you today and declare the AOA's support for the enactment of catastrophic illness insurance.

The American Osteopathic Association is the national professional organization which represents the approximately 17,000 osteopathic physicians. The osteopathic profession delivers quality inpatient services, through its 208 osteopathic hospitals. The 14 colleges of osteopathic medicine will graduate in excess of 1,000 students this year.

In 1970, the American Osteopathic Association first went on record as being in conditional support of the concept of a national health insurance program. The association's endorsement was predicated on the assumption that the American public wanted, and the American economy could support, pervasive federally underwritten health insurance.

Furthermore, support for any program was conditioned on its including a number of elements the profession saw as sine qua nons, including: Preservation of freedom of choice of physician, freedom of choice for method of payment of services, inclusion of an effective system of true peer review, an emphasis on primary health care and preventive medicine and provision for the payment of costs of major or catastrophic illness.

During the last several years a number of factors have combined to cause the association to reevaluate its posture of conditionally endorsing the concept of comprehensive national health insurance.

First, the medicare and medicaid programs have tended to show that broader based federally underwritten health coverage would be so expensive that inevitable program compromises would do a disservice to the American public and the American physician. Medicare and medicaid have failed to keep the promise to older and needy Americans to provide access to high quality health care of the character required.

As medical costs have risen, along with the cost of all other goods and services, the Federal Government has increasingly curtailed the scope of benefits available to beneficiaries under the medicare and medicaid programs. The result has been a breach of the original promise made to that sector of our patients and an increasing subsidization of the program by the practicing physician.

To extrapolate the experience of medicare and medicaid and project it into a broad-based national health insurance program leads us to the inescapable conclusion that, either access to or the quality of health care, or both, would suffer or that the program would be financially unacceptable to Congress and the American public.

Second, the financial implausibility of comprehensive national health insurance has been exacerbated by the growing problems in the American economy. At a time when we are experiencing double digit inflation and, simultaneously, a slowdown in the economy, increasing taxes to finance such a major new expenditure is fiscally unsupportable.

Last, although the congressional debate over national health insurance has now continued for almost a decade, there appears to be no significant public interest in or support for such a broadly based endeavor. We believe that there are two important reasons for the lack of spontaneous demand for national health insurance.

First, the American patient is generally satisfied with the freedom of options and quality of health care experienced, within the framework of the existing delivery system. Second, an analysis of the health insurance coverage currently in force indicates that we presently have a national health system, through separate programs for the elderly, through medicare, the indigent, through medicaid, employment based groups, VA, military dependents and individually owned policies; there are really very few gaps in the coverage.

It is the observation of the American Osteopathic Association that what the American family is concerned about is how it will defray the costs of any catastrophic medical episode, for which most have no coverage. It is further the observation and conclusion of the American Osteopathic Association that the extension of such coverage is not only the most needed area of health insurance, but also probably the only one that is financially feasible, under the circumstances outlined above.

Accordingly, the American Osteopathic Association supports the enactment of legislation which will establish a program of insurance to underwrite the costs of catastrophic illness for all Americans.

We thank you again for the opportunity to share our views with you. We will be pleased to answer any questions you may have.

I would like to interpose that we would like the opportunity later, after we have analyzed the most recently introduced bills, to submit some further comments to the committee.

Senator TALMADGE. Thank you very much. We appreciate your contribution.

Any questions, Senator Danforth?

Senator DANFORTH. My State is the birthplace of your profession, I believe, doctor, and there are many—when you talk about the distribution of health care throughout the country, there are many communities, at least in our State, which are dependent on your profession and are very, very well served by it.

I am delighted to see you here and appreciate your testimony.

Dr. SIEHL. Thank you.

Senator TALMADGE. Thank you, sir.

The next witness is Dr. Jose L. Garcia Oller, president, Private Doctors of America.

Doctor, you may insert your full statement in the record, sir, and summarize it, not to exceed 10 minutes.

STATEMENT OF JOSE L. GARCIA OLLER, M.D., PRESIDENT, PRIVATE DOCTORS OF AMERICA

Dr. OLLER. Thank you, Senator Talmadge, Senator Danforth, Senator Ribicoff.

I am Dr. Jose Garcia Oller, president of Private Doctors of America and with me is Dr. Wesley Segre, our vice president. I am a practicing neurological surgeon; Dr. Segre is a pediatrician. Both of us have been in private practice for about 30 years, taking care also of the indigent for free for 20 years in the ghettos and in the charity hospitals. We now represent Private Doctors of America, the largest association of private practicing doctors, exclusively, 43,000 in 49 States, Puerto Rico, and the Virgin Islands.

In the brief minutes ahead, I would like to make an introduction and then our recommendations.

The first introduction comes from the Washington Star last night: First, Senator Kennedy's new latest national health insurance plan, second, the U.S. Senate making a statement that the budget will be balanced and, at the same time, raising the Federal debt limit by $32 billion.

Further introductory comment is that, as we plunge into a nearly $1 trillion debt with interest alone of $65 billion, adding $100 billion every 2 years to our national budget when it used to take ten years to do so just ten years ago, creating a massive health inflation and the nightmare regulation and rationing; when medicare spending rose from $1.5 billion to $21 billion; when our medical school tuition is $7,000-plus a year, 16 times what I paid for medical school; when Federal regulations alone cost $100 billion and Federal paperwork alone $100 billion, the Federal share $43 billion; when one-quarter of the cost of a hospital room is now to pay for the deadheads in the Federal bureaucracy in our hospitals; when the PSRO review system which, with good intentions was passed by Congress, substitutes what was done for free for doctors, before, is now costing an estimate soon of $500 million a year, and after 10 years are yet to be proven effective.

Now comes Senator Kennedy, in the midst of proposition 13 and the awakening of the people to the yoke of the Federal bureaucracy and the burden of taxation, to propose the ultimate deception: That, by spending $130 billion, we will save money; in which new mathematical theory Mr. Califano and President Carter seem to believe, that by adding $15 billion with a new baby called health care—give or take a few billion—we will now save more money.

Having said this, Mr. Chairman, bearing witness that this Congress should stop the disastrous course of Federal spending, let's stop adding new Federal programs contemplated by this bill. We do not need national health insurance, or catastrophic. Having said this, however, we did 4 years ago recognize that there is a need for improvement in the care of the poor and there is a need for improvement in the catastrophic health care delivery system, and there are gaps in health care.

In our full written testimony, you will see a two-page, 10 point statement as to our positive health plan recommendations, as to the gaps in health care. But we believe, Mr. Chairman, these should be addressed from the standpoint of the private enterprise system.

Very quickly then, what are our recommendations to solve this definite, real problem?

We have to briefly summarize as follows. We have achieved national health insurance under the private system in America today, with 94.5 percent of the population covered by insurance. Today 85 percent of Americans are covered by catastrophic coverage; 77 percent under private insurance. Even in low-income groups, 37 percent have major medical.

That is the dimension of the problem. It is true that the risk to the average citizen is remote. Only 4 out of 10,000 population will sustain an out-of-pocket loss of $5,000.

Mr. Califano could really help his image by asking our citizens to give up one pack of cigarettes a week, because, Mr. Chairman, that is the cost to buy unlimited, multi million dollar catastrophic coverage for a 32-year old in this country; $50 a year, for a catastrophic policy with a $10,000 deductible.

We challenge the private insurance system to join with us in a massive educational program to let the people know the best kept secret in the United States: Give up one pack of cigarettes a day to buy unlimited catastrophic insurance with a ceiling of over $1 million. Again, there would be no more necessity for the total NHI of Mr. Kennedy.

We believe the catastrophic bill is not needed, but we do need the response for the private enterprise system. I think that the health insurers are not selling this policy, Senator Talmadge, because they do not make much money out of a $50 sell. But if we go nationally, for voluntary cost containment and put our shoulders to the wheel, we can solve this problem.

We oppose, therefore, the definition of catastrophic given by the bill, $2,000 medical expenses, 60 days hospitalization. An average automobile today costs $6,475 and the average American family has two of these catastrophes, so we believe that one or two catastrophes can be financed by the American people.

Let us be practical and say, catastrophic is defined as an out-of-pocket loss, not total expenses. 94 percent of hospital expense is covered by third-parties, as you Senators well know. Therefore, the dollar amount of hospitalization is not defining. The same way, with medical expenses. Let's define it, please, as out-of-pocket costs, and we suggest $5,000 or $10,000—one or two automobile catastrophes.

We have further specific recommendations for your serious consideration. No. 1, tax relief.

Mr. Chairman, our people need tax relief and we recommend that all medical expenses be considered tax deductible and not just a 3-percent above income under the current law; and if the law exceeds the taxes in the current year, we believe this should be carried over as tax deductibility into subsequent years.

In the case of a real catastrophe of an uncovered individual, this is the time that we could have low-interest Federal loans that

could be repaid in the form of tax deductibility for subsequent years. Let the citizen help the Federal Government in paying, instead of universal taxation in the bill.

We do agree with the various recommendations of these bills before us to eliminate medicaid. We believe that we should have a system in this country that covers all the indigent and underserved in this country. In our formal testimony, we call it a "first-class citizen indigent care program." We believe the poor are underserved, but we think that there should not be a two-class system.

We, as private practicing doctors, would like to treat every citizen equally—by that, I mean with the same dignity and individuality. That means—and we beg you to consider a direct billing option. Give us the option to choose that the patient be paid by the Government's reimbursement, not the physician, so we do not become employees of the Government, but servants of the patient.

We ask that you change medicaid to allow the option of direct billing to all patients and have a uniform, nationwide good treatment for the poor.

Voluntary riders to insurance policies should cover 1 full year of unemployment, for the unemployed. The insurance company should insure that there is a rider so that as your bills are proposing, we should have 1 year of unemployment coverage.

Finally, the care of the aged, institutionalized, as Senator Talmadge has pointed out in this hearing, is one of the real problems of cost of health care in our country. We urge you to give serious consideration of better coverage for skilled facilities, institutions and nursing homes.

Senator Dole's bill, which I have just briefly reviewed, does address this.

Finally, we make this very specific recommendation. Will you gentlemen on the Senate Finance Committee seriously consider that whatever solution you report out, to please make it a pilot study? Let's not have another dramatic overburdening of our system, let's try a pilot study, like in bankrupt New York or our friendly Louisiana.

Give us the chance. We would be happy to make first-class care for the poor work, and we will work with this committee in any way we can to make our medical care system remain the best in the world and serve those who are underserved.

Thank you.

Senator TALMADGE. Thank you very much.

Are there any questions?

[The prepared statement of Dr. Oller follows:]

STATEMENT OF PRIVATE DOCTORS OF AMERICA

Mr. Chairman and members of the subcommittee, I am Dr. José L. García Oller, President of Private Doctors of America. With me is Dr. Wesley N. Segre, Founder Vice President. We testify in behalf of Private Doctors of America, the Nation's largest association representing only privately practicing doctors. PDA was founded in 1968 as the Council of Medical Staffs, and our current voting membership is 43,000 doctors in 49 states, Puerto Rico and the Virgin Islands. I have practiced neurosurgery in Louisiana for the past 29 years. Dr. Wesley Segre is a practicing pediatrician for 40 years and past-president of the Louisiana Medical Association, the black physicians of Louisiana.

INTRODUCTION

As we plunge into a near $1 trillion debt, with interest alone of $65 billion; as Congress adds $100 billion every 2 years to our national budget when it took 10 years to do so in 1965, and 30 years in 1940; as the federal outlays for health surge from $1.5 billion in 1959 to $60 billion, creating massive inflation and a nightmare of regulation and rationing; as medicare exploded from $1.5 to $21 billion; when our medical schools' tuition climbs to $7,000 a year (16 times what I paid 30 years ago); when Federal regulations alone cost $100 billion; when the total cost of Federal paperwork alone is $100 billion, with the Federal Government's share at $43 billion; when 25 percent of the cost of a hospital room is now due to the regulatory demands by the Federal bureaucracy; when the PSRO review system, once done by doctors for free, will soon cost $0.5 billion a year, and after 10 years they are yet to be proven effective, yet utilizing and wasting the manpower equivalent of several medical schools, and exceeding the budgets of most NHI Institutes; when the cost of HSA's "social planners" waste enough millions to provide the medical advances that they ration as "too expensive" * * * NOW comes Senator Kennedy, in the midst of Proposition 13 and the awakening of the people to the yoke of federal bureaucracy and the burden of taxation, to propound the ultimate deception that spending $130 billion to federalize all health care will save money. Now Mr. Califano has joined the "Big Deception", claiming that federal edicts of "cost containment" will save billions, enough to pay, of course, for new Federal programs. Now last week, President Carter proposes we begin again on the irresponsible road of national "HealthCare" through the "First Step" that will cost $10 or $15 billion, give or take a few billion.

Today, PDA bears witness that we want this Congress to stop the disastrous course of Federal spending on new Federal programs, with more regulations, more rationing of health care, more inflation. This testimony will document, Mr. Chairman, that we do not need NHI or catastrophic insurance. Implementation of federalized catastrophic insurance will only destroy the private health insurance system and lead to federalization of all health care.

General population coverage: 92 to 95 percent

Mr. Chairman, we have today practically achieved National Health Insurance under the private system in America.

From Congressional Budget Office estimates, 92-95 percent of Americans are now covered by insurance" "5 to 8 percent have no protection." This agrees with the 1977 Sudovar-Sullivan Study finding that 94.5 percent of the U.S. population to be covered by insurance.

5.5 percent of the population has inadequate coverage and is poor

From Mr. Califano's own statistics submitted with the NHI guidelines, we hear of the 24 million without insurance, 18 million with inadequate insurance, 6.9 million families with out-of-pocket expenses that exceed 15 percent of their income. But the key question is, how may of those not covered, or inadequately covered, are poor?

94.5 percent of population covered—or has income to buy it

From Mr. Califano's own statistics, we have calculated that 94.5 percent of the population is either adequately insured, or has the income to buy insurance. Only 5.5 percent of the population has inadequate or no insurance and is poor: 8 million without insurance, 2 million "inadequate insurance"; 4.1 million made out-of-pocket payments over 15 percent of income.

Those 12.1 million poor who are not properly insured should be our initial target for medicaid-medicare reform. The 94.5 percent coverage of population hardly deserves Mr. Califano's remarks last Thursday, that millions are "scandalously" underinsured.

Catastrophic coverage in low income group: 30.7 percent

What is the insurance coverage of the low income group? According to the National Center for Health Services Resources, HRA, HEW-sponsored study, reported in 1978 by Birnbaum, 89.7 percent of the noninstitutionalized "low" income group is insured, 27 percent by medicaid, 62.7 percent by private insurance. And, 49 percent of the privately insured have major medical. 30.7 percent of the poor have major medical coverage. This ABT Associates study estimated that 6,713 million poor were uninsured in 1974. Low income is not synonymous with lack of major medical coverage.

Catastrophic coverage: 85 percent of the population

The achievement of the private health insurance sector in coverage for catastrophic bills should be a source of great pride for free enterprise. In 1960, only 25.4 million had this coverage, but today, 150 million Americans have private major medical (catastrophic) insurance, or 77.3 percent of the population under 65 (Health Insurance Institute). In addition, 11.8 percent of the general population has medicare (26 million); 10 percent medicaid (22 million), 12 percent Veterans (26.6 million) 1 percent disabled (2.4 million); 240,000 have renal disease coverage, plus coverage of the Military and dependents, State hospitals, prisons, the Indian Health services, etc. Allowing for "multiple coverage," about 85 percent of the U.S. population is covered by Catastrophic Insurance.

Only 4 of 10,000 have out-of-pocket expenses $5,000

Birnbaum states that only 4 out of 10,000 population under 65 who are not institutionalized, will have out-of-pocket expenses of $5,000 or more. This is also true for the non-institutionalized aged population. The average price tag of a 1978 automobile is $6,475 which many families own. The "Catastrophic" price tag could better be defined as a two-car catastrophe, $12,000. For the "poor" of course, any expense could be "catastrophic" but this has to do with income-maintenance. See our recommendations below. This bill with $2,000 definition for medical services and 60 day hospitalization may well become the vehicle for universal compulsory NHI, when Congress brings the definition of catastrophic down until the entire population has "NHI".

Federalization of private insurance

This bill proposes to cover the entire population and creates a new tax for all employers and the self-employed, whether they use the "private insurance" option of the bill, or not. This federalizes the investment of the private sector, and thru the "certification" of approved "private" insurance, begins the nationalization of the major medical catastrophic policies of 800 insurance companies and 68 Blue Cross, 69 Blue Shield plans and the 400 prepaid plans. The $49.3 billion in premiums of private enterprise would thus be transferred to the public sector.

A HUGE NEW BUREAUCRACY

The bill requires that HEW approve every private and public health insurance plan in the country. The cost and regulation of this new bureaucracy will probably be staggering.

HEW Regularly underestimates costs tenfold

The danger of accepting the "estimated $7 billion cost" of the Long-Ribicoff bill must not be understated. Medicare was estimated in 1965 to cost $3.1 billion in 1970, with 1990 costs of $8.8 billion. In 1977, we are paying out benefits of $14.4 billion. Medicaid started at $1.5 billion, now exceeds $14 billion. The Kidney dialysis subsidy which just began in 1974 at an estimated $200 million now exceeds $1 billion. We cannot afford to believe these government estimates!

Pack of cigarettes a week—The cost of private catastrophic insurance

Mr. Chairman, the best kept secret from the American people is the very low cost of catastrophic insurance. Mr. Califano could really help his image tremendously by asking citizens to give up one pack of cigarettes a week to buy catastrophic coverage. Examples of coverage:

A. (1) Individual insurance: age 32, $10,000 deductible, unlimited (multi-million) coverage is $50 a year. (2) Group Insurance: age 32, $10,000 deductible is $21 a year.

B. Basic and Catastrophic, Unlimited ceiling, maximum $1,100 out-of-pocket: Individual under 30, $128.00 a year. Group (PDA), $47.88 a year.

Do we need a national law for $50 to $150 a year subsidy? We can save the huge and expensive bureaucracy spawned by all Federal programs.

The need: The uninsured, a national campaign for public education

PDA proposes to the insurance industry, that it intensify efforts thru national advertising campaign to inform the people of the availability of inexpensive catastrophic coverage emphasizing the small cost of protection against large medical bills.

A real need: The uninsurable

PDA challenges the private insurance industry to pool their resources at the State level to voluntarily guarantee issue of catastrophic coverage to the "uninsurable". Congress could adopt appropriate legislation to provide immunity from antitrust

allegations by the FTC for this voluntary effort as is provided in S. 350 for the compulsory bill.

Tax relief for catastrophic expenses

We recommend immediate tax relief for medical care expenses. Such losses are not "income" and should not be taxed. PDA recommends full tax deductibility of all actual health care financial loss, not just that which exceeds 3 percent of income. If the loss exceeds the taxes, the loss should be carried against subsequent years taxes. For those whose catastrophic loss exceed their current means, we recommend Federal catastrophic loans to be paid against subsequent years tax deductibles. Thus the loss is spread over the years for equitable tax relief, and the citizen pays for his care.

For the unemployed

Voluntary riders should be added to existing policies by the insurance companies to prepay the extension of coverage for one year during unemployment and during periods of part-time employment.

For the poor

Concerning title II of the bill to federalize medicaid, we recommend: For the poor of all ages, a "First-Class Citizen, Indigent Health Care Program" with uniform payments benefits throughout the country through private health insurance with guarantees from Congress that the Government would agree to:

(1) Choice of hospital, doctor and treatment by patient.

(2) A sliding scale of deductibles and co-payments for all patients, even the poor, to maintain responsibility and cost consciousness to curb overutilization and abuse.

(3) Choice of payment to the patient ("Direct Billing" to patients by the physician), so as to maintain the patient-physician accountability.

(4) First class drugs for the poor, not generic drugs, not drugs rejected by the military, not a choice of drugs limited by an administrator's list.

(5) For the small minority whose illness cannot be treated in private hospitals, use of VA and PHS hospitals.

(6) Medicaid recognized as a failure and repealed. "Medicare" should based on financial need. Both should be replaced by the "Indigent Health Care program."

Stop subsidizing failures

We oppose the PSRO (title I, section 1922(b)) and HMO (title II, section 1921(c)(1)) components of the bill. Continued Federal subsidy of these failures must be stopped.

Direct billing

Mr. Chairman, we cannot emphasize too strongly our repulsion to treat the poor as a second class citizen by requiring that doctors accept assignment. Let's treat all citizens, elderly or young, medicare or medicaid, the same. Let the government reimburse the patient. Let the patient as a consumer then pay the doctor and the hospital. Only in this manner can we expand patient choice, quality care and the dignity of the sick.

Title III—Certification of insurance

We strongly oppose Federal Certification of private insurance policies provided by employers or further federal takeover of the insurance system, except for the truly indigent. State Insurance Commissions should continue to handle the insurance policy oversight for catastrophic and all other policies under State Legislation.

State barriers for group insurance

Some States, e.g. Texas, do not allow group insurance from national groups. Florida does not allow employees of group insured members to be insured. We recommend legislation to allow free access to group insurance nationwide.

Long-term care needs of the institutionalized

The problem of the long-term illness, nursing home institutionalized affects 0.6 percent of the population, 9 percent of national expenditures, 20 percent of all hospital and nursing care; totals $9.48 billion, average cost is $7,400. Private insurance pays 55 percent, public funding 45 percent (77 percent medicaid). Less than 10 percent, however, have an out-of-pocket expense of over $5,000. PDA again recommends that the private insurance industry intensify its efforts on coverage for long-term disability, as it has under catastrophic insurance, to provide for nursing home care. For the truly indigent, government efforts must continue to upgrade the care of the institutionalized.

PDA Health plan

The PDA Positive National Health Plan is appended for your consideration.

CONCLUSION

In conclusion, private and public insurance catastrophic coverage already covers most of the population. The recommendations presented will provide the tax relief and loan arrangements that will permit the citizen to continue to pay his way while avoiding hardship to those not yet covered. We see no need to federalize the American health insurance industry, to impose yet another tax on employees and spawn yet another expensive and unnecessary bureaucracy.

THE CMS PRIVATE DOCTORS OF AMERICA HEALTH PLAN

(1) *For the poor of all ages.*—A "First-Class Citizen, Indigent Health Care Program" with uniform specific benefits throughout the country through purchase by government of private health insurance with guarantees from Congress that the government would agree to:

a. Choice of hospital, doctor and treatment;

b. A sliding scale of deductibles and co-payments for all patients to maintain responsibility and cost consciousness to curb over-utilization and abuse;

c. Choice of payment to the patient ("Direct-Billing" to patients by the physician), so as to maintain the patient-physician accountability;

d. First class drugs for the poor, not generic drugs, not drugs rejected by the military, not a choice of drugs limited by an administrator's list;

e. For the small minority whose illness cannot be treated in private hospitals, use of VA and PHS hospitals; and

f. Medicaid recognized as a failure and repealed.

(2) *For the affluent.*—Stop give-away programs for the rich. If a person can afford his own medical costs, why should the government take on this financial burden? The affluent should not be eligible for Medicare, as government should not pay for services that a patient can well afford—and can purchase more cheaply without the administrative cost overkill. Let the employers who are now subsidizing insurance for their employees, continue to do so. Keep in mind that 84 percent of the population is now covered by catastrophic insurance.

(3) *For the unemployed.*—Voluntary riders should be added to existing policies to prepay the extension of coverage during unemployment, during periods of part-time employment, or coverage of the survivor on death of the employee. Educational programs to encourage group coverage of even small groups of 2 to 3 employees.

(4) *For the uninsurable.*—Each State legislature may require insurance companies not to discriminate against the sick or disabled, but to pool their resources to offer coverage at a reasonable cost. Noting that currently 80 percent of companies will insure alcoholism, 92 percent automatically cover nervous and mental disorders, use of this coverage should be encouraged and amplified to all insurance.

(5) *For the few communities without a doctor.*—Forgive the income tax for 3 years for any doctor who volunteers to work there—instead of forcing doctors to serve, as in the legislation proposed by Senator Kennedy.

(6) *The cost of long-term care* in nursing homes should be addressed by the addition of new and appropriate coverage by the insurance industry into current disability income policies, now owned by 37 percent of the population.

(7) *Rising cost of hospitalization.*—The huge cost of government regulations must be recognized and stopped. Repeal of PSRO, fiscal utilization review boards, and HSA Planning boards which are failures and have escalated costs and changed our hospitals from medical care into expensive "papercare centers." Government utilization review programs are costing $34,000 to find one patient who stayed a few days too long in the hospital! The cost of PSRO for 1 year would provide a free CAT Scanner (the new X-ray miracle) to every hospital in the country! These rationing mechanisms waste critical medical and nursing manpower and exert a chilling effect on medical progress. The open-ended subsidization of social, rehabilitative, home health, occupational and therapy programs should be reassessed.

(8) *For the bureaucracy crisis: Accountability.*—Regular Government Accounting Office and independent audits of all existing government health programs: Mental Health Clinics, Neighborhood Clinics, Veterans Administration Hospitals, Health Maintenance Organizations, Foundations for Medical Care, Professional Standards Review Organizations, etc. Successful pilot studies of new health care proposals before imposing such experiments on the people nationwide should be required. Hold the health bureaucrat personally responsible for any fraud, deception, or coverup. Government's inefficient health care political system, the VA and PHS

hospitals should be phased into the private medical care system as recently recommended by the National Academy of Sciences commission.

(9) *For privacy.*—A one page summary of the hospital record with diagnosis, care and treatment specified should be available, but entire medical records, which necessarily contain sensitive details of patients' private lives should never by available to the health bureaucracy or collected by any Federal agency, or microfilmed in Washington, or programmed into Federal computers, as is now done by Medicare and Medicaid.

(10) *Educational programs for citizens* should be encouraged to emphasize the important preventive medicine role of citizens' life-style: nutrition, exercise, smoking, alcohol, the automobile, and the positive aspects of early diagnosis by visiting their doctor.

PRIVATE DOCTORS OF AMERICA MEMBERSHIP—MARCH 1979

Chapter	Number of staffs	Voting members
Alabama: 1. Northern Alabama	1	93
Arizona: 2. Central Arizona	1	458
Arkansas (see Gr. Memphis)		
California (V-7194):		
3. San Diego Imperial	2	205
4. Southern California	50	6,989
Colorado: 5. San Luis Valley area	1	18
Florida (V-3608):		
6. Florida West Coast	6	641
7. Fort Lauderdale area	2	436
8. Mid east Florida area	6	684
9. South Florida area	12	1,847
Georgia (V-579):		
10. Central Savannah River	2	242
11. Northeast Georgia area	1	11
12. Northern Georgia area	1	326
Illinois: 13. Northern Illinois area	9	1,210
Indiana (V-241):		
14. Northeast Indiana area	2	85
15. South Central Indiana area	1	43
16. Southern Indiana area	2	113
Iowa: 17. Black Hawk area	2	61
Kansas (see mid America):		
Kentucky (V-273):		
18. Bluegrass area	1	19
19. Green River area	2	108
20. Northern Kentucky area	2	140
21. Pennyrile area	0	6
Louisiana (V-2957):		
22. Acadiana area	4	81
23. Baton Rouge area	3	234
24. Central Louisiana area	1	30
25. Greater Monroe area	3	184
26. Lake Charles area	5	210
27. New Orleans area	37	1,960
28. Shreveport area	1	258
Massachusetts: 29. Merrimack Valley area	7	642
Michigan (V-5697):		
30. Albion area	1	42
31. Greater Detroit area	49	5,347
32. Jackson/Hillsdl/Lenawee	7	292
33. Northern Michigan	1	16
Minnesota: 34. South Central Minnesota	1	9
Mississippi (V-424)		

PRIVATE DOCTORS OF AMERICA MEMBERSHIP—MARCH 1979—Continued

Chapter	Number of staffs	Voting members
35. Central Mississippi	2	273
36. Northern Mississippi	1	9
37. Northwest Mississippi	1	22
38. Southeast Mississippi	3	120
Missouri (V-1,789):		
39. Gr. St. Louis (IL)	9	1,296
40. Mid America (KS)	2	493
Montana: 41. Montana area 2	3	152
New Hampshire: 42. New Hampshire area	1	172
New Jersey (V-1243):		
43. Northern New Jersey	7	994
44. Southern New Jersey	2	249
New Mexico: 45. New Mexico area	4	78
New York: 46. Nassau-Suffolk	6	1,113
North Carolina (V-627):		
47. Clinton-Fayetteville	1	29
48. Kinston area	1	71
49. Rocky Mount area	2	98
50. Winston-Salem area	2	497
Ohio (V-4301):		
51. Eastern Ohio area	6	767
52. Mid Ohio area	17	1,338
53. North Central Ohio	2	145
54. Northeast Ohio	12	1,135
55. Northwest Ohio	10	762
56. Southwest Central Ohio	1	154
Oklahoma: 57. Oklahoma City area	0	8
Oregon: 58. Portland area	1	82
Pennsylvania (V-5795):		
59. Allegheny Valley area	10	1,304
60. Central Pennsylvania area	1	87
61. Delaware Valley area	25	3,889
62. Northeast Pennsylvania area	3	342
63. Northwest Pennsylvania area	2	57
64. South Central Penn. area	2	116
Rhode Island: 65. Rhode Island	2	215
Tennessee (AR & MS) (V-842):		
66. East Tennessee area	1	31
67. Greater Memphis area	2	811
Texas (V-2559):		
68. Alamo Area	0	2
69. Gr. Houston/Galveston	11	1,203
70. Lower Rio Grande area	0	17
71. North Ctl. Texas area	18	1,101
72. South East Texas area	1	236
Virginia: 73. Southwest area	1	20
Individual members		641
Total	402	43,151

Senator TALMADGE. Thank you, sir. We appreciate your contribution.

The next witness is Dr. Jane Preston, president, Texas district branch, American Psychiatric Association.

Dr. Preston, we are delighted to have you. You may insert your full statement in the record and summarize it as you see fit.

STATEMENT OF JANE PRESTON, M.D., PRESIDENT, TEXAS DISTRICT BRANCH, AMERICAN PSYCHIATRIC ASSOCIATION

Dr. PRESTON. I am Dr. Jane Preston, a physician in the private practice of psychiatry, trained in internal medicine as well as psychiatry. I am an associate clinical professor at the Baylor College of Medicine and I am president-elect of the Texas District Branch of the American Psychiatric Association.

I have come here today to do what I can to help you in the task of differentiating and discriminating about what needs to go, and what needs not to go, into a program that, in general, we are certainly for.

I realize that you must discriminate. There is only so much money, only so many services, only so many trained people, and you have that monumental task to address.

I would like to share with you some definitions that I hope will be helpful as you make those discriminations. One of them is I would like to define a hospital, because the notion of hospitalization has been equated with catastrophic treatment and that is an erroneous notion, perhaps because of a lack of understanding of what hospitals have become.

Hospitals are places where equipment is gathered for certain kinds of diagnostic and treatment procedures. Some of those relate to catastrophic illnesses; many do not. That does not mean that they are not valuable, but if you are addressing catastrophic illness, it is important to realize that hospitalization per se is not the treatment of catastrophic illnesses.

I would like to define catastrophic illnesses. They are those illnesses which, by their inherent nature, can be guaranteed to produce major disability and/or hazard to life. Diseases such as diabetes, multiple sclerosis, manic depressive illness, schizophrenia—these are catastrophic illnesses. There are 10 million diabetics who are out doing quite well, although they have a catastrophic illness. They would have all been dead prior to the discoveries of the 1920's that enabled us to have outpatient care for them.

The same is true of schizophrenic and manic depressive patients. Let me tell you about a patient that I called this morning. She is a 22-year-old young woman who has, in effect, grown up in a closet. She has been in the closet of the overprotectiveness of her mother and father. They were protecting her, not because they were bizarre parents, but because she lived in terror of hallucinations. By their being with her and walking her to school, she was able to get through high school and to the college level.

She had attempted response to all sorts of advice, treatments, a great many counseling sessions, none of which worked. Within 2 months, she is now in college. She is going on the bus to school. I called her this morning because I had been seeing her every day for 15 minutes only. During that time, she has been able to respond physiologically to the sound of a voice, one that is no longer threatening to her.

Our physiology is what is at stake; if we do not understand that then we no longer understand catastrophic illnesses. Our bodies

are attuned to certain amounts of stress for certain periods of time, but not beyond that. Our ability to handle it physiologically rests on our ability to think and recognize what our limits are, and then find ways in which we can respond to those limits, ways that enable us to go back and face the stress, no matter what amount.

This young woman has been able to come forward and to take the medications that have made a difference for her—aided by having a bridge of trust built on the sound of my voice. It is not that my voice is so important; it is that I know enough about her physiology to see when she is too frightened to hear.

I would like to address the rate of change that is inherent in medical practice today, because that is what is a part of the bill.

There have been changes in the bill. Senator Ribicoff has talked about having an open mind on the changes that are necessary, and certainly we in psychiatry would underwrite that. We have been accused of being diffuse, disorganized, more than eclectic. I certainly have felt that I have been very consistent about medicine, over the years, but maybe everybody else does, too. But change demands response.

I think that the opportunities that we have seen to try a range of things need not be looked upon as foolishness. It would be very foolish if anyone in medicine assumed that we had it all in hand today, and I hope any bill would address the fact that change is going to go forward.

Prior to the invention of the electric shock treatment, there was therapy going forward that did help some people. When I had a rotating internship, I shocked 50 patients a morning, electric shock treatment. During the 2 months I was on psychiatry, I thought I would never do psychiatry.

By the time I had spent 2 years abroad working in a socialized medicine system, drugs had been discovered and things were quite different. We are at the threshold of tremendous changes.

In previous testimony, a discussion was mentioned of discovery of beta endorphines, a morphine substitute. The discoveries were much more important than a substitute morphine. The basic discovery was of beta alpatropine, a long chain polypeptide, something very similar to the pituitary gland in its many actions. Beta endorphines are only one part of the chain. When that long chain breaks in certain points, the result is calmed behavior. It is schizophrenia when the chain breaks at other points. At other points it is violent behavior. When it breaks at yet other points, it is manic-depressive behavior.

We are on a threshold of tremendous psychiatric progress, medical progress.

I think it is important to recognize, if I can convey this accurately, that psychiatry is a part of medicine whether it is recognized or not. It is a fact. We cannot define away mental illness; it will still be there.

I am all for psychologists, social workers and others who assist in this field being paid for the services they render in appropriate ways. What I am concerned about is that that which is not medical will be looked upon as medical but, more importantly, that which is medical may be looked upon as not medical.

I am speaking to the point of keeping a psychiatrist in positions of responsibility at the intake point of any program and in an ongoing, consultative capacity. I am speaking to the point of not eliminating psychiatric coverage or not treating it as something separate, simply because psychiatrists are few and the illness is not a pleasant one to contemplate, or because we feel illness is being out of control or being weak or immoral.

These are not moral issues. They are not issues just of a style of life. They are issues of a physiology struggling to meet the day.

Thank you, sir.

Senator TALMADGE. Thank you very much.

In your statement, you are recommending that medical treatment of mental and nervous disorders be covered on a parity with physical disorders. Do you consider psychotherapy and other forms of so-called talk therapy to be medical treatment and should be covered?

Dr. PRESTON. Psychotherapy is not a treatment in and of itself. It is the use of certain skills in the administration of treatment

I would liken it to the use of a crutch. It is more than that, but it is similar to the use of a crutch if someone has a broken leg. I have often heard people say that psychiatry is just a crutch. I think it is nothing but foolishness if someone has broken a leg to walk around with the leg and let it mend at an angle rather than utilizing a crutch while a good cast is applied after the bone is set straight.

I do not think that talk therapy is in any way medical. However, psychotherapy may be useful. It is similar to exercise. Exercise may, at times, be lifesaving.

If you wiggle your toes and that prevents a clot going to the heart, that is treatment exercise, and should be paid for medically. If you do something similar to be a better football player—I am all for football, being from Texas, but that is not medical treatment.

Senator TALMADGE. Are there any other questions?

Thank you very much, Dr. Preston. We appreciate your coming before the committee.

[The prepared statement of Dr. Preston follows:]

STATEMENT BY JANE PRESTON, M.D., FOR THE AMERICAN PSYCHIATRIC ASSOCIATION

Mr. Chairman, the American Psychiatric Association, a medical specialty society representing over 24,000 psychiatrists nationwide, appreciates the opportunity to testify before your subcommittee on the issues of catastrophic illness insurance coverage and a federalized medicaid program, reflected by S.350 and S.351.

I am Dr. Jane Preston, in the private practice of psychiatry, President of the Texas District Branch of the APA and an associate clinical professor of psychiatry at Baylor College of Medicine.

As the Congress and this committee debate the appropriate scope of Federal health insurance programs, the APA, in its historical role as advocate for the mentally ill, welcomes the opportunity to share our views on the need for nondiscriminatory treatment for nervous, mental or emotional disorders under any enacted Federal health program, whether catastrophic, or phased-in comprehensive.

Unfortunately the fear and misunderstanding of mental illness and emotional problems are deeply imbedded in our society. Stigma, fear and misrepresentation perpetuate a reluctance to seek treatment for mental illness.

The stigma is heightened further because the discrimination has become institutionalized—written in the medicare law, written in the restrictive language for treatment of mental illness contained in most of the national health insurance bills now pending before this committee and restrictive measures contained in most private health insurance plans. All suggest that mental illness is grossly different

from physical illness—not treatable, not reversible and not equally reimbursable when treatment is provided.

Regrettably, the cited pending bills do little to help us understand that none of us are immune from mental illness or emotional problems.

It is a sad commentary that legislation targeted toward responding to our most pressing health care needs—as we believe are the goals of S. 350 and S. 351—continue the prejudice against the mentally ill.

The American Psychiatric Association does not have all the answers on how to end the fears and anxieties which lead to thoughtless, even cruel responses to those who need help and understanding. But we do know that with your help we can assist in achieving such goal.

Accordingly, we urge the committee to reconsider the following provisions of S. 350 and S. 351, which perpetuate public and private health insurance programs which have resulted in years of neglect of the mentally ill.

(1) Section 2104(c)(3) establishes a discriminatory $500 ceiling on the extent to which medical expenses incurred for the treatment of "mental, psychoneurotic or personality disorders" may accrue for the purpose of establishing the medical deductible expenditure.

We recommend that medical treatment of mental, emotional or nervous disorders be brought under the catastrophic health insurance umbrella with parity of coverage with that established for medical treatment of physical disorders, including the establishment of comparable deductibles and coinsurance.

Parenthetically we assume (i) that in regard to section 2104(e)(2) of both S. 350 and S. 351, there was a typographical error and the comma between the words "mental" and "psychoneurotic" was inadvertently omitted in S. 350 as reprinted in the Congressional Record; and (ii) that the section was inadvertently misnumbered since no section 2104(d) appears to exist.

(2) Section 2104(e)(2) defines mental health care services with respect to the treatment of "mental, psychoneurotic, and personality disorders" whether on an inpatient, partial hospitalization or outpatient basis. However, subsection (c)(ii) thereof then discriminates against one of the most serious of psychiatric conditions, "acute psychosis," when it is provided by the only individual trained to provide medical treatment for an "acute psychosis," to wit: a psychiatrist. The provision establishes an arbitrary limitation on treatment by a psychiatrist as contrasted to that provided by a community mental health center where regrettably there may not be a psychiatrist on staff to provide medical treatment for mental illness. The subsection provides that mental health services do "not include any outpatient services provided by a psychiatrist, during a 12-month period, for purposes of diagnosis or treatment of acute psychosis in excess of (I) five visits, plus (II) such additional visits as shall have been approved in advance by an appropriate professional review mechanism upon a finding that, in the absence of such additional visits the patient will require institutional care."

The real tragedy is not that such subsection discriminates against medical treatment by a psychiatrist but rather that is perpetuates a discriminatory response to those tragically afflicted by an acute manifestation of mental illness as contrasted to an acute manifestation of a physical illness. It says, for example, that if you have an acute diabetic attack your physician can provide medical therapy as appropriate without any arbitrary limit on the number of outpatient visits to treat such physical illness. However, if you are unfortunately mentally ill and have an "acute psychosis" then the course of your outpatient medical treatment must be limited to five visits unless additional treatment is approved in advance and such would be in lieu of institutionalization.

Is it any wonder why patients must live in fear of the stigma of being labelled mentally ill and resist coming out of hiding to accept the treatment they so urgently need?

3. Section 1945(a) repeats the discriminatory features of the previously cited section 2104(e)(2).

Moreover, section 1945(b) creates a unique new discrimination against mentally ill patients receiving drug therapy. It requires that such patients can only receive their physician-prescribed drug if—"(A) such drug is included on the list (referred to in paragraph (2)) and is prescribed in accordance with the criteria indicated in such list, and (B) such physician determines that unless such patient receives such drug, such patient can reasonably be expected to require institutional care."

Thus, a mentally ill patient who requires drug therapy is essentially threatened with stigmatizing institutionalization as the alternative for drug therapy. While good medical practice might dictate a safe and efficacious minor tranquilizer for the mentally ill patient, the patient now views himself or herself as so profoundly ill as

to require such medication only to avoid being institutionalized. Such a drug therapy would be the antithesis of good psychiatric practice.

Further, paragraph "(2)" thereof authorizes after consultation with appropriate professional individuals and organizations, the Secretary "to compile and publish (and from time to time revise) a list of drugs which he has determined to be effective in the treatment of various mental conditions. Such list shall indicate, with respect to each drug included therein, the particular mental conditions with respect to which such drug is effective, and the appropriate dosage (in terms of quantity and intervals at which such drug shall be administered) of such drug."

Without regard to any other comments on such a compendium reducing the availability of patient treatment by restricting the physician's armamentarium to treat illness and interfering with good medical practice—in making therapeutic decisions, different physicians can reasonably and appropriately reach different conclusions as to appropriate medical treatment for the same patient—the provision discriminates against medical treatment of mental illness. The standard of such provision does not apply equally—nor should it—to medical treatment for physical illness. Rather it discriminates against patients with mental, nervous or emotional disorders treated by their physician with drug therapy to ameliorate patient symptoms and, when possible, to effect a cure.

In selecting any course of treatment, the responsible physician examines the patient in order to diagnose the patient's problem. This process usually includes the taking of a complete medical history of the patient, a physical examination, and in some cases diagnostic tests and procedures. The physician then evaluates the data received from the examination with information that he has acquired through formal and continuing medical education, clinical experience, articles published in the scientific literature, consultation with other physicians, current reference texts and, in the case of drugs, the FDA approved labelling for the drug. He then reaches a decision on how to proceed in the particular patient's case. In many instances, this evaluation will lead the physician to choose drug therapy as the most appropriate treatment mode. A psychotropic drug may be selected by the physician when the medical indication for the use of such drug is present. This examination, evaluation and selection process constitutes the very essence of good medical practice.

I would urge you most strongly to reconsider this discriminatory provision for, I repeat, it should be noted that a drug does not always have the same effect in different mentally ill patients, nor for that matter in the same patient at different times. The response of the mentally ill patient is highly dependent on the status of his or her disease or illness. Because of these individual differences, the right of the mentally ill patient to have available to him or her the best medication for his or her specific condition and situation makes it essential that psychiatrists be accorded wide discretion in determining appropriate drug therapy.

(4) Section 1504, relating to standards with respect to insurance policies, continues forward discrimination against the treatment of mental illness. Subsection (c)(ii) thereof authorizes an approvable health insurance policy to contain an artibrary dollar limitation of $400 for treatment by a psychiatrist.

Thus, while no other medical treatment of physical illness, other than for the usual health insurance exclusions (for example, "not reasonable and necessary for the diagnosis or treatment," or "routine physical checkups" or "cosmetic surgery"), is authorized to be limited in an approved health insurance policy, medical treatment for patients suffering from mental illness is singled out for discrimination.

It is shocking that the plight of Americans with chronic mental illnesses and who lack adequate health insurance coverage, one of the most costly and pressing health problems confronting us today, is permitted to continue by this provision.

(5) Section 402, which relates to expanding psychiatric benefits for Medicare, while a good faith effort in responding to the serious discriminatory provisions of such law, regrettably does not go far enough.

Medicare stands as a gross example of what a Federal health insurance program has done to assure mentally ill elderly Americans second class citizenship compared to that provided to them for other health care. I am speaking specifically of the restrictions imposed under both parts A and B which arbitrarily reduce the benefit for mental health treatment below those benefits provided for the balance of medical care. Part A limits lifetime inpatient benefits to 190 days and part B limits annual outpatient coverage for mental illness to $250 per year (resulting from a $500 ceiling and a fifty percent copayment)—including ancillary medical services. This provision would increase the outpatient psychiatric benefit to $625 per year and bring the copayment into conformity with copayment for medical treatment for physical illness.

The mentally ill elderly are stigmatized thrice—once by the fact of old age, once by the fact of mental illness, and once by the fact that treatment is too costly beyond the limited benefits of medicare.

In 1971, the American Psychiatric Association task force on aging, established to report on critical mental health issues identified by the 1971 White House Conference on Aging, pointed out that progress made during the previous two decades had been minimal. Among the reasons cited were the growth in number of the aging population, the recognition that their diversified needs may require diversified services, and that medicare did not provide sufficient benefits to allow adequate reimbursement for the treatment of nervous, mental or emotional disorders. In Aging and Mental Health, Dr. Robert Butler, head of the National Institute on Aging, pointed out that "Medicare coverage for psychiatric disorders is unrealistically limited and was inserted as a kind of afterthought * * * . The system obviously affords inadequate coverage."

It is a sad commentary to note that today, many of the same problems exist: The population of elderly persons continues to increase, and the number of those in need of mental health care continues to rise. In many ways, our recognition that diversified services are needed has languished, unimplemented, and only now is the benefits package being reassessed. The General Accounting Office in its recommendations to the 95th Congress reported that mental health benefits under medicare should be broadened. The Age Discrimination Study of the U.S. Commission on Civil Rights noted that the elderly are grossly underserved in comparison to other age groups within federally supported Community Mental Health Centers. The President's Commission on Mental Health recognized the elderly as a target group which is "unserved, underserved, or inappropriately served" insofar as mental health care is concerned. The Report of the American Psychiatric Association's Task Force on the Chronic Mental Patient singled out medicare as in need of amendment when it stated: "Chronic mental patients are entitled to full participation in the health care system. *Medicare,* medicaid and future NHI, *should not* single the chronically mentally ill out as a class or *discriminate against them in any way.*" (Emphasis supplied.)

The benefits of expanded mental health coverage under medicare are many. Too often the elderly are told, and many believe, that adverse psychological symptoms are natural aspects of growing old. Senility is a term loosely applied to thousands of older Americans, yet as the President's Commission on Mental Health noted, "as many as 20 to 30 percent of those so labeled have specific conditions that can be *diagnosed, treated and often reversed.*" (Emphasis supplied.) As such, medicare costs would be ultimately reduced, and those individuals with reversible conditions would be able to become more productive, contributing and independent members of society.

Moreover, it is essential to recognize that adequate, cost effective mental health services can have the effect of lowering the costs of other health care services by as much as fifty percent for the average patient. This is evidenced in study after study:

(1) In Texas, a longitudinal study (1973-77) demonstrated that access to needed treatment for mental illness resulted in a reduction in mean length of stay of over-65 patients in inpatient facilities from 111 days to 53 days. This halving of hospital stays resulted in a cost reduction of more than $1.1 million.

(2) Group Health Association of Washington indicated that patients treated by mental health providers reduced their nonpsychiatric physician usage within the HMO by 30.7 percent in the year after referral for mental health care compared to the previous year. Use of laboratory and x-ray services declined by 29.8 percent.

(3) Kaiser Plan in California estimated that the subsequent savings for each patient receiving psychiatric treatment were on the order of $250 per year.

(4) Blue Cross of western Pennsylvania assessed the medical/surgical utilization of a group of subscribers who used a psychotherapy outpatient benefit in community mental health centers with a comparison group of subscribers for whom such services were not made available. The findings showed that the medical/surgical utilization rate was reduced significantly for the group which used the psychiatric benefits. The monthly cost per patient for medical services was more than halved—dropping from $16.47 to $7.06.

The cost of nondiscriminatory Medicare legislation as contrasted to the bill's limited response is fiscally responsible. The cost, $45 million, developed by the Social Security Administration, and borne out by the Report of the President's Commission on Mental Health, does not reflect the savings to be realized from anticipated lower hospitalization expenditures or the substitution for existing part B expenditures. As noted in the Texas study, if the $1.1 million savings were extrapo-

lated to the entire Medicare population in need of mental health care, the effect could be a significant lowering of overall medicare costs.

Dr. Robert Butler, Director of the National Institute on Aging, pointed out in Aging and Mental Health that "There is also no proof that the deductible features of Medicare deter unnecessary use of health services. Instead, the exclusions may actually increase the government's bill by discouraging preventive and early rehabilitative care * * *. Some old people get themselves checked into a hospital just to get a physical examination (basing it on some physical complaint) because this will not be paid for on an outpatient basis." The same situation is true for mental health coverage—other physical complaints form the basis for hospitalization or outpatient visits, thereby raising the cost of Medicare coverage and possibly masking the psychiatric illness with physical symptoms. All too often, inappropriate placement is skilled nursing homes and intermediate care facilities takes place since reimbursement is available for such "treatment." Such facilities generally lack the resources to treat the emotionally disturbed, thereby prolonging the illness and misutilizing resources. It has been noted that as many as 30 percent of those described as "senile" actually have reversible psychiatric conditions, i.e., reversible treatable brain syndromes and depression which, if treated, would allow those individuals to become productive members of society and would save countless medicare dollars. As such, the elimination of caps on mental health coverage under Medicare could prove a valuable fiscal yardstick against which to measure comparable health insurance parity coverage.

A major step to assure independence and dignity to this nation's elserly population would be taken by ending arbitrary discrimination against the mentally ill elderly who are doubly damned by the stigmas of age and mental illness.

Unfortunately, the discriminatory provisions herein set forth repeat themselves in S. 351, as it tracks the provisions of S. 350.

We agree that it is time to stop talking about how serious illness can wipe out a lifetime of savings and property and to take appropriate legislative steps to eliminate the ravages of catastrophic illness. However, when the talking ceases and the legislating begins, all must be treated equally. You should not discriminate against mental illness—it is equally as serious as any physical illness castrophy, perhaps more so because of its stigma, fear and misunderstanding.

Our most important concern about the measures before this committee is the need for equal protection of catastrophic health—physical and mental—insurance protection. We are deeply distressed by legislation that discriminates against 20 million or more Americans in need of psychiatric care, who if they remain untreated will have a devastating impact in both human and economic terms upon our economy.

We realize you carry a heavy burden respecting vast expenditures of public funds. You must be sure that the expenditures will improve the health of Americans, that the services will be effective, and that any health insurance program will be fiscally sound.

The American Psychiatric Association welcomes the increased emphasis on medical care evaluation and the overall expectation by government leaders for accountability from all elements of our society. This is not an easy assignment for health professionals, and I stress health not just mental health, as the pending bills would seek to accomplish, because somehow mental health has been always singled out for special challenges respecting effectiveness without regard to tens of millions of physician visits for such ailments as colds, back problems, headaches, fatigue, etc., for which there is no definitive medical cure. This is not a complaint, for you have every right to ask us to demonstrate the effectiveness of mental health services.

We simply want to put the cost effectiveness issue into perspective. It is a problem for all medicine, not just psychiatry.

We ask you to join us in slaying the mythical dragon that mental health is uninsurable or that arbitrary limits need to be imposed on mental health benefits, unlike the benefits for "physical illness." The risk of insurability of mental illness is reasonable and acceptable.

In closing we would suggest that, rather than rely solely upon Time for an analysis of psychiatry as a medical specialty, you also review the world reknowned and distinguished medical journal, The Lancet.

In the February 3, 1979 edition, in an article entitled "A Reappraisal of American Psychiatry" it states: "American psychiatry has a distinguished history of clinical care, scholarship, and research. Furthermore, psychiatry has been accepted to a greater degree by the medical professional and by the general public in the U.S.A. than in any other nation."

In summary it indicates that remarkable changes have taken place in American psychiatry over the past 20 years. The era of psychoanalytical supremacy has passed, and realism is replacing the exaggerated claims which were made of psychiatry's ability to produce personal, social, and even political change. The importance of phenomenology and accurate diagnosis is increasingly recognized, and American researchers have made many impressive contributions to psychiatric genetics and to psychopharmacology.

We have made this our closing theme so the committee can know a vigorous effort is now under way to help psychiatrists maintain and enrich their identification with the mainstream of medicine, and simultaneously there are new efforts being made to help general medicine practitioners to realize how much of their work pertains to the care of patients with varying degrees and levels of psychiatric problems.

We are hopeful that the Committee will respond fairly, equitably and in a nondiscriminatory fashion to the plight of the mentally ill in our country.

Senator TALMADGE. The next witness is Dr. Thomas D. Hannie, Jr., president, Louisiana Psychological Association on behalf of the Louisiana Psychological Association and the association for the Advancement of Psychology. He is accompanied by Clarence J. Martin, executive director, general counsel, Association for the Advancement of Psychology.

Doctors, as I have stated, Chairman Long is at the White House. He will come back just as soon as we can. We are delighted to have you. You may insert your full statement in the record and summarize it, not to exceed 10 minutes.

STATEMENT OF THOMAS D. HANNIE, JR., PH. D., PRESIDENT, LOUISIANA PSYCHOLOGICAL ASSOCIATION, ON BEHALF OF LOUISIANA PSYCHOLOGICAL ASSOCIATION AND ASSOCIATION FOR THE ADVANCEMENT OF PSYCHOLOGY, ACCOMPANIED BY CLARENCE J. MARTIN, EXECUTIVE DIRECTOR AND GENERAL COUNSEL, ASSOCIATION FOR THE ADVANCEMENT OF PSYCHOLOGY

Mr. HANNIE. Mr. Chairman and members of the committee, it is an honor to be here today to testify on behalf of the Louisiana State Psychological Association, the American Psychological Association, and the Association for the Advancement of Psychology.

My name is Dr. Thomas J. Hannie, Jr. I am a practicing clinical psychologist in Metairie, La., and I am the current president of the Louisiana State Psychological Association. I am accompanied here by Clarence J. Martin, executive director and general counsel of the Association for the Advancement of Psychology.

We would like to commend the chairman for including provisions for mental health coverage in S. 350 and S. 351, proposals for the protection of the American public from the high cost of catastrophic illness.

We believe that any meaningful Federal health program must contain realistic mental health coverage. That coverage must include services delivered in inpatient settings as well as community mental health centers and a variety of private practice settings. The coverage for mental health programs should also be commensurate and on a parity with that for physical health programs.

Any Federal program should support and offer to the public services comparable with those they would receive if they were covered by a third-party group or commercial contract.

And any package of federally legislated health programs should reflect an equal sense of public interest and fiscal responsibility.

These bills, as presently constituted, fall short of these goals.

Numerous Federal, State, and private programs have proven the efficacy of mental health coverage in health insurance programs. The results of these programs reveal a market-proven benefits package and delivery system which has been abandoned by these bills.

Emphasis must be put on outpatient treatment as the most efficacious, humane and cost-efficient benefit.

Though provisions must be made for institutionalized persons, it is necessary to recognize that the most generally effective and cost-efficient way to deliver mental health services is through outpatient settings. As this bill presently reads, however, the only eligible providers of outpatient mental health care services would be "qualified community mental health centers" and "psychiatrists."

These limitations are too severe. Community mental health centers and psychiatrists should surely be covered, but there are far too many areas in the country where neither is available. Other practitioners and settings should be encouraged to provide mental health services, and be reimbursed for them. It is vitally important that psychologists also be reimbursed for the provision of mental health care services, and that such services be covered whether provided by the solo practitioner, in a small group practice or in a multidisciplinary structure such as have been encouraged by HMO legislation.

It can be strongly emphasized that, for the economic well-being of the Nation, we would rather see no national health insurance system at all rather than one which would reimburse providers without any system of cost control and quality assurance. We are highly supportive of peer review mechanisms, as required in this bill, that would evaluate treatment plans and progress—thus protecting the patient and the taxpayer from abuses within the insurance system.

A comprehensive system of community mental health centers, as envisioned 20 years ago, has simply not come to pass. Of the 1,500 designated mental health catchment areas in America, less than half are served by a qualified CMHC. Particularly because of issues around population density, financial ability, and the relative need in various areas for mental health services as comprehensive as those mandated for a CMHC, it is simply a fact that many of the unserved catchment areas will never have a community mental health center. Under the existing provisions of these bills, unfortunately, those citizens living in an unserved CMCH catchment area would not be reimbursed for quality mental health services unless they were provided only by a psychiatrist, who may not be available within many miles.

In my own State of Louisiana, for instance, there is a severe shortage of both psychiatrists and psychologists both in the community mental health center system and outside of it.

In the 1978 Louisiana State plan for comprehensive mental health services it was stated that there was only "a marginally adequate supply of appropriately trained mental health personnel." In 34 CMHC's in Louisiana in 1977, there were only 16 psychia-

trists and 11 psychologists. In 1979, with 38 facilities in operation, the manpower problem is even greater.

Both psychiatrists and psychologists are in short supply. The President's Commission on Mental Health noted that psychiatrists were largely unavailable to serve rural, inner city, and ethnic minority communities.

S. 350 and S. 351 as presently constituted would confine the access of the American public in need of mental health services to the smallest and geographically least well-distributed of the mental health service providers.

With psychiatrists in such short supply, compounded by the geographic maldistribution afflicting most of the mental health professions, we cannot count on psychiatrists alone to deliver the mental health care services that are needed.

In a study from the Washington Business Group of Health and the Boston University Center for Industry and Health Care entitled "Some Simple Projections of the Cost of National Health Insurance for the Private Practice of Psychiatry," a very basic supply-and-demand analysis was used to consider the economic impact of including mental health benefits in a national health insurance program. This study concluded that without any restraints whatever on the utilization or charges of mental health care services, the hourly fees of mental health practitioners would be expected to increase by 52 percent if only psychiatrists were recognized under the insurance plan. If, however, both psychologists and psychiatrists are recognized, the hourly fee would be expected to increase only 11 percent—under this absolutely free-market analysis.

The acceptability of psychologists as independent providers of mental health services is well established in both the public and private sector.

Third-party carrier recognition of psychological services are commonplace. Insurance companies which reimburse psychologists directly include Aetna, Bankers Life, Blue Cross/Blue Shield, Continental Assurance, John Hancock, Lincoln National Life, Massachusetts Mutual, Northwestern National Life, Phoenix Mutual, Provident, Prudential, Hartford, as well as Travelers, Metropolitan, and Equitable mentioned elsewhere.

The United Rubber, Cork, Linoleum & Plastic Workers of America in their industrywide insurance plan recognize psychologists as independent providers.

Delta Airlines, one of the largest nonunion employers nationwide, has recently included psychological services in their health plan which covers 26,000 workers—11,000 of them in Georgia.

In 1977 the Washington Business Group on Health did a study of mental health benefits in insurance programs of major corporations. All 79 of their respondents provided a program of mental health benefits.

Only 1 of the 79 used a prepaid program. Many companies insure their plans with several commercial carriers. Equitable, Metropolitan, and Travelers were the most frequently named.

Eighty percent of these programs provide reimbursement for mental health practitioners other than physicians. About 5 percent

of the total health benefits cost are attributable to mental health benefits or services.

Twenty-nine States presently have legislation mandating that insurance policyholders have the right to choose physicians or qualified psychologists as service providers.

Twelve States have enacted mandatory minimal mental health coverage legislation which requires all insurance plans, including group medical service plans such as Blue Shield and health maintenance organizations, to offer at least a minimal amount of coverage for mental and nervous disorders.

Laws dealing with mental health and alcoholism coverage in insurance contracts have also been enacted in Georgia, Louisiana, and Rhode Island. Organizations representing the core professions in mental health have worked together to support this type of health legislation.

Six States also have some form of catastrophic health care program.

We have included in our program some 15 major Federal programs that recognize psychologists as independent mental health service providers.

In summary, mental health coverage for catastrophic costs are needed both as an inpatient and outpatient benefit.

The provider structure for outpatient mental health care services as defined in S. 350 and S. 351 would severely limit access by citizens to needed mental health care.

The inclusion of coverage for other practitioners, including psychologists, and other service settings, including group practice and multidisciplinary structures, are vital and appropriate.

Contemporary private health insurance and health maintenance organization experience strongly supports the conclusion that mental health benefits provided in outpatient settings are both the most economical and effective form of mental health care delivery.

State and Federal statutes support the inclusion of a variety of appropriate practitioners and service settings—and these statutes should not be undermined.

Any program for health insurance should include provisions for cost control and quality assurance. We are very supportive of the provisions for peer review in this bill.

Senator TALMADGE. Thank you very much, Mr. Hannie.

In the current program evaluation summary on community mental health centers led by the National Institute of Mental Health for the Secretary of HEW, it was stated that the program has been studied and analyzed much more intensively than any other component of the Nation's mental health system.

The summary went on to state that unfortunately the effects of community mental health centers and other components to the Nation's mental health system including the private sector upon the emotional well-being of their client, their communities are not known at this time.

The question about the effectiveness of tools such as psychotherapy remain unresolved and the scientific assessment of a complex organization upon the mental health of their clients and their host communities is still in its infancy.

Would you care to comment on the National Institute of Mental Health's evaluation?

Mr. HANNIE. Sir, I am not fully conversant with that particular study, however, I do know that the cost-effectiveness of the inclusion of psychotherapeutic benefits has been studied around the world and it has been consistently shown that in the health care system, inclusion of these provisions decrease costs and decrease the utilization of medical services. It is a cost-effective system.

Some psychotherapeutic modes have been very well-validated and shown to be effective; others have not.

In your community mental health systems you have a very wide diversity of approaches that are used. Trying to group them all together would be a very difficult task and I agree it would be very hard to pull out any positive effects from this.

Senator TALMADGE. We have a Federal employee health insurance program that includes mental health benefits. Hasn't there been some serious problems?

Mr. MARTIN. Mr. Chairman, if I may, I do not know what serious problems you are mentioning.

Senator TALMADGE. The high cost.

Mr. MARTIN. One high cost in this particular area, there was a high-cost incident when the program was first initiated and it was primarily attributed to, as I recall, the utilization of unlimited mental health benefits being used by some individuals who were using the psychotherapy, the analytical psychotherapy, long-term psychotherapy, under their program in the course of their education and training in their field. I think that has been corrected and that has been cut out.

I do not have with me at the moment the statistics on the Federal employees health benefits cost, but I think that nationwide in all the various insurance programs we have looked at, the costs have run somewhere between 3 and 7 percent of the total cost of the insurance package and I think that is a reasonable and expected figure.

Senator TALMADGE. How about the CHAMPUS program for armed service personnel?

Mr. MARTIN. We are very involved in the CHAMPUS program. As a matter of fact, the American Psychological Association presently has a contract with CHAMPUS to organize and to present a process of cost containment, peer review and prospective review of treatment plants that I am under the impression has been very well-received by CHAMPUS and I would be delighted to supply the committee for the record a copy of that analysis of that program and the cost under it and I believe Dr. Döorken, the author of the ten-state study of the CHAMPUS program has inserted in the record of this committee in previous hearings his analysis of that program and its cost.

Senator TALMADGE. Wasn't that study made at the request of CHAMPUS because their costs were getting out of hand?

Mr. MARTIN. Yes; it was.

[The following was subsequently supplied for the record:]

ASSOCIATION FOR THE ADVANCEMENT OF PSYCHOLOGY,
Washington, D.C., April 6, 1979.

Hon. HERMAN TALMADGE,
Chairman, Subcommittee on Health, Senate Finance Committee,
U.S. Senate, Washington, D.C.

DEAR MR. CHAIRMAN: In the course of our testimony on March 29, 1979, you asked for comments on the cost of two experiences with the inclusion of psychologists as independent providers of mental health services under Federal programs, FEHB and CHAMPUS.

I am pleased to supply the following data in response to your inquiries.

Prior to the passage in 1974 of Public Law 93-363 which recognized psychologists as independent providers of mental health services there was indeed a "scare" concerning cost overrun of mental health benefits under FEHB.

In the years since the passage of Public Law 93-363, however, mental health benefits in FEHB have shown a stability, predictability and lack of escalation unique in the health arena. This stability is due in part to peer review procedures, which we supported in our testimony and of which we believe you approve; partly, it is due to the realistic limitation of treatment modalities which we supported in our testimony and of which we believe you approve; and partly, to the inclusion of psychologists as autonomous providers which we supported in our testimony and of which we hope you will come to approve.

Prior to Public Law 93-363 the combined mental health cost of carriers at risk for mental health benefits comprised slightly more than 8 percent of the total national health cost of FEHB.

During the period from 1975 through 1977, utilization under Blue Cross (which since 1975 is at risk for all federal employees who submit claims for mental disorders) shows both a reduction of cost to below 8 percent of the total health package and amazing stability.

TRENDS IN UTILIZATION UNDER BLUE CROSS BLUE SHIELD, FEDERAL EMPLOYEES PROGRAMS

[Dollars in thousands]

Total benefits	1975	1976	1977
All services	$1,218.3	$1,406.7	$1,505.4
Mental and nervous (percent)	90.8	108.4	116.0
Mental and nervous as percent of total	7.5	7.7	7.7
Mental and nervous per covered person	$15.39	$18.91	$21.01
Consumer Price Index, all medical services w/1974 = $100	$112.00	$122.70	$134.50
Medical and nervous, benefits per covered person (constant dollar)	$13.74	$15.41	$15.62

Source: Stevens S Sharfstein, M D, co-project Director, MANDUCS

The most revealing statistics is the last line which adjusts per person benefits payments for medical cost with inflation as measured in the consumer price index. From 1976 to 1977 the increase in real terms was scarcely one percent which given the vagaries of CPI is certainly stability.

In response to your second question. The experience with CHAMPUS is similar. The Civilian Health and Medical Program of the Uniformed Services is the single largest group health plan in the Nation with nearly 8 million beneficiaries. Since its inception CHAMPUS has contained liberal benefits for mental health services rendered by psychologists as well as other mental health professionals. In this program, as in FEHB, mental health benefits have remained remarkably stable and predictable.

CHAMPUS EXPENDITURES FOR INPATIENT AND OUTPATIENT MENTAL HEALTH SERVICES

[In thousands of dollars]

Fiscal year	Inpatient	Outpatient
1975	65,089	21,509
1976	62,573	21,523
1977	65,191	21,445

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CHAMPUS EXPENDITURES FOR INPATIENT AND OUTPATIENT MENTAL HEALTH SERVICES—Continued

[In thousands of dollars]

Fiscal year	Inpatient	Outpatient
Totals	192,853	64,477

All mental health costs ($257 million for the period of 1975–77) can be compared with the cost of nonmental health services for the same period ($1.201 billion for the period of 1975–77).

MENTAL AND NONMENTAL COST COMPARISON CHART (CHAMPUS 1975–77)

[Dollars in millions]

		Mental health as percent of Mental health total basic program	Total basic program
Fiscal year:			
1975	$86,598	$485,033	5.60
1976	84,096	473,360	5.62
1977	86,636	499,973	5.77
Total	257,330	$1,458,366	5.66

Source: CHAMPUS

Obviously mental health costs have remained uniquely stable and predictable relative to other health costs. Again, we attribute this to the progressive use in the CHAMPUS mental health program of peer review, benefits limitation and competitive service providers; all of which we advocated in our testimony.

In closing let me reiterate some significant facts relative to our testimony:

S. 350 and S. 351 as presently constituted would confine the access of the American public in need of mental health services to the smallest and geographically least well-distributed of the mental health service providers.

It would mean that citizens in the metropolitan areas would receive preferred treatment over the rural and small-town people whose tax dollars contribute equally to the Federal funding of this legislation.

It would mean that the highest cost mental health services presently available would be encouraged by the laws of supply and demand and monopoly to become even higher and the cost of mental health would escalate.

If S. 350 and S. 351 were amended to provide that psychologists qualified as mental health providers be included such an amendment would triple the available manpower and would assure a substantially better geographical distribution of mental health care providers than available under the present language. Such an amendment would make real the promise of mental health care under these bills while incurring no new cost.

One other issue should be weighted. Competition reduces prices. The availability of both psychiatrists and psychologists in the mental health marketplace will stimulate both professions to provide the best possible services at the lowest possible cost.

I believe these changes would be in the best interest of fiscal responsibility on behalf of the Congress, improve services for the American public and provide equity for the mental health professionals.

Sincerely,

CLARENCE J. MARTIN,
Executive Director and General Counsel.

Senator TALMADGE. Thank you very much.

Are there any further questions?

[The prepared statement of Dr. Hannie follows:]

Statement of Thomas J. Hannie, Jr., Ph. D., for the Louisiana State Psychological Association, the American Psychological Association, and Association for the Advancement of Psychology

SUMMARY

The testimony of the Louisiana State Psychological Association, the American Psychological Association and the Association for the Advancement of Psychology includes the following points relative to the Catastrophic Health Insurance and Medical Assistance Reform Act.

Mental health coverage for catastrophic costs are needed both as an inpatient and outpatient benefit.

The provider structure for outpatient mental health care services as defined in S. 350 and S. 351 would severely limit access by citizens to needed mental health care.

The inclusion of coverage for other practitioners, including psychologists, and other service settings, including group practice and multidisciplinary structures, are vital and appropriate.

Contemporary private health insurance and health maintenance organization experience strongly supports the conclusion that mental health benefits provided in outpatient settings are both the most economical and effective form of mental health care delivery.

State and Federal statutes support the inclusion of a variety of appropriate practitioners and service settings—and these statutes should not be undermined.

Any program for health insurance should include provisions for cost control and quality assurance. We are very supportive of the provisions for peer review in this bill.

STATEMENT

Mr. Chairman, members of the committee, it is an honor to be here today to testify on behalf of the Louisiana State Psychological Association, the American Psychological Association and the Association for the Advancement of Psychology.

My name is Thomas J. Hannie, Jr., I am a practicing clinical psychologist in Metairie, Louisiana and I am the current President of the Louisiana State Psychological Association. I am accompanied here by Clarence J. Martin, Executive Director and General Counsel of the Association for the Advancement of Psychology.

We would like to commend the Chairman for including provisions for mental health coverage in S. 350 and S. 351, proposals for the protection of the American public from the high cost of catastrophic illness.

We believe that any meaningful Federal health program must contain realistic mental health coverage. That coverage must include services delivered in inpatient settings as well as community mental health centers and a variety of private practice settings. The coverage for mental health programs should also be commensurate and on a parity with that for physical health programs.

Any Federal program should support and offer to the public services comparable with those they would receive if they were covered by a third-party group or commercial contract.

And any package of federally legislated health programs should reflect an equal sense of public interest and fiscal responsibility.

These bills, as presently constituted, fall short of these goals.

Numerous Federal, State and private programs have proven the efficacy of mental health coverage in health insurance programs. The results of these programs reveal a market-proven benefits package and delivery system which has been abandoned by these bills.

Emphasis must be put on outpatient treatment as the most efficacious, humane and cost-efficient benefit.

Though provisions must be made for institutionalized persons, it is necessary to recognize that the most generally effective and cost-efficient way to deliver mental health services is through outpatient settings. As this bill presently reads, however, the only eligible providers of outpatient mental health care services would be "qualified community mental health centers" and "psychiatrists."

These limitations are too severe. Community Mental Health Centers and psychiatrists should surely be covered, but there are far too many areas in the country where neither is available. Other practitioners and settings should be encouraged to provide mental health services, and be reimbursed for them. It is vitally important that psychologists also be reimbursed for the provision of mental health care services, and that such services be covered whether provided by the solo practitioner, in a small group practice or in a multi-disciplinary structure such as have been encouraged by HMO legislation.

The Health Maintenance Organization program, which has been the most major innovation in health care delivery in recent years, requires all federally-qualified HMO's to include mental health services. Indeed, the majority of research studies regarding the efficacy of mental health care in the overall health care system have taken place within HMO's. Every one of these studies has shown a total cost savings as a result of the availability of mental health services.

In these research studies, the length of treatment through outpatient psychotherapy has been shown repeatedly to average between 6 and 12 sessions. It has also been consistently demonstrated that 80 percent of psychotherapy patients successfully complete their treatment in 20 or fewer sessions.

Most of these studies have also examined the cost savings of including mental health coverage in a total health care package. These cost "offset" studies have been conducted in HMO's because this is one of the few settings in which researchers can ethically (and readily) have access to all of the data needed for this type of analysis.

A group of psychiatrists assessed the impact of short-term outpatient mental health coverage on the utilization of general medical services at the Group Health Association of Washington, D.C. They found a resulting 30 percent reduction in the use of general health services. Similar data has been reported from studies in HMO's in New York, Oregon, Maryland, Wisconsin, and Massachusetts.

The psychologist/psychiatrist team of Cummings and Follette have reported on 20 years of research on the Kaiser-Permanente Health Plan in California. They present striking evidence that emotionally distressed individuals are high utilizers of general health services. They found significant declines in medical utilization when such patients received psychological services, as compared to a control group of similarly distressed persons who did not receive such services. Followup studies showed that these decreases were sustained for 5 years after termination of psychotherapy.

The National Institute of Mental Health recently reviewed 20 studies about the impact of mental health treatment on medical care utilization and expenditures, and found that 19 of these 20 studies showed a significant reduction in medical utilization after psychological intervention. Reductions in medical utilization ranged from 11 percent to 85 percent—and the average reduction was more than 40 percent.

We know of only one study on this mental health "offset" that uses the traditional private health insurance system for its research. That study too confirms the HMO results. Blue Cross of western Pennsylvania collected data prior to adding mental health benefits to their insurance package. After examining the claims of patients who subsequently utilized psychological services, they found that total costs to the insurer were lowered. Comparing a 21-month time span prior to involvement with the mental health services to a 26-month time span after such contact, they found that the total cost (for both physical and mental health care) per patient per month decreased by over 30 percent.

Studies such as these have convinced policymakers that psychological care is not only effective for the patient, it is also cost-effective for the health care financing and delivery system as a whole.

It can be strongly emphasized that, for the economic well-being of the Nation, we would rather see no national health insurance system at all rather than one which would reimburse providers without any system of cost control and quality assurance. We are highly supportive of peer review mechanisms, as required in this bill, that would evaluate treatment plans and progress—thus protecting the patient and the taxpayer from abuses within the insurance system.

A comprehensive system of community mental health centers, as envisioned 20 years ago, has simply not come to pass. Of the 1,500 designated mental health catchment areas in America, less than half are served by a qualified CMHC. Particularly because of issues around population density, financial ability, and the relative need in various areas for mental health services as comprehensive as those mandated for a CMHC, it is simply a fact that many of the unserved catchment areas will never have a community mental health center. Under the existing provisions of these bills, unfortunately, those citizens living in an unserved CMCH catchment area would not be reimbursed for quality mental health services unless they were provided only by a psychiatrist, who may not be available within many miles. We have recently received the following letter which reflects the situation in one State, New Mexico.

"I wish to call your attention to a situation here is Lea County which, I feel sure, exists in many other places in our State and in the country. Residents of Good Samaritan Village and La Siesta Retirement Center are being deprived of their rights to quality health care services by medicare rules.

Under those rules, services provided by a licensed clinical psychologist, even when ordered or requested by a primary care physician, will not be paid for by medicare. Here in Lea County, I am the only licensed or certified mental health care service provider. There is not a psychiatrist in the county, or within a 100-mile radius of Hobbs. Psychological treatment services are needed by many of the elderly persons living in the two facilities mentioned. Additionally, I have the professional expertise to aid administrations of both facilities to take account of the psychological and behavioral needs of the residents in their care. Because medicare will not pay for my services, residents and administrators alike are deprived of their rights to freely choose who will deliver psychological services to them. Physicians are similarly restricted from choosing to use my services on a consulting basis."

In my own State of Louisiana, for instance, there is a severe shortage of both psychiatrists and psychologists both in the community mental health center system and outside of it.

In the 1978 Louisiana State Plan for Comprehensive Mental Health Services it was stated that there was only " * * * a marginally adequate supply of appropriately trained mental health personnel * * * " In 34 CMHC's in Louisiana in 1977 there were only 16 psychiatrists and 10 psychologists employed on a full time basis. In 1978, 17 psychiatrists and 11 psychologists. In 1979, with 38 facilities in operation, the manpower problem is even greater. The modest goal of the May 15, 1979 Louisiana State Plan for CMHC's includes * * *.

"Within 1 year to assure that there is at least one full-time licensed psychologist employed in community mental health in each state planning district, and that at least one day per week of psychological time is available in each full-time community mental health facility."

Both psychiatrists and psychologists are in short supply. The President's Commission on Mental Health noted that psychiatrists were largely unavailable to serve rural, inner city and ethnic minority communities.

In no way do I wish to disparage the profession of psychiatry, but the fact remains that psychiatrists are limited in numbers and not broadly distributed geographically.

The "Report of Selected Activities of the American Psychiatric Association" to the National Advisory Mental Health Counsel (May 1, 1978) suggested that of the estimated 27,500 psychiatrists in the country, there are only about 8,000 full-time qualified private practice psychiatrists available to render services such as required under this Bill.

In a letter dated February 24, 1978, Dr. Melvin Sabshin, Medical Director of the American Psychiatric Association, points out to Dr. Daniel Whiteside, Director, Bureau of Health Manpower, Health Resources Administration, HEW, (p. 8), that "Nationwide there are only 2,500 child psychiatrists, or one child psychiatrist for every 30,800 children * * * clearly a severe shortage."

Not only is there a severe shortage of psychiatrists, but they are not well-distributed geographically. In their August 25, 1978, issue of Advancedata, the Office of Vital and Health Statistics of the National Center for Health Statistics reported that, "most visits to psychiatrists were to offices located in metropolitan areas (94 percent); this was a higher proportion than for all specialists."

S. 350 and S. 351 as presently constituted would confine the access of the American public in need of mental health services to the smallest and geographically least well-distributed of the mental health service providers.

With psychiatrists in such short supply, compounded by the geographic maldistribution afflicting most of the mental health professions, we can not count on psychiatrists alone to deliver the mental health care services that are needed.

The necessary conclusion is that psychologists should be included in this catastrophic health insurance program. The inclusion of psychologists is not only appropriate; it is the only reasonable way to realize this bill's noble goals for mental health care services. It is also a logical conclusion based on the experiments and the experience of private health insurance plans, other federal health insurance programs, and the health care delivery systems created and developed through Federal guidance.

In a study from the Washington Business Group on Health and the Boston University Center for Industry and Health Care entitled "Some Simple Projections of the Cost of National Health Insurance for the Private Practice of Psychiatry," "a very basic supply-and-demand analysis was used to consider the economic impact of including mental health benefits in a national health insurance program. This study concluded that without any restraints whatever on the utilization or charges of mental health care services, the hourly fees of mental health practitioners would be expected to increase by 52 percent if only psychiatrists were recognized under the

insurance plan. If, however, both psychologists and psychiatrists are recognized, the hourly fee would be expected to increase only 11 percent—under this absolutely free-market analysis.

The acceptability of psychologists as independent providers of mental health services is well established in both the public and private sector.

Third party carrier recognition of psychological services are commonplace. Insurance companies which reimburse psychologists directly include, Aetna, Bankers Life, Blue Cross/Blue Shield, Continental Assurance, John Hancock, Lincoln National Life, Massachusetts Mutual, Northwestern National Life, Phoenix Mutual, Provident, Prudential, Hartford, as well as Travelers, Metropolitan and Equitable mentioned elsewhere.

The United Rubber, Cork, Linoleum and Plastic Workers of America in their industrywide insurance plan recognize psychologists as independent providers.

Delta Airlines, one of the largest nonunion employers nationwide, has recently included psychological services in their health plan which covers 26,000 workers (11,000 of them in Georgia).

In 1977 the Washington Business Group on Health did a study of mental health benefits in insurance programs of major corporations. All 79 of their respondents provided a program of mental health benefits.

Only one of the 79 used a prepaid program. Many companies insure their plans with several commercial carriers. (Equitable, Metropolitan, and Travelers were the most frequently named.)

Eighty percent of these programs provide reimbursement for mental health practitioners other than physicians. About 5 percent of the total health benefits cost are attributable to mental health benefits or services.

As part of the survey, each company was asked to identify the ways if felt the provision of mental health benefits helped the company. The answers were:

(a) Improved employee moral;
(b) Lowered employee absenteeism;
(c) Fewer instances of severe mental disorders;
(d) Improved employee productivity;
(e) Reduced hospital utilization; and
(f) Lower total insurance premiums.

Twenty-nine States presently have legislation mandating that insurance policyholders have the right to choose physicians or qualified psychologists as service providers. The following list includes the State and year of enactment of these freedom of choice statutes:

State	Year	State	Year
Arkansas	1975	Nebraska	1974
California	1969	New Jersey	1974
Colorado	1971	New Mexico	1977
Connecticut	1975	New York	1969
District of Columbia	1975	North Carolina	1977
Illinois	1976	Ohio	1973
Kansas	1974	Oklahoma	1971
Louisiana	1974	Oregon	1973
Maine	1976	Pennsylvania	1978
Maryland	1973	Tennessee	1974
Massachusetts	1975	Texas	1977
Michigan	1968	Utah	1969
Minnesota	1975	Virginia	1973
Mississippi	1974	Washington	1971
Montana	1971		

Twelve states have enacted mandatory minimal mental health coverage legislation which requires all insurance plans, including group medical service plans such as Blue Shield and Health Maintance Organizations, to offer at least a minimal amount of coverage for mental and nervous disorders. They are: Colorado, Connecticut, Illinois, Maryland, Massachusetts, Minnesota, Ohio, New Hampshire, New York, North Dakota, Virginia, and Wisconsin.

Laws dealing with mental health and alcoholism coverage in insurance contracts have also been enacted in Georgia, Louisiana and Rhode Island. Organizations representing the core professions in mental health have worked together to support this type of health legislation.

Six states also have some form of catastrophic health care program. They are: Alaska, Connecticut, Maine, Minnesota, New York, and Rhode Island.

All include mental health benefits and all recognize psychologists as qualified providers.

The following public programs, based in Federal law, have also endorsed psychologists by inclusion:

The Rehabilitation Act of 1973 (Public Law 93-112) recognizes licensed/certified psychologists as independent providers of diagnostic and restorative services.

Federal Employees Health Benefits Program (Public Law 93-363) recognizes clinical psychologists as independent providers of services for approximately 10 million government workers and their beneficiaries.

The civilian health and medical program of the uniformed services (CHAMPUS) (Public Law 95-111) recognizes the autonomous practice of psychology in its nationwide health benefits program, covering both in- and outpatient services for approximately 8.5 million dependents of military personnel, retired military personnel, and other beneficiaries. Under law, covered services are those which are "medically or psychologically necessary" as diagnosed by a physician, dentist, or clinical psychologist.

The civilian health and medical program of the Veterans Administration (CHAMPVA), a program for the dependents of totally disabled veterans established in the Veterans Health Care Expansion Act of 1973 (Public Law 93-82), recognizes the independent practice of psychology.

Community Mental Health Center regulations implementing Public Law 88-164 and subsequent amendments provide that psychologists may serve as center directors as well as in clinical, training and research positions.

The Veterans Administration regulation provide that qualified psychologists may be directors of VA mental hygiene clinics, day treatment centers, day hospitals, alcohol and drug dependency programs, and medical centers. The regulation also provide that psychologists may provide direct services without physician referral or supervision.

The Department of Defense includes psychologists in its policy which provides that any qulified health professional officer serving in the armed forces may command or exercise administrative direction of a military health care facility without regard to the officer's basic health profession.

The work incentive program (WIN) accepts professional evaluation by licensed/certified psychologists as evidence of illness or determinable physical or mental impairment.

The Federal Employees Compensation Act (as amended by Public Law 93-416) relating to work injuries compensation of Federal employees includes clinical psychologists in its definitions of "physician" and providers of "medical, surgical, and hospital services and supplies."

Health Maintenance Organization regulations (implementing Public Law 92-222) include clinical psychologists among recognized health practitioners.

The Internal Revenue Service instructions for Standard Form 1040 itemized deductions for medical and dental expenses have included payment of psychologists since 1973.

The comprehensive manpower program (regulations implementing Public Law 93-203) of the Department of Labor defines psychological services to be part of health care to the extent that this treatment is necessary to retain or obtain employment.

The Disaster Relief Act of 1974 (Public Law 93-288) provides for professional counseling by psychologists for mental health problems caused or aggravated by a disaster.

Medicaid coverage (title XIX, Social Security Act) has been extended in almost half of the States to include psychological services.

The Social Security Administration's Bureau of Disability Insurance recognizes "reports of licensed or certified clinical psychologists" as "acceptable medical sources" to form the basis for a decision regarding disability in mental disorders.

SUMMARY

The testimony of the Louisiana State Psychological Association, the American Psychological Association and the Association for the Advancement of Psychology includes the following points relative to the Catastrophic Health Insurance and Medical Assistance Reform Act.

Mental health coverage for catastrophic costs are needed both as an inpatient and outpatient benefit.

The provider structure for outpatient mental health care services as defined in S. 350 and S. 351 would severely limit access by citizens to needed mental health care.

The inclusion of coverage for other practitioners, including psychologists, and other service settings, including group practice and multidisciplinary structures, are vital and appropriate.

Contemporary private health insurance and health maintenance organization experience strongly supports the conclusion that mental health benefits provided in outpatient settings are both the most economical and effective form of mental health care delivery.

State and Federal statutes support the inclusion of a variety of appropriate practitioners and service settings—and these statutes should not be undermined.

Any program for health insurance should include provisions for cost control and quality assurance. We are very supportive of the provisions for peer review in this bill.

Senator TALMADGE. Senator Long is in route from the White House and, without objection, the committee will stand in recess until the arrival of the chairman.

[A brief recess was taken.]

The CHAIRMAN. Let me just say that I have asked that Mr. Kilpatrick and his group should not be heard until I could be here. I am familiar with their views and it seems to me they have the most challenging type of approach that I have heard for some time.

And it really deserves thoughtful consideration of everyone interested in health insurance and I think that I would invite everyone who is studying this issue to hear and analyze what the Connecticut Insurance Co. is saying.

Our staff wants to go over their figures with them and see how they arrive at them. I would invite everybody here to take a copy of their statement home with them and study it; I find it extremely challenging.

I would like to hear from Mr. Kilpatrick who, incidentally, is from Louisiana. We once had you down there, and we invite you back.

Mr. KILPATRICK. Thank you, Senator. It is an honor for us to appear here before your committee here today.

Senator, on my left is Brooks Chandler, vice chairman of the Provident Life and Accident Insurance Co. of Chattanooga, Tenn.; and on my right is Ted Allison, assistant vice president of Metropolitan Life Insurance Co. of New York.

STATEMENT OF ROBERT D. KILPATRICK, PRESIDENT AND CHIEF EXECUTIVE OFFICER, CONNECTICUT GENERAL INSURANCE CORP., HARTFORD, CONN., ACCOMPANIED BY BROOKS CHANDLER, VICE CHAIRMAN OF THE BOARD, PROVIDENT LIFE & ACCIDENT INSURANCE CO., CHATTANOOGA, TENN., AND THEODORE ALLISON, ASSISTANT VICE PRESIDENT, METROPOLITAN LIFE INSURANCE CO., NEW YORK CITY

Mr. KILPATRICK. We are appearing here today on behalf of the Health Insurance Association of America, some 320 insurance companies that, along with other insurers, provide health insurance coverage for more than 150 million Americans, roughly about 95 percent of the employed population.

We do appreciate the opportunity to appear before the Committee on Finance to present a proposal which will extend, at a very modest cost to the economy and without the need for any new taxes, catastrophic health insurance protection to millions of our citizens. The bills before the committee, Mr. Chairman, including the one you introduced on Monday, share this common objective, but rather than focus my comments on different bills, some parts of which we may not agree with, we propose to discuss a program

that we believe can move forward now. We are convinced that it is possible, through the private sector, to provide all workers including the self-employed and their dependents with access to adequate catastrophic health insurance protection. This would be a major first and affordable step toward the comprehensive health insurance that we have long advocated.

Our catastrophic health insurance proposal would utilize a combination of tax provisions to expand the already broad base of existing private group and individual health insurance coverage to certain key unprotected portions of the working population—including the self-employed—and their dependents. The major features of the proposal are these:

One, the plan would call for a single annual dollar amount of out-of-pocket expense, before catastrophic benefits begin. This amount should be high enough to discourage any abuse, yet low enough so that no one faces financial ruin. We have used ranges of $2,000 to $5,000 per individual and $4,000 to $10,000 per family in estimating cost.

Two, payment should be made in full for medical bills above the out of pocket limit.

Three, during the 1974 recession, we found that many workers lost not only their jobs—they also lost health insurance for themselves and their families. The result for some was devastating. Most workers who lose their jobs find new work or return to their old jobs within 6 months. We believe benefits should be extended for 180 days—a full 6 months for those workers—and their families—who lose their jobs. This is particularly necessary in these uncertain economic times.

Four, nothing is more unfortunate, when a worker dies, than to have his family left totally and needlessly unprotected against catastrophic health expenses. Benefits should also be continued for 6 months for widows and widowers, and their dependents. The same 6-month continuation should apply when divorce or legal separation breaks up a family.

Five, today many young people do not enter the work force immediately after graduation from high school or college. In most of these situations, they are no longer considered dependent and thus, are not covered under their parents' insurance program. We estimate that as many as 3 million young adults in this category are without catastrophic protection, but do not have to be. Broader coverage for dependents—at least to age 26, or even older, if they are truly unable to care for themselves, such as the severely handicapped—should be provided.

We present this proposal, Mr. Chairman, to underscore our firm conviction that adequate access to quality health care is an important right of every citizen. Unfortunately, families do face bankruptcy or financial ruin as a consequence of costly illnesses or accidents. The private sector can never completely eliminate that threat acting alone, but we can and we have minimized it.

We need only the determination and the willingness of the Federal Government and the private sector to act in a statesmanlike manner. If we can bring the public policy-setting power of the Federal Government and the existing resources of the private sector to bear, adequate catastrophic protection can be a reality for

all Americans within the near future. It is within our grasp to take this significant first step now with the Federal Government and the private sector acting as partners.

It is time we started to solve this problem that we have debated so long, and we ought to be realistic and get going one step at a time.

I am happy to say that the recent trend in expanding health insurance coverage is encouraging. The chart my colleague is now presenting.

The CHAIRMAN. Let me suggest that you put that chart where everybody in the audience can see it. Put it up here, because I think it is very significant. Put it over to the left, on the Republican side. Put it here, where Bob Dole can get a good look at it.

Mr. KILPATRICK. What we have here shows the situation in 1973 relative to some trends in catastrophic health insurance and the same kind of picture in 1978.

What this relates to is new group insurance plans sold in those years. If you look at 1973, you will notice that most of the catastrophic group insurance sold then had relatively low benefit maximums. Most of it was $50,000 or less. Only 24 percent had maximum payouts possible of $100,000 or more.

You really need insurance more than $100,000 to call it catastrophic, you really do.

Look what happened in 1978. In 1978, over 88 percent of the new group insurance programs sold had benefits of more than $100,000. Interestingly, nearly half of these people covered here had protection of $1 million or more, while another one-third even had unlimited benefits, no maximum at all.

Senator DOLE. How many people are we talking about?

Mr. KILPATRICK. Our figures show that three out of four Americans have some form of major medical insurance. Three out of four.

Senator DOLE. How many in that 88.5 group?

Mr. KILPATRICK. I do not have that figure.

Mr. MARKUS. This is a sample distribution of approximately 800,000 workers and their dependents in 1978.

Mr. KILPATRICK. Another part of this is that even though millions have high maximum individual major medical policies, not all citizens have the level of protection we are all talking about in this chart.

Our proposal built on this base.

As I mentioned earlier, Mr. Chairman and Senator Dole, we are confident that a combination of tax incentives and tax disincentives would be effective in extending catastrophic protection to the working population and their dependents, including the self-employed. We, of course, leave to the committee's judgment and expertise the specific types and mix of tax incentives and disincentives that would be necessary.

Obviously, it is important to take into account the impact of such a tax program on employers—particularly small employers and the self-employed—and on the economy as a whole. However structured, the program must assure that gaps in coverage are not created by any employer who would, for whatever reason, fail to provide adequate catastrophic insurance protection for his employees.

As you can see, Mr. Chairman, so far we have focused only on increasing catastrophic protection and closing key gaps in coverage for those who can afford to pay, namely, the vast majority of Americans in the working population and their dependents. We are also very concerned about those who cannot afford to pay.

To extend similar catastrophic health care coverage to these groups, we recommend that changes be made in the medicare and medicaid programs. These groups—the aged and the poor—are, and should, remain the financial responsibility of Government through its taxing power. Government should concentrate its financial resources on these groups, while the private sector, guided by public policy, concentrates its efforts on providing adequate protection for the 165 million Americans who can afford to pay. Dividing the financial responsibilities this way establishes a partnership that we believe is both appropriate and efficient.

Even if changes are made in the medicare and medicaid programs, and even if private sector coverage is expanded as we have proposed, there may be individuals such as those who are very high risks who are denied access to coverage. To address this potential problem, we are proposing that State pool arrangements be created along the lines of those we have in Connecticut and Minnesota.

These pools provide a guarantee that every citizen who can afford to purchase coverage will have the opportunity to do so at a reasonable price and without regard to insurability. Because of the ready availability of group and individual insurance, the number of individuals who would have to resort to these pools would be quite small.

I might add, Mr. Chairman, that although this hearing does not specifically address the cost containment issue, we continue to advocate that cost containment legislation be given the highest priority by Congress. As we testified earlier this month, we steadfastly support legislation to moderate rising hospital costs, if the voluntary efforts on the part of the hospital industry are not successful. We have supported the President's program to combat inflation and have accepted the special pricing guidelines applicable to health insurers. We are convinced that cost containment should be an integral part of any national health insurance deliberation in this period of high inflation.

Mr. Chairman, we believe that our proposal offers a number of significant advantages.

One, it fills critical gaps in coverage and assures 165 million Americans of adequate catastrophic health insurance coverage—an important step toward complete comprehensive protection.

Senator DOLE. Is that an advantage over any legislation that has been introduced, or are you speaking generally?

Mr. KILPATRICK. I am speaking generally, Senator, and there are some advantages over certain pieces of legislation. We have not had time to fully analyze the bill that Senator Long submitted this week and the one that you submitted this week.

We do note on a quick reading, though, that there are many things in both pieces of legislation which are entirely compatible with my testimony.

Senator DOLE. Maybe you can give us an analysis of your comments on both S. 748 and S. 760 which we could include in the record.

Mr. KILPATRICK. Yes senator, we will.

[The following was subsequently supplied for the record:]

CONNECTICUT GENERAL LIFE INSURANCE CO.,
Hartford Conn., April 13, 1979.

Hon. RUSSELL B. LONG,
Chairman, Committee on Finance, U.S. Senate,
Dirksen Senate Office Building; Washington, D.C.

DEAR MR. CHAIRMAN: During my appearance before your committee on March 29, 1979, Senator Robert Dole asked that we provide our comments on S. 748 and S. 760 for the hearing record. Each of these proposals was introduced shortly before my testimony on catastrophic health insurance on behalf of the Health Insurance Association of America.

S. 748 and S. 760 share many common objectives. Both measures seek to extend catastrophic health insurance protection to all citizens by building upon the existing base of coverage now provided to most workers and their dependents through the private sector. These proposals would also make important improvements in the public programs that are intended to address the needs of the poor and the elderly. In the following comments, I would like to offer a few thoughts for your consideration on how these bills might be improved.

Definition of employers/employees

Since both of these bills build upon the current system of employment-based coverage, we strongly urge that the definitions of "employer" and "full-time employee" used in the legislation be as broad as possible. In S. 748, for example, it would be desirable to include states and certain other political subdivisions in the definition of "employer."

Employee premium contributions

S. 760 prohibits any employee contribution to group health insurance premiums, while S. 748 provides that employees may not be required to contribute more than 25 percent of the cost of the group premium. We agree that employers should be required to contribute at least a specified minimum amount to premiums unless a collectively bargained agreement provides otherwise. This is the approach adopted in S. 748.

Out-of-pocket expenses

In terms of the amount of expense that an individual or family should be required to incur before catastrophic coverage begins, our industry proposal recommends the use of a single annual dollar amount of out-of-pocket expenses for covered benefits. We feel that this approach is more equitable and more efficient and easier to administer than the benefit periods and separate hospital and medical deductibles employed in S. 748.

Extension provisions

In my testimony, I pointed to the temporarily unemployed, those left without coverage due to death or divorce, and dependents under 26 (older if disabled) as three of the most regrettable gaps in coverage. To close these gaps, we proposed a 180-day continuation of benefits. We feel that this approach is preferable to the open enrollment after a "change in circumstances" as in S. 748, and recommend that the 90-day continuation of coverage for dependents and terminated employees currently contained in S. 748 be lengthened to 180 days. This extension of the continuation of coverage period can be accomplished for a relatively modest marginal increase in cost and would significantly improve protection for these people.

State pools

Both our proposal and S. 748 propose the establishment of State residual market mechanisms, commonly referred to as "pools," in order to assure the availability of coverage to individuals who cannot obtain protection elsewhere. We strongly recommend that any legislation establishing State pools should require self-insured employers to be subject to the operating assessments that may be levied on pool participants. While benefit standards and other legislative provisions will assure adequate coverage for the employees of self-insured employers, it is also necessary to assure that these employers fulfill their obligation within the system as a whole

through appropriate regulation of their activities. Further, the provisions in S. 748 which require state pools to have annual open enrollment periods, and which disallow pre-existing condition exclusions or premium variations dependent upon conditions of health, will significantly encourage adverse selection. We recommend, instead, that there be continuous open enrollment in the pools, together with a pre-existing condition limitation. This limitation would exclude during the first 6 months of coverage payment for any condition that manifested itself during the 6-month period prior to commencement of coverage. If this were combined with a provision removing the pre-existing condition limitation for persons who have been continuously insured for 6 months immediately prior to eligibility for the pool, the system would be both sound and equitable.

Tax incentives/disincentives

We feel that a combination of tax incentives and disincentives is an appropriate means of encouraging purchase of catastrophic insurance protection. We recognize the need to develop a tax program which alleviates the financial pressures for specially affected employers and we applaud the efforts of both S. 748 and S. 760 to do so. As I mentioned in my testimony, we would be happy to work with the Committee in the design of such tax provisions.

Other regulation

Naturally, Congress is concerned with assuring that catastrophic coverage is available to the entire population. We believe that a combination of appropriate tax incentives and penalties and the establishment of state availability pools will achieve this objective. The health insurance industry is already adequately regulated at the state level, and State pools will subject the industry to further state regulatory oversight. We do not think it necessary, therefore, to provide for any direct participation by the Secretary of DHEW in the health insurance marketplace, as S. 760 would require.

Thank you for this opportunity to amplify my oral testimony. We continue our industry's offer to explore these and other issues with members of the committee and staff at their convenience.

ROBERT D. KILPATRICK,
President.

Mr. KILPATRICK. The second advantage, Senator, is that it can be implemented without a tax increase.

Third, the proposal is modest in cost to the economy, in general, and easily implemented, since it is essentially an extension of existing private sector insurance programs.

Fourth, it avoids the need to create a massive new regulatory mechanism and an expensive and unnecessary Federal bureaucracy.

Fifth, it maintains vital employer participation in cost-containment efforts by continuing to relate premium costs to the health experience of the employer's work force. Containing costs is a major concern of employers and their constructive efforts must be encouraged.

Sixth, it provides a unique opportunity to use the public policy-making power of the Government and the expertise of the private sector to reach a goal that will ultimately benefit all Americans.

I have four charts that I would like to share with you, gentlemen, to put my testimony in perspective, particularly as it relates to cost.

Now, the chart on your left relates to the incremental cost that would be needed to extend our proposal to the employed population. If you look over to the left, we have talked about the employed who have some coverage now—and I mentioned about 150 million people have some health insurance coverage now.

If you look across and if we assume, for example, you had an out-of-pocket deductible of $3,000 before the catastrophic program

kicked in, that would be 0.002 percent of payroll in this country. That is about $25 million.

Or, if you look at the 5 percent or so——

The CHARIMAN. Would you mind repeating that first figure, how much money?

Mr. KILPATRICK. About $25 million.

The CHAIRMAN. All right.

Mr. KILPATRICK. Without coverage. Those who are without coverage, employed, but without coverage. It would cost more to extend it to them on that same $3,000 basis. That is eighty-three-thousandths.

Now, to make the much needed extension to cover that 3 million young people who almost every year fall right out of their parents' insurance coverage but do not enter the work force, that would cost, as you see across, to provide this program to them 0.037 percent.

Totaling it up down there, gentlemen, we have only a little more than $1.4 billion in cost to the economy, spread right across the economy.

Now, look at the chart on the right, to give you a better perspective, too, on the incremental cost. Bear in mind, these are incremental because they are costs over exiting programs.

They do not involve any new taxes at all.

To extend coverage to certain groups, again as a percent of total payroll, the temporarily unemployed I mentioned—principally those people who are laid off, lose their jobs, and both of you, I suspect, remember the troubles that we had in 1974 when so many of our citizens lost their coverage—to extend that coverage for 180 days, the same benefits they have the day they are laid off. Our actuaries come up with a figure of only .056 percent.

The CHAIRMAN. How much money is that?

Mr. KILPATRICK. About $600 million. I have the exact figure here; $672 million to provide coverage to the temporarily unemployed. For those people unfortunate enough to lose the wage earner in the family, widows, widowers, a divorce, a legal separation, the cost is also fairly negligible.

The CHAIRMAN. About $150 million?

Mr. KILPATRICK. About $200 million, Senator.

Here the cost figures for these, this one here converts those payroll figures to dollars. This puts it into dollars. You can see here, gentlemen, on the left for the employed population we are talking about a cost distributed throughout the economy for a $3,000 deductible of about $1.4 billion to provide all of these things on the right here, particularly on a 180-day basis, you are talking about around $900 million, or you come up with a total cost of this package to the economy of about $2.4 billion.

To put that in perspective relative to the cost that is paid now for health insurance in the country—employers typically, the combination of employee-employer contributions—are spending 5.5 percent of payroll for health benefits. To provide this program would add another 0.2 to that. It would bring it to 5.7 percent to provide everything we have talked about here.

The CHAIRMAN. Let me say this, Mr. Kilpatrick, if I might interject at this point. When you told me that figure some time ago,

about a week or so ago, I could not believe that you could do all of that with such a small amount of money, and our staff has difficulty in believing that, too. That is why we want to carefully check over your figures, compare those with the Department's to see if those figures really can be substantiated.

I want to interrogate you in some detail about how that could be done.

If what you are saying is correct, you could insure people down to a $1,000 deductible for the part B type coverage, and 60 days and beyond for hospitilization at a net cost of $3,480 million. This is the same thing we are talking about, but with a much higher deductible, and it would cost about $7 billion.

Mr. KILPATRICK. The difference, Sentor, is that you are talking about a payroll tax of a certain amount. I forget the exact number.

The CHAIRMAN. 1 percent.

Mr. KILPATRICK. We are talking about incremental c[illegible] here added on to an already very extensive program of health insurance. These are incremental costs. They add to it, and I believe the figures are correct on the assumptions that we have made. As a matter of fact, we think we have made fairly conservative estimates

Senator DOLE. They do not cover the unemployed.

The CHAIRMAN. Those figures cover the unemployed, do they not?

Mr. KILPATRICK. They cover the unemployed, Senator, for 6 months, for a period of 6 months they would be picked up.

Mr. MARKUS. What is excluded are the medicare populations and the poor.

Mr. KILPATRICK. The unemployed, experience has shown that for those people who are laid off, most of them return to their old jobs or get other jobs and are therefore under the program again. About 90 percent go back. It does not take care of the long-term, hardcore unemployed.

One other chart, if I may, Mr. Chairman. What the highlights are of this proposal, very briefly, with significant improvements, in medicaid and medicare we would have a universally available catastrophic health insurance program with a single total dollar deductible. We have talked about $2,000 to $4,000 for individual; $4,000 to $8,000 per family. You would have to have strong incentives to insure compliance.

We believe the proper mechanism is tax incentives and tax disincentives. There are some significant gaps that this proposal covers. First, it does cover the people who are laid off, temporarily unemployed. It does cover the temporarily uinsured through a family tragedy. It does cover those young people who do not now have coverage, roughly 3 million of them.

It does provide State pools and we have some experience with that already, and it looks to States, State pools, to cover those very high risk uninsurables who would not qualify for public programs such as medicaid and might not be insurable under some of these programs here.

To have a universal program, it will require significant and, I think, fairly costly changes in medicare and medicaid. To implement this for the working population—the vast majority of people

in this country, and fill significant gaps—you could do it without a tax increase—and it could be implemented fairly quickly.

The major advantages that we see are these. It responds to a critical need. It is my belief that the time is now; the conditions are ripe to take this significant first step. It is modest in cost as far as the working population is concerned, $2 billion-plus distributed across the economy, a fraction of the payroll. It does not require new taxes to extend it to the working population. It capitalizes on the strengths of the existing private sector. No nation on Earth has had concerted national health insurance, ever had anything like the base of the private insurance we have in this country.

It avoids adding to the Federal bureaucracy. My belief, gentlemen, is that the Federal government is already overextended in its administrative capacity and this does not provide an opportunity to burden it further.

It encourages cost containment by setting the deductible high enough, at $3,000 or so, so that the patient has some incentive for cost containment. It encourages employers, since premium costs will be related to their claim experience, to have an interest in it, and importantly, it encourages insurance companies.

The insurance business in this country is a very, very competitive business. The association I represent today has more than 300 companies. We are all selling health insurance. There is a strong incentive on us to do our very best towards cost containment.

Mr. Chairman, this concludes my formal remarks. I appreciate very much your attention and your questions and my colleagues and I will be happy to answer any questions you may have.

[The attachments to the statement of Mr. Kilpatrick follow:]

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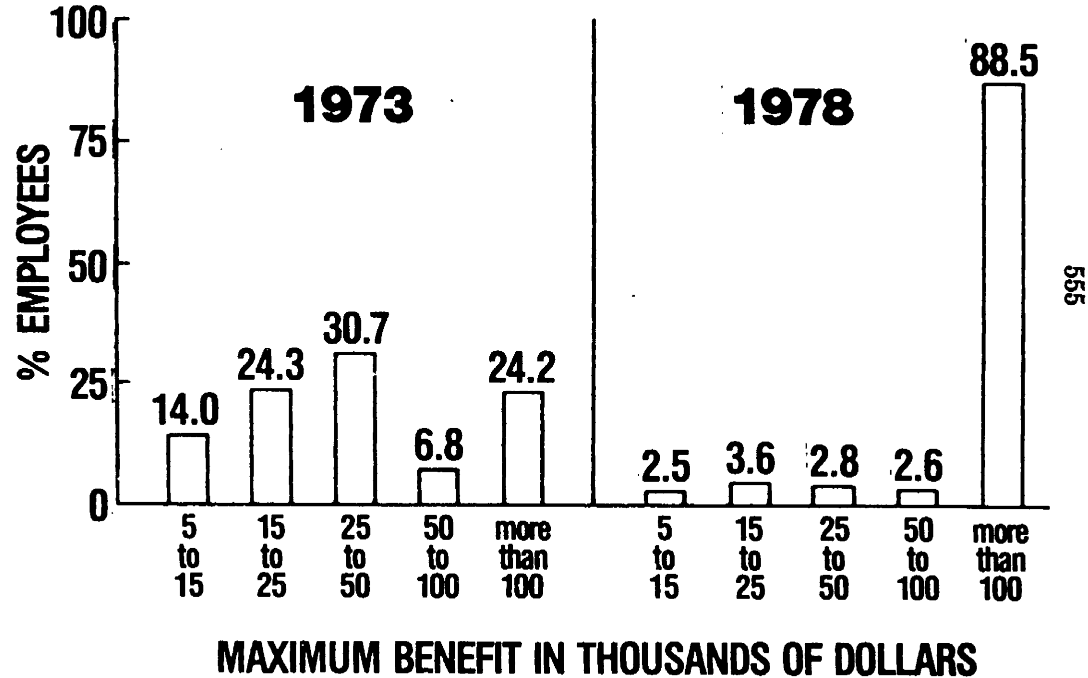
TRENDS IN PRIVATE CATASTROPHIC HEALTH INSURANCE



CATASTROPHIC HEALTH INSURANCE

ESTIMATES OF THE INCREMENTAL COST TO COVER EMPLOYED POPULATION & DEPENDENTS AS % OF TOTAL PAYROLL

	PER PERSON DEDUCTIBLE				
	$1,000	$2,000	$3,000	$4,000	$5,000
EMPLOYED					
WITH SOME COVERAGE	.040	.011	.002	—	—
WITHOUT COVERAGE	.173	.112	.083	.061	.053
DEPENDENTS					
19-26 YEAR OLDS	.077	.050	.037	.027	.024
	.290	.173	.122	.088	.077

CATASTROPHIC HEALTH INSURANCE

ESTIMATES OF THE INCREMENTAL COST TO EXTEND COVERAGE FOR SPECIAL GROUPS AS % OF TOTAL PAYROLL

	60 DAYS	90 DAYS	180 DAYS
TEMPORARILY UNEMPLOYED	.034	.045	.056
TEMPORARILY UNINSURED	.006	.008	.017

HIGHLIGHTS OF THE PROPOSAL

- UNIVERSALLY AVAILABLE CATASTROPHIC HEALTH INSURANCE
  - SINGLE TOTAL DOLLAR DEDUCTIBLE
- STRONG INCENTIVES TO ASSURE COMPLIANCE
- EXTENSIONS OF COVERAGE
  - TEMPORARILY UNEMPLOYED
  - TEMPORARILY UNINSURED
  - DEPENDENTS TO AGE 26
- STATE AVAILABILITY POOLS
- MEDICAID AND MEDICARE IMPROVEMENTS

MAJOR ADVANTAGES

- RESPONDS TO CRITICAL NEEDS
- RELATIVELY MODEST IN COST — $2.4 BILLION
- DOES NOT REQUIRE NEW TAXES
- CAPITALIZES ON THE STRENGTHS OF THE EXISTING PRIVATE SECTOR
- AVOIDS ADDING TO THE FEDERAL BUREAUCRACY
- ENCOURAGES COST CONTAINMENT

The CHAIRMAN. I will ask one or more that occur to me.

Do you think that what you are advocating could be done, put into place, by January of 1980?

Mr. KILPATRICK. Senator, I think that this program could be effective January 1, 1980, if we used all of 1980 as a phase-in period. Most private health insurance contracts, group and individual, have an annual renewal date that comes due throughout the year. Those with a January 1 date, I think could be implemented then.

I would believe that the State pools probably could not be created by the States until 1981.

My belief is, if we made it effective January 1, 1980, a law that year to implement the whole program could be in effect by January, 1981.

The CHAIRMAN. Right.

Maybe by putting your imagination to it, you may figure out how we can do it sooner. It is amazing what people can do when they want to do something.

I used to have a friend in the Navy who was in the insurance business and he would go out and try to sell some fellow and maybe he had not quite been able to make the sale. Then the guy had an accident. Well, my friend would say, just between us, the deal was made yesterday; I just had not gotten around to writing up the policy, but we have a good faith commitment to take care of you.

Have you ever heard of something like that being done?

Mr. KILPATRICK. Is that fellow still in the job market? The point is, if the company wants the business bad enough, sometimes they will go the extra mile to get it. If we want the job done, it seems to me that there may be some ways to do it. Is that correct, or not?

Mr. KILPATRICK. Senator, I do not think the problem is with the insurance companies. I think that we could do our part of this. I am not sure of the political acceptability of it because of the burdens it would lay on the employers and I also really do not believe that the states themselves could get their act together on the state pools, which is a vital part.

The CHAIRMAN. It would seem to me, if we say we want this to be done and we mandated it, a lot of this could even be done on an informal basis where somebody agreed starting on January 1, you are covered.

Mr. KILPATRICK. If it were mandated, the insurance companies would get their piece of it done without question.

The CHAIRMAN. Does what you have in mind envisioned rewriting quite a few policies? People like Blue Cross try to insure first-dollar coverage. Some of us have always felt that tends to be inflationary. It causes the patient to have no concern about how much something is going to cost. Where there is a copay or deductible feature, the patient would be more inclined to complain about a high cost charge by the doctor or the hospital, so that he would join his efforts with those on the insurance end to try to hold the price down.

Does this proposition you have rely in part on rewriting some of those policies and reducing the first dollar?

Mr. KILPATRICK. No, sir, it does not.

The CHAIRMAN. You could reduce the cost if you wanted to by giving employers the option of reducing some of the front-end coverage.

Mr. KILPATRICK. Yes; it is possible, relying on the private sector. If this were mandated, some employees might want to make some changes in the underlying coverage and produce better cost-containment features or distribute the money differently, their contribution differently.

The CHAIRMAN. It seems to me if they want to do that, they ought to have that privilege.

Mr. KILPATRICK. I agree with you totally. In my view, we should rely on the mechanism including the business that is already there and the existing mechanism that is already there to the fullest extent possible.

The CHAIRMAN. Here is one other point that occurred to me. I should think there would be a lot of people concerned about the increase in cost of social security taxes, of which medicare is a part. Over the years the cost of medicare, particularly with the coverage of the disabled getting greater and greater, has forced us into a higher and higher social security tax than otherwise would be the case.

What is your reaction?

I am asking you to talk for the whole industry, but what if we elected to take the route you are advocating, and also gradually began to shift some of this medicare cost over by simply saying the first year or thereafter when you retire, you would be covered. Then a year or so later, you would be covered for 2 years after you retire, then 3 years, then 4 years, and so forth.

How do you think the industry would react if we asked them to load the policy to take care of the aged in some fashion?

Mr. KILPATRICK. I do not know the answer, Senator. I will give you my opinion.

I believe that, in time, we should move toward a program that does not differentiate between the poor and the elderly, if you will. I think there are two parts to it. One, a financial responsibility for the poor and elderly which I think should be born by the economy through taxes. The administrative responsibility—and a large part of this is administrative—might very well be something that the private sector could have a broader role than is now contemplated. It would depend on the form.

So in the latter part, the administrative responsibility, it is hard to answer, but I do believe the financial responsibility is clearly the responsibility of taxes, and I believe if we take a significant first step, and if we are not too impatient and learn a little bit as we go, we can make improvements from time to time.

It is important to me that we take a step. We have been debating this thing—someone this morning said for a decade, but actually we have been debating it since Woodrow Wilson was President, and we can do what I talk about here, and frankly many of the things that you advocate in your bills, we can do these things now. We do not have to wait forever to get this done.

This is not to say that this is where America should ultimately be, but until we get started, we do not know where we should be.

The CHAIRMAN. I believe you are right about that, Mr. Kilpatrick. Rather than continue to argue about doing everything that people think might be a good idea, if we concentrate on doing what can be done now, particularly for the people who are going to suffer and die during the next 2 and 3 years and then do what we can next year and the year after that to improve and try to find better answers, I think we will all be better off than to keep delaying things looking for an answer to everything.

If we would have tried to do that in other areas, we never would have gotten anywhere in this country, even winning our independence. It was a long, drawn-out war. If you think you are going to achieve everything the first day, that is not true.

Senator Dole?

Senator DOLE. I just have a couple of questions. You use a dollar deductible, some mix dollars and days. Do you think it is just better to stick with the dollar deductible rather than a mixed dollar and hospital stay?

Mr. KILPATRICK. I do, Senator. I think a fixed dollar is simpler, much easier for the public and those who are administering it to understand. I think it is more effective in the sense of equity if you will and also the days approach I have never been impressed with, because it encourages people to stay in the hospital to qualify.

We think that whether the medical expenses is incurred in or out of the hospital, it should be made as simple as possible. So we do think that a single, annual dollar deductible is the best approach.

We have had a lot of experience with that in our industry and it really does seem to work better.

Senator DOLE. I do not know offhand, but I imagine that you could reach a deductible very quickly.

Mr. KILPATRICK. You could.

Senator DOLE. In a day, a half a day.

What about cost sharing? Do you believe, as far as premiums are concerned, it ought to be cost sharing with the employee and the employer?

Mr. KILPATRICK. Senator, I believe, first of all, that the bill should not mandate that. Presently, there is a wide, wide variety of ways that costs are shared between employer and employee. Some employers pay all; almost all pay some portion, and the employer portion is growing as time goes on. It is also subject to collective bargaining.

My belief is that the bill should not attempt to decide what an employer should do between himself and his employee. There are collective bargaining processes and there are company decisions that are made relative to that. I believe we should leave that freedom intact. It is one of the important features of a private system.

Senator DOLE. There is also the fact that the employee would know before the illness that he is participating in a program, would know something about the benefits and also, hopefully, about the cost because of his direct participation.

Mr. KILPATRICK. My own personal view is that there should be employee participation in the cost of his health insurance program. Some of the areas, particularly those with strong unions that have

been negotiating so that the employers pay the whole cost of it, I think you would have more effective cost containment if the employee is involved.

Senator DOLE. What do you do about the poor and elderly? Do you see any role for private insurers?

Mr. KILPATRICK. As I commented earlier, I think the financial responsibility for the poor and elderly should be borne by taxes, distributed through the economy. It is quite possible that there could be a more significant role for private insurers to assume administrative responsibility for the poor and the elderly.

So, I think that if we could deal with the financial issue as a first step in the longer term, one of the learnings is that there might be a role for private industry to administer programs for the poor and the elderly. That might be more effective than having Government administer it itself. I do not know.

Senator DOLE. Who do you consider to be high risk? Who does that include?

Mr. KILPATRICK. In terms of individual insurance, it would be people who have had a recent heart attack, for example. In terms of group insurance where most of this is, typically some industry hazard, saw mills, dynamite manufacturers, this kind of thing.

Senator DOLE. Nuclear plants?

Mr. KILPATRICK. No, we do not consider nuclear plants high risk.

Senator DOLE. Still, after yesterday?

Mr. KILPATRICK. I will reserve that.

Senator DOLE. Senator Long had one question that he did not have a chance to ask. There are about 150 million people who are insured under various types of major medical policies, as you pointed out. One thing that has been suggested by other witnesses that if all we are going to do is protect against catastrophic expenses we would further encourage costly and excessive and inappropriate medical and hospital care.

Has that been your experience? Have we encouraged costly and excessive medical care because of this?

Mr. KILPATRICK. It is not catastrophic that is the cause of the problems we have had in our medical sector. It is the first dollar, the much broader type of benefits, before you get to the catastrophic illness.

Catastrophic illness is a real catastrophe. The ones we read about so often in the paper, the ones that should be covered, they are terribly infrequent. They are costly when they occur, but as a percentage of total claim payments, they are quite limited.

I suppose that it could be argued that increasing the medical insurance bill in this country, the insured bill by 0.2 of a point is inflationary. Any increase in costs, perhaps, is inflationary, but the facts are that the economy is already bearing the cost of those unfortunate people. I do not see this as terribly inflationary, I really do not. I see it as affordable.

I think that the time is ripe now, the country is ready for this type of innovative approach, and I think the circumstances are right.

Senator DOLE. We would appreciate it if you would comment and make available for the record your analysis and views on S. 748 the legislation introduced by myself, Senator Danforth and Senator

Domenici and on S. 760 the legislation introduced by Senator Long on Monday of this week.[1]

This, at least for the time being, concludes the hearings. I appreciate very much your testimony and the testimony of other witnesses for the past 3 days.

Thank you.

[Whereupon, at 1:15 p.m., the committee recessed, to reconvene at the call of the Chair.]

[By direction of the chairman the following communications were made a part of the hearing record:]

STATEMENT OF SENATOR GARY HART

Mr. Chairman, I appreciate very much the opportunity to testify on the matter of national health care legislation because it is one of the most important domestic issues facing the country today. It takes on particular significance now because, in addition to the need to respond to unmet health care requirements of many citizens, the current health care system is one of the primary contributors to the inflation. With the Federal government paying almost one-third of the nation's medical bills, national health care legislation becomes a necessity to help reduce inflation and control Federal spending. I commend you and the Committee for moving promptly and decisively to begin the debate needed on this subject.

Mr. Chairman, it is with mixed emotions that I testify on S. 351 today. The bill is an admirable response to a health concern often expressed by the public—fear of financial catastrophe resulting from medical expenses. This concern must be addressed in any national health care debate in this Congress. I am aware that your bill represents the end product of several years' effort and applaud you for your tremendous efforts in this area.

I am concerned that any proposal for catastrophic health insurance alone does not address the central issue of the national health care debate—the need to reform the present system. Our current medical care delivery system provides services for most Americans but does not adequately serve the needs of at least two major groups—children and the elderly, particularly those who are poor. It is cost-ineffective and inflationary because it is dominated by third-party payments so that there is no focus of responsibility for cost control. Controls which do exist are usually government-mandated revenue caps which tend to be inflexible, unfair and ineffective; the cost increases in Medicare despite cost controls are a good example. Physicians, the true controllers of health care costs, have little or no incentive to hold them down. Cost controls implemented through cost reimbursement do not provide incentive to do anything other than raise allowable costs. That is part of the reason why health care costs have risen at twice the rate of the Consumer Price Index for the past several years.

Perhaps the greatest deficiency of the present system is that is directs most of our resources toward costly hospital-based, crisis-type care instead of toward more cost-effective preventive care. Real improvement in the public health and restraint of health care inflation lies with routine, periodic medical attention emphasizing preventive services and health promotion throughout life rather than with exotic and expensive procedures.

Mr. Chairman, any national health care legislation passed by the Congress should embody at least the following principles:

1. First and foremost, it should promote a more reasonable balance between cost-efficient routine health care and the costly crisis care which dominates our present system. It is of dubious economic and health value to continue allocating most of the country's health care resources to expensive curative procedures after a lifetime of too little medical attention and bad health habits.

2. It should establish positive incentives for physicians to hold down health care expenses while providing quality medical services. The institutionalization of the present third-party payer/cost reimbursement system will lead to yet higher costs and necessitate ven more government interference by regulation instead of expenditures for delivery of services.

3. It should provide protection for everyone against financial ruin as a result of needed medical expenses. A financial burden on a family is, by definition, dependent upon economic resources; any catastrophic insurance program should therefore be linked to income.

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[1] See p. 550

4. It should be administratively and fiscally reasonable. Legislation reorganizing the present system must be phased in as administrative and fiscal resources permit.

Mr. Chairman, my concern with S. 351 is that it does not address many of the reforms I have outlined. Its passage would certainly alleviate he legitimate need of many people but it would certainly blunt the effort to the present health care delivery system for everyone. Also, it places a disproportionate, heavy burden upon indigent and low-income individuals.

Mr. Chairman, I will introduce a bill which addresses not only the question of catastrophic health insurance but also incorporates necessary reforms. I would like to briefly outline its provisions. My plan features as its centerpiece the provision of comprehensive health care services to pregnant women and pre-school age children with emphasis on routine and preventive-type services. It would be universally available with no means test, deductible or co-insurance to bar access.

Pregnant women and children are the logical place to begin such a program because they represent the nation's future health care requirements and costs. Promoting their good health now will lessen the incidence of ill health and the attendant cost of treatment in the future. The care they require is mostly routine, predictable, easily produceable and relatively cheap. For these reasons, they are unlikely to overutilize services and bust the budget. It also makes quality review much easier than that for other types of care.

The Federal government would pay participating physicians on a per-capita basis. There would be no fee-setting, revenue caps or other government interference except to ensure that the agreed quality services were provided in return for the payment. This arrangement would provide positive incentive for the physician to make good economic as well as medical decisions while reducing much of the paperwork involved in fee-for-service claims. Participation by physicians and patients would be entirely voluntary and would not preclude a simultaneous fee-for-service practice. However, the capitation fee would be paid only on behalf of patients enrolled with a participating physician.

While it may be desirable to provide everyone with comprehensive health care under this arrangement, it is clear that other population groups will have to be phased in as administrative and fiscal resources allow. To protect everyone against catastrophic medical expenses, my plan provides a government-paid insurance policy purchased through the private sector for all legal residents of the United States. The policy would pay 50 percent of out-of-pocket medical expenses which exceed 10 percent of adjusted gross income and 100 percent of those expenses exceeding 20 percent of income. No family would pay more than 15 percent of their annual income for needed medical care. There would be no restriction on having any other health insurance, although payment by the catastrophic policy would be made only after the 10 percent-of-income deductible had been satisfied. This built-in cost control places the burden for generally affordable expenses on the individual but provides relief at the point where expenses become unaffordable. The key feature is that there would be the same relative financial burden placed on all families, providing particular assistance to the poor who often cannot afford even routine medical care.

The administrative and quality review mechanisms specified in my bill make maximum use of existing successful organizations so that a new bureaucracy will not be created. The bill particularly specifies involvement by local providers and consumers on health service area boards which will negotiate capitation rates and make recommendations for program implementation and improvement.

Mr. Chairman, the system reform proposed in my bill would save money now and in the future. Two examples reflect the potential savings this legislation can being about. In 1978, this country paid $10.6 billion for 3 million births and the treatment of 17 million pre-school-age children. If those services had been provided in the manner intended by my plan, the cost would have been $4.4 billion. That is a savings of $6.2 billion of the national health care total in one year. It will cost an average $50,000 in 1978 dollars to treat each child born last year over that child's lifetime if we retain the present system. If instead, each child were to be provided the routine, preventive services advocated in my plan, that cost could be reduced by 20 percent or more. A 20 percent reduction in the national health care bill translates into tremendous yearly savings. And, as significant as the yearly figures are, they pale in comparison to the future savings to be had by making the cost-effective policy changes set forth in my legislation. Neither I nor any other responsible member of this body can advocate moving recklessly into the establishment of a new national health care system. But no one can deny that the rapid rise in the nation's health care bill is detrimental to the economic well-being of the country. And, the fact that the level of public health has not increased commensurate with

the increase in cost illustrates the inherently inefficient nature of the current system.

Mr. Chairman, I share with my colleagues a strong commitment to balance the Federal budget. I have defined a detailed, economically informed and practicable plan to accomplish this at other times on the Floor of the Senate as well as during Budget Committee deliberations. I want to assure my colleagues that the health care plan I propose today is fully compatible with my proposal to balance the Federal budget by fiscal year 1981 for several reasons.

First, the legislation states specifically that benefits under this program cannot begin before January of 1982. As a practical matter, the bulk of the program costs could not accrue earlier than fiscal year 1982. Start-up costs to initiate the necessary organization which would eventually deliver the benefits would equal approximately $700 million spread over the course of two years. These expenses can be accommodated within the budget I envision for 1981, 1982, and the out years thereafter.

Second, our best estimate to date is that the cost of this legislation if fully implemented would be about $18 billion a year. However, this program would replace some existing Federal health care programs which cost about $5 billion. The net cost to the Federal budget in 1982 will be about $13 billion. In fiscal year 1982, my proposal for a balanced budget will produce a Federal surplus which would pay for this new program and therefore retain the balanced budget we will have achieved in 1981.

Third, my plan has built-in cost controls. In the Maternal and Child health protions of the bill, overall costs for medical benefits are held down by the cost-saving incentives of a capitation payment program. The catastrophic insurance I suggest will not pay for expenses in the range incurred by most people. The burden for generally affordable expenses will continue to be borne by the individual and relief would be available only after the point where expenses as determined by income become unaffordable. This is an incentive to all to avoid unnecessary health expenditures.

Fourth, my proposal avoids the creation of a new bureaucracy. My proposal would make maximum use of existing successful organizations for administration and quality review.

Fifth, there would be the long-term savings for Federal spending I described earlier resulting from the emphasis placed on preventive health care in my legislation.

Finally, my legislation contains a built-in guard against runaway costs for an inefficient or unaccountable program—it contains a sunset clause. This sunset provision requires that Congress evaluate the program after five years to determine its success before the program can be expanded or even before it can be reauthorized.

Mr. Chairman, I welcome advice from you and other health care experts on how to build upon these basic concepts. We all share the same fundamental goal of providing everyone with the best care available at the lowest reasonable cost. We are all aware that the health and economic consequences of continued delay in effecting reform of the present system are ominous. I hope you and the Committee will give this proposal the benefit of your thoughtful consideration so that we can move forward toward our common goal. Thank you.

Statement of Sister Regina Foppe, O.L.V.M., Representing the Diocese of Amarillo

The Honorable Russell B. Long, Chairman of the Senate Finance Committee; The Honorable Herman E. Talmadge, Chairman of the Senate Health Committee; and members of the same, Gentlemen, I am Sister Regina Foppe, O.L.V.M., Director of Social Action Services for the Diocese of Amarillo, with residence in Lubbock, Texas, District 19. I submit in writing this testimony against Catastrophic National Health Insurance, since my written requests of February 19th and March 2nd went unanswered, and my followup phone calls of March 7th and March 16th were denied on the grounds too many had requested to testify. Were they all before February 19th?

District 19, my territory, covers 46 counties, including much of District 13 and a portion of District 17. I represent the little people who are seldom heard and less listened to because it is not economically feasible for them to leave their jobs. They lack the finances for travel, find it difficult to express their needs, are in failing health or are incapacitated. Northwest Texas rates above the national average for the percentage of persons living at poverty or below poverty level.

Much of what I say regarding persons living in the geographical area of the Diocese of Amarillo is relevant for much of the State of Texas. In a testimony I presented here on November 12, 1975 before the Honorable Daniel Rostenkowski and Members of the Health Subcommittee of the House Ways and Means Committee, I noted that the Census of 1970 shows Texas having a population of 11,196,730. Using a conservative estimate of 150 percent of Poverty Level, 2,832.773 persons are in this group. Allowing fifty per cent of the elderly, age 65 and over, 171,874, are without any type of health insurance, including Medicare or Medicaid, either through ignorance or denial. To this number add the 316,194 persons under age 18 on AFDC receiving Medicaid, then, allowing for an additional adult in the same household (household of four) receiving the same benefits, which is not always the case, another 105,398 can be added, totalling 593,466. In the 150 percent of poverty levels there would remain 2,239,307 people in Texas without any health insurance coverage whatsoever. For the most part, these are the low-income blue collar workers with their families who struggle to provide for our needs and services and the elderly who have struggled to build our state and our nation.

Let us look at this more specifically for West Texas through a recent survey. This health insurance poll was taken during the last six weeks in six parish churches, three in Lubbock, a city of approximately 175,000, and three in Ralls, Lorenzo and Crosbyton, rural parishes in Crosby County. All the parishioners are of Hispanic descent. In the table attached[1] you will note that of the 1,014 Heads of Family, 728 or sixty-four per cent (63.8 percent) had health insurance. Of the 2,590 family members 1,875 or fifty-two percent (52 percent) had health insurance. Of the total insured a little less than four per cent (4 percent) had coverage under Medicare and/or Medicaid, a minimal figure in such a broad survey. Overall, fifty per cent (50 percent) of those polled had no health insurance.

I read with concern the statement on S.B. 350 and 351 in the Congressional Record of February 6, 1979, p. S1130ff. My reaction was:

1. The Sponsors of this bill are completely ignorant of the needs of the working poor and the elderly. Of the working poor and their families in this area, more than ninety-five per cent (95 percent) have no health insurance whatsoever. The other five percent (5 percent) have coverage ranging from eighty per cent (80 percent) decreasing to twenty per cent (20 percent). Think for a moment what a cost it would be to insure them under your plan under Medicaid by the government before "catastrophic" insurance would carry the balance! True, for some death would have taken over, for others, if they were fortunate enough to be cared for by a doctor and admitted to a hospital, they will be paying on that medical debt for the next ten (10) to fifty (50) years.

For the elderly on Medicare without supplemental insurance, most are left with paying the costs of prescriptions, partial doctors' fees and partial hospital costs, amounting to sixty-two per cent (62 percent) of these costs per year.

The answer given to all this is "inflation." But let's reduce "inflation" to the reality of daily living for the working poor and the elderly.

Since 1970 inflation has taken its toll on basics and the first to be affected are the working poor, the elderly and disabled and those on welfare.

Since 1970 they are being deprived of: (1) Nutritional food, prices soaring 94 percent; (2) energy/fuel, prices soaring 118 percent; (3) housing/rental costs, prices soaring 88% (and much of what they must exist in is substandard and has a multiplying costs factor on energy/fuel ranging from 200 to 300 per cent; and (4) medical care costs, prices soaring 97 percent.[2]

Moving one step further, ninety-five per cent (95 percent) of the middle and upper income families listed on the survey have nothing to gain from the catastrophic health insurance. It is a bill to help the "privileged few" who have a catastrophe. It lacks promotion of the general well-being in health care of the American people. Let's scrap it.

Thirteen reasons why the "catastrophic" insurance won't work:

1. It will accelerate the current inflation of health care costs by adding the incentives for very expensive care and discentives for more cost-effective preventive and ambulatory care.

2. It will divert public attention from serious consideration of a comprehensive national health insurance program on the theory that the most serious problems were being dealt with by providing coverage for catastrophic expenses.

3. It will do nothing to provide protection against the expense of long-term care, a major source of catastrophic cost.

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[1] Health Insurance Poll, Lubbock and Crosby Counties, Appendix I.

[2] "People and Taxes," Vol. VII, No. 1 and 2/January-February, 1979. Public Citizens Tax Reform Research Group, Washington, D.C. 20044, pp. 2-3.

4. It will invite providers of services to raise prices, especially for the seriously ill and dying on the excuse that the family or individual would thereby become eligible for catastrophic benefits. The net result would be a price rise in all aspects of health care.

5. It will create incentives for longer hospitalization and other institutional care. There would be tremendous pressure to keep the patient in the hospital until the trigger point for catastropic was reached.

6. It will weaken efforts to institute quality controls since catastrophic coverage would not take effect until after the 60th day of hospitalization (and consequently any controls written into the bill could not be instituted until after the 60th day of hospitalization).

7. It will further distort the allocation of national health care resources because of the high deductibles, the overwhelming emphasis on catastrophic disease and the neglect of early diagnosis of disease, home health care and other essential services.

8. It will aggravate the maldistribution of services caused by economic factors since the major beneficiaries of catastrophic coverage would be those who are able to spend the deductible amounts.

9. It will further skew manpower away from rural and small town areas by increasing the funds available to pay lucrative specialities in the urban areas.

10. It will fail to deal with access to care by leaving the present delivery system intact.

11. It will require the poor and the working people to pay for a program that will mostly benefit the rich. Also, less healthy employer groups will pay more because insurance companies consider them "higher risks."

12. It will increase the cost of Medicaid and Medicare and other proprograms.

13. It will increase the fragmentation and complexities of the financing system.

What the American people need, first of all, is a national health insurance that gives adequate coverage to every Americna in early stages of illness and educates the American public in preventive medicine. With it, but secondary, should be a catastrophic national health care plan.

Today within my geographical assignment, people are denied admittance to a hospital because they cannot pay the deposit or have the acceptable insurance policy. In most cases, they continue to carry the burden silently and alone, only occasionally does a case draw public attention through the media statewide or nationwide as did the child's death in Dimmitt, Texas, January 26 of this year[3] or that of the incident at Littlefield, Texas on March 4, 1976,[4] both of which happened in Northwest Texas.

Some doctors' offices have signs, "No Medicare and Medicaid Clients acccepted." Others carry the placards in waiting and examining rooms stating, "Cash payments are to be made following each visit and/or exam" which places the burden on the client to try to get the reimbursement from the insurance firm, often unsuccessfully, with the result that they are forced to exist without the basic necessities of life. These posted notices speak clearly. We need to find a better way to finance our "health care delivery system" and keep people and their health at the top of the priority list, rather than the "dollar" and "greed."

Billings from hospitals on Health Sciences Centers are in themselves very complex and in my opinion not intended for the average lay person to comprehend their meaning. Apparently, it is hoped that people will simply be docile and pay them.

A case from Floydada, Texas was recently called to my attention. Three of the teenage children in one family, along with an aunt, were involved in an accident. By ambulance they were first transported to the nearest hospital, but due to multiple injuries referred to the Texas Tech University School of Medicine Health Sciences Center at Lubbock. One of the young women died within 24 hours. The others were released for the funeral, a stay of less than three days each. The teenagers' parents had what is considered a good insurance: $100 deductible, 80 percent hospital and medical coverage. The billing maze was astronomical. Added to that a long list of medical services in the hospital were listed as not covered. When the insurance company had finally settled with the Health Sciences Center, the family were caught with the balance of $4,000 for the remaining costs of the short stay to be met from their wages of $750 gross income per month supporting the remaining six members, four of whom ar pre-school and elementary or secondary. How can this family meet these payments? With the excalation of inflation it will require ten years or more, much of it being paid in interest on this bill. And they will probably go without basic needs and have additional medical bills.

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[3] P. C. Jennings, "A Death in Dimmitt." The Texas Observer, February 16, 1979 (appendix II).
[4] Ibid., May 21, 1976 (appendix III).

The same holds true on the thousands of varied forms sent repeatedly by insurance firms to clients to be filled out months unending before clients can collect the monies paid out on their prescriptions and/or on docotrs' visit and exams. I see and hear it day in and day out.

The present "illness oriented" health care system controlled by doctors, hospitals and insurance companies is a vicious circle entrapping the American public with no end in sight of the escalation of inflation.

The statement, "we cannot afford a comprehensive, universal health care delivery system" should read: "we can no longer be without a comprehensive universal health care system." This is supported by the Texas Catholic Conference and the Texas Conference of Churches in which I hold membership.[5] The present "Health Care System" is a sick system and its sky-rocketing costs will bankrupt us and leave us with a "sick society"[6] which will require decades, if not a century, to make a complete recovery.

Thank you.

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[5] Resolutions of Texas Catholic Conference and Texas Conference of Churches, Austin, Tex. (appendix IV).

[6] "El Editor," Vol. 11, No. 16, Week of March 2-8, 1979, Lubbock, Tex. Tod Robberson, UD, Reporter, reprinted with permission, "Authorities argue indigent care obligations."

HEALTH INSURANCE ( ) URBAN PARISHES, LUBBOCK; LUBBOCK CO., TEXAS) ( ) RURAL PARISHES, CROSBY COUNTY, TEXAS) IN DIOCESE OF AMARILLO *

Parish Units	Family	Members in Family	Families Below Poverty	Members in Poverty	% Poverty	Families Above Poverty	Members Above Poverty	% Above Poverty	Head With Ins.	Head % Ins.	All/Part Paid by Self	Family Members with Ins.	Members % Insured	All/Part Paid by Insured	Paid Through Medicare	Paid Through Medicaid	Total Insured	Location (Texas)
U R B A N																		
Our L. Grace	426	1930	90	491	25%	336	1,439	75%	320	75%	179	831	55%	143	43	30	60%	Lubbock
St. Joseph	328	1514	84	399	26%	245	1,115	74%	251	77%	123	667	56%	235	39	34	61%	Lubbock
St. Patrick	84	373	16	92	25%	68	281	75%	61	73%	34	144	46%	36	12	6	55%	Lubbock
TOTAL	838	3817	190	982	25.3%	649	2,835	74.7%	632	75%	336	1642	52.3%	414	94	70	58.7%	Partial Lubbock Parishes
R U R A L																		
St. Michael	76	296	23	100	34%	53	196	66%	44	58%	19	84	33%	17	14	12	43%	Ralls, Crosby Co.
San Jose	57	268	17	90	34%	40	178	66%	36	63%	24	94	41%	16	5	4	49%	Crosbyton, Crosby Co.
San Lorenzo	43	223	16	93	42%	27	130	58%	16	37%	9	55	27%	9	2	4	32%	Lorenzo, Crosby Co.
TOTAL	176	787	56	283	36%	120	504	64%	96	52.7%	52	233	33.7%	42	21	20	41.3%	Crosby Co.
GRAND TOTALS	1014	4604	246	1,265	27%	769	3,339	75%	728	63.8%	388	1875	43%	456	115	90	50%	-

Compiled by Sister Regina Poppe, O.L.V.M., Social Action Service, Diocese of Amarillo, P. O. Box 5914, Lubbock, Texas 79417

Prepared March 1979

* Hispanic Population

A death in Dimmitt

By P. C. Jennings

Dimmitt, Hereford

On January 26 a mistrial was declared in the misdemeanor prosecution of Dimmitt, Texas, hospital administrator Jack Newsom, who was charged with refusing to admit the 11-month-old son of a farmworker for emergency care last December 8 because his parents couldn't pay for it. The child died later the same day. The six jurors who heard the case could not decide on a verdict, and Dimmitt district attorney Jimmy Davis has until February 25 to decide whether to seek a new trial. If Newsom is tried again and convicted, his maximum punishment would be a $200 fine.

Before last month's trial, P. C. Jennings traveled to the Panhandle and returned with this report. —Eds.

The houses lining U.S. Highway 385 in Hereford have a solid, prosperous look. One-story brick homes that would fit nicely in a middle-class Dallas suburb are set back on lawns divided by broad, direct driveways. Grain elevators tower over the center of town, testifying to Hereford's status as county seat of Deaf Smith County, the most productive agricultural county in Texas and hub of one of the richest agribusiness areas in the world. The people here are open and friendly, easy to talk to, proud of their heritage, their accomplishments and their way of life.

But behind their backyard lots, in some of which you can see ponies grazing, another impression of Hereford, not visible from the highway, awaits the visitor. Here you see the San Juan Mission barrio, a South Texas *colonia* improbably transplanted to this Panhandle community. Squalid shacks crowd the muddy streets. The air is thick with the stench of outdoor privies. The privately owned well that provides the residents' only water (at prices higher than city water commands) is polluted with raw sewage and has been condemned by state public health authorities. The Hereford city fathers have twice denied applications from the people who live here for annexation by the city, so the barrio receives not even the most basic municipal services. Although over half of Hereford's population is Mexican-American, city officials and the folks who put them in office are neither Mexican-American nor farmworkers,

Photos by P. C. Jennings

and they don't see why they should spend local tax money on the barrio's problems

Twenty one miles to the south on Highway 385 lies Dimmitt, county seat of Castro County, a smaller, somewhat less affluent version of Hereford. A drive out from the bank-like courthouse in the middle of town, past the packing sheds and the sugar refinery, almost to the edge of the surrounding fields, brings you to the Castro County labor camp—more precisely, the Castro County Agricultural Housing Authority—which consists of dormitory-style buildings enclosed by a six-foot high, chain-link fence topped by strands of barbed wire. The barbed wire slants inward

It was here on the morning of December 8 that Isidro and Rachel Aguinagas decided their infant son should be seen by a doctor. They took him to the public clinic in Dimmitt, where the child was found to be feverish, suffering from respiratory infection and dehydration, and nearly dead. The doctor there told them to take the child at once to nearby Plains Memorial, a tax-supported public hospital, while he called ahead to have emergency care readied. The Aguinagases rushed to the hospital, but were turned away (so they later charged) by hospital administrator Jack Newsom, who told them through an interpreter that unless they could produce a $400 cash deposit the baby would not be admitted. Isidro Aguinagas's account of the incident: "The administrator asked me if I was working. I said I had found some work gathering corn. He said, 'If you are working, then you should have money.' I said, 'But I have not been able to work these few days because of the snow in the fields.' He said, 'No money, no nothing.' "

The Aguinagases then drove 45 miles to Tulia in adjoining Swisher County, but their son was denied admission at the county hospital there also, this time because they were not county residents. By now the child's condition had worsened, so they headed back toward Dimmitt with the intention of finding someone at the county courthouse who would help. But on the way, Isidro Aguinagas Jr. died

The next day Father Raphael Chen, a Catholic priest who has been fighting the local establishment on behalf of the poor ever since he was assigned to the Amarillo diocese 17 years ago, got a call from one of his parishioners, who asked him to help arrange the immediate burial of an infant. Word of the circumstances surrounding the Aguinagas child's death had begun to circulate through the labor camp, and a sizable number of people attended the funeral. Deaths among the farmworkers here typically attract little notice, and Chen, surprised at the crowd, asked one of his parishioners for an explanation. Having heard the story of the previous day's events, he says, he paid the Aguinagas family a visit and asked them what their plans were. They told him they were leaving town that afternoon. The priest paused for a moment, and then said, "I have just buried your son. If that is how you want to leave things, fine." They asked him what would happen next. If they left, he replied, probably nothing. Then he asked them to think about the parents of the child that would die next time

The Aguinagases decided to stay. Before the grand jury that convened to consider their complaint against Jack Newsom, they heard a doctor testify that the baby probably would have died anyway. Newsom claimed that the whole incident was based on a misunderstanding, on the parents' inability to speak English, and later announced that hospital policy had been "clarified" to insure that children under 12 would be admitted to the emergency room first and the question of payment would be taken up with the parents later. On December 20, while the grand jury deliberated, the *Hereford Brand*, a newspaper widely read in Dimmitt, ran a front-page story on the problem of uncollectable accounts at another area hospital

Isidro and Rachel Aguinagas are now working again, getting up every morning before dawn, traveling as far as 130 miles to work in the fields. They return each night to the labor camp after dark. The expenses of the baby's funeral set them back, and now they are several weeks behind in their rent. But they are staying

The mayor of Dimmitt has written a letter to the *Castro County News* complaining that the media has already found 5,000 people guilty of the baby's death, and he has a point. The gnarled rancher, the placid banker, the harried public official—these are decent, upstanding people who resent having to justify their ways to outsiders. The child's death, they insist, was due to "tragic circumstances, an "unfortunate misunderstanding," nothing more

But the rationalizations wear thin when you hear, from a lawyer at the local legal aid office, about the case of a woman brought into Plains Memorial for an emergency Caesarean section less than a year ago who was denied admission because it was Sunday and the money for her cash deposit was in the bank. How the money collected by frantic relatives and friends included rolls of coins which had to be unwrapped and counted before she was given treatment. Or Father Chen's story of the victims of a fatal car wreck arriving at the hospital, the bodies of the anglo teenagers in an ambulance, the bodies of the farmworkers in the back of a pickup. Or how schoolchildren who couldn't speak English were assigned to classrooms for the retarded. And eventually you hear enough to make you realize that the extraordinary thing about the Aguinagas family is not that they were ready to leave town the day of their son's funeral, but that they were willing to stay. □

P. C. Jennings is a freelance writer from Houston.

The Aguinagas family at home

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Sister agitates on health

. . . that Sister Regina. She's created a great stir in the church, you know. She's a turrible great activist, she is.

Father O'Brien of Amarillo

Lubbock

Sister Regina Foppe of Lubbock is the director of Social Action Services for the Diocese of Amarillo and she is indeed a turrible great activist. A political nun, no less. Every spring for the past four years, Sister Regina has gone off to Washington to be a lobbyist. Last November she was up testifying before a congressional committee. In April, she went to Atlanta to testify before the platform committee of the Democratic Party. In between times, she does grass-roots organizing, supports Common Cause, operates her office in a black neighborhood and, above all, works with the *chicanos* of West Texas. Her particular cause is national health insurance because she knows, first-hand, what happens to people who cannot afford health care or health insurance.

"Many people in West Texas today are denied preventive health care services because of lack of ability to pay," she told the subcommittee on health of the House Ways and Means Committee last winter. "To my knowledge, there are no county hospitals, and most of the communities have no free clinics, a number of small communities are without doctors. This has created serious problems, and when those least able to pay must finally be hospitalized, their hospital stays are longer and more costly, creating a complex monster which ruins families. Good credit ratings are destroyed for the next seven years, in most instances a vicious cycle of poverty is created, and the economic base of the family is totally destroyed. Most low-income blue collar workers do not understand or use laws pertaining to the declaration of bankruptcy, so they lose their houses, home furnishings, and car as they go into repossession. Motivation is impaired and finally drives them to enter the welfare rolls."

From the *Lubbock Avalanche-Journal*, March 4, 1976: headline: HOSPITAL REFUSES TO ADMIT TINY ASSAULT VICTIM: THREE-YEAR-OLD RAPE VICTIM DENIED HOSPITAL ADMITTANCE: dateline, Littlefield—A three-year-old girl, who was raped and beaten before she was hurled into a pig pen, was refused hospitalization here Friday because her mother didn't have a $400 deposit.

The child underwent emergency treatment at Littlefield Hospital and Clinic, but administrator Kenneth Day refused to admit her as a patient because her mother didn't have insurance, didn't qualify for county indigent medical care and lacked a $400 deposit.

The child's mother, however, had a federal

Sister Regina

Medicaid card from Colorado which the hospital refused to accept.

The Mexican-American child, hemorrhaging from lacerations and tears she suffered in the rape, was transferred about three blocks away to Medical Arts Clinic Hospital where doctors listed her in serious condition.

Sister Regina has been working on collecting statistics about health care, or the lack of it, among South Plains *chicanos*. When one testifies before government committees or church conferences or political groups, she has discovered, it is helpful to have some numbers—numbers seem to impress some people more than stories of what is happening to human beings. Sister Regina is particularly concerned with the plight of those who have fallen into the crevices between the creaking parts of our jerry-built health care system. What happens to those who are too poor to afford health insurance, who work where there is no employee insurance program, who are too "rich" to be on Medicare or Medicaid?

"I had a captive audience to get my information," said Sister Regina, beaming at the thought. Specifically, she used the parishioners of several entirely *chicano* churches in the area. On Sunday, Oct. 26, 1975, seven churches cooperated in a "Poll on Health Insurance for the Family." West Texas Health Systems and James E. Archer & Associates in Lubbock assisted in computerizing the results.

Of the 694 families polled, almost 54 percent had incomes within 150 percent of the poverty level, i.e., are almost poor.

In this slightly-better-than-poverty-level group, the poll found that there was simply no way the families could handle health insurance. Most of the adults work in agriculture related fields—at compresses, cotton seed mills, irrigation work, field work. An average of 41.8 percent of the families in all the parishes had no medical insurance whatever. Many of those who qualify for Medicare or Medicaid are without insurance either through ignorance or denial. Of those adults who are employed where there are insurance programs available, 42.5 percent of the other members in these households have no insurance.

Three hours later the child was taken by ambulance to Lubbock's Methodist Hospital where she underwent surgery. She was released Tuesday.

According to county welfare worker Doris Frey, she phoned Medical Arts hospital after a friend of the child's family and the county attorney notified her of the child's condition and Littlefield Hospital's refusal to admit her.

"They said the woman [child's mother] had a federal Medicaid card from Colorado, so I called Medical Arts and they said they'd take her," Mrs. Frey said.

Mrs. Carlene King, administrator of Medical Arts, confirmed the woman had a Medicaid card issued in Colorado where she lived.

"We've had no trouble collecting on out-of-state Medicaid," Mrs. King said. "We'll be a long time getting our money, but that's not important right now."

Mrs. King said the girl was screaming and in obvious pain when she was brought to Medical Arts. "A nurse carried her up the stairs and she screamed with each step. It upset us all—she was in bad shape."

"You see, there are no county hospitals for the poor out here in West Texas," said Sister Regina. "The only place that will take them here in Lubbock is the Catholic hospital. I'm on the board there, and even we get a little nervous sometimes."

According to attending physicians there, the child suffered a large tear in her genital area and abrasions and lacerations over her body.

The little girl's relatives said they found her in a pig pen after they missed her from a party they were having at a farmhouse about four miles from this farming community....

According to Day, the administrator who refused to hospitalize the child, a doctor at Littlefield Hospital "examined the child and cleaned her up."

Day said the doctor advised against stitching the girl's wound because of the possibility of later infection from debris in the pig pen where she was found. "He told the woman to take her home, keep it [wound] clean, and to watch for infection," Day said. "He said after it healed, to bring her back for plastic surgery."

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According to Day, the attending physician didn't recommend hospitalization. "It was the mother who demanded she [the girl] be hospitalized," the administrator said. "I personally handled this situation.

"They did have Colorado state welfare," Day said. "There was no means whatsoever to pay for this bill. She [the girl's mother] was demanding hospitalization, not the physician. I've got a Colorado claim I've been trying to collect on for months with no result. They won't even write."

According to Day, the county's indigent medical care program wouldn't cover the child's hospital costs because she wasn't a resident of Lamb County. Under county guidelines, the county pays 60 percent of hospital bills for patients who require immediate hospitalization.

The hospital administrator said commissioners refused four months ago to pay a $1,000 hospitalization claim for two Mexican nationals who were badly burned on a farm near Littlefield. "This was after the county's agent [Mrs. Frey of the welfare office] had approved it," Day said. "It's got to stop somewhere."

It's got to stop somewhere.

"It will take a long time," said Sister Regina "There is so much resistance to national health insurance. Of course, you have the doctors and the insurance companies against you. And many do benefit from this system—Blue Cross and Shield, the companies that do the data processing. But I am always amazed at the opposition because national health insurance so clearly works. All you have to do is look across the Canadian border. America is the only industrialized country without a health insurance system.

"And when the opposition talks about cost, they never talk about what we are spending on health care now. We spend $118 billion a year for a system that doesn't even work."

Using 1970 census figures and the results of her own research on lack of coverage among those at near poverty level, Sister Regina asserts that there are 2,239,300 Texans without health insurance. The coverage of those who do have it is frequently inadequate. Ten percent coverage is not unusual, she said.

Sister Regina is capable of launching enthusiastically into an animated discussion of the different health insurance bills now in the congressional hopper. The doctors are pushing one bill, and the insurance companies another, and Sister Regina is happy to explain why either one would be a disaster. She favors the Health Security Act by Corman and Kennedy, the most comprehensive and expensive of the plans. She discusses the political maneuvering on the bills with the zest of an old pro.

Regina is one of the "Network Sisters." They are the activist offshoot of the National Association of Women Religious (N A W R), which represents all the major orders in the U S. Four years ago, the Network Sisters, numbering about 200, decided to get directly involved in the political process. Each June they hold a lobby workshop session in Washington and then descend on the Congress. Regina recalled the year Sen. Edward Kennedy, who is generally behind the "good" health insurance bills, went off the track and was supporting a weak compromise version.

"We set up a meeting with him and there was a photographer there and all I guess he thought it was going to be a great publicity thing for him, because of course sisters would be expected to be supportive of a Kennedy. But when he came in, we really clobbered him " She laughed with glee at the memory. "And he never did put out any pictures or press releases on *that* meeting "

Regina Foppe looks deceptively like a very kind woman who is fond of laughing. She is actually some form of natural force. In addition to her duties as director of Social Action Services, she is the director of the Campaign for Human Development of the Amarillo Diocese (Panhandle and South Plains), has just completed her master's thesis in history at Texas Tech, serves on the Diocesan Council of Religious Women, the Sisters Senate, the Catholic Conference Urban Ministry, the Deaconate Committee—Amarillo Diocese, the Sisters Legislative Seminar in Washington, the N.A.W.R , the Texas Catholic Conference as a delegate member, and the Texas Conference of Churches as a delegate. She is also a member of the advisory board on bilingual education of the Lubbock Independent School District (in 1972 she spent the summer studying Spanish in Cuernavaca), a member of Caprock Girl Scout Council, part of the Common Cause telephone chain, a member of several historical associations and a representative on Lubbock's Community Development Advisory Association. When something like the May, 1970, tornado disaster strikes Lubbock, Sister Regina simply takes on more responsibilities.

Sister Regina has also gotten into some spirited skirmishing with the church hierarchy. She testified at the Texas Catholic Conference in San Antonio in March and has been carrying on a battle to get her health-care resolution out of a conference committee she regards with less-than-loving spirit.

For Sister Regina, it is incidents like the March rape of the three-year-old that fuel her implacable resolve to change the system. As the man said, it's got to stop somewhere.

M. I.

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No. 14

CONCERNING NATIONAL HEALTH INSURANCE

(Approved by majority vote by members of the 10th annual Assembly of Representatives of the Texas Conference of Churches, February 19-21, 1979, in Austin. Mr. Philip A. Masquelette and Rev. C. J. Freudenberg voted negatively.)

WHEREAS the ministry of Jesus was characterized by preaching, teaching and healing the physical and emotional suffering of all people without regard to social distinctions; and

WHEREAS, responding to the injunction to be Christ's body in his world, the Church has historically initiated healing ministries and has followed the example of Christ in reaching out particularly to society's dispossessed people: the poor, the lepers, the untouchables; and

WHEREAS the present national health delivery system in the United States leaves at least 35 million Americans dispossessed because they lack the financial resources to buy the health care they need; and

WHEREAS more millions are denied health care because of rising costs; and

WHEREAS many persons in rural America are denied access to health care because of geographical locations; and

WHEREAS the anxiety of the non-covered families contributes to the mental and physical health problems in our highly industrialized nation; and

WHEREAS we believe that all persons are children of God and therefore should have equal access to good health care,

THEREFORE BE IT RESOLVED that the tenth annual Assembly of Representatives of the Texas Conference of Churches in session February 19-21, 1979, in Austin, endorses the basic concept of universal and comprehensive health care; and

BE IT FURTHER RESOLVED that the Texas Conference of Churches favors the passage of a national health insurance act that will assure that all residents of the United States have access to such health care; and

BE IT FURTHER RESOLVED that this resolution, upon approval, be communicated to the President of the United States and to appropriate members of the Congress of the United States.

No. 15

CONCERNING THE HOSPICE MOVEMENT

(Approved by unanimous vote by members of the 10th annual Assembly of Representatives of the Texas Conference of Churches, February 19-21, 1979, in Austin.)

WHEREAS in recent years the Texas Conference of Churches has focused a major portion of its attention and resources upon the value of life; and

WHEREAS, in the course of its study of the value of life, the Texas Conference of Churches has come to affirm the right of persons to dignity through supportive care as they approach death; and

WHEREAS the hospice movement, as developed in England and practiced in New Haven, Connecticut, and other parts of the United States, has demonstrated its concern for the terminally ill in the context of ministry to the total person, including medical care, social and other services, and psychological and pastoral counseling,

THEREFORE BE IT RESOLVED that the tenth annual Assembly of Representatives of the Texas Conference of Churches in session February 19-21, 1979, in Austin encourages the development of hospices in Texas, to provide this ministry to dying people and their families; and

BE IT FURTHER RESOLVED that the Texas Conference of Churches supports efforts in the Texas legislature to define, license and regulate hospices as a component of health services available in Texas.

EL EDITOR

Vol. II No. 16 Week of March 2-8, 1979 Lubbock, Texas Price .20

Authorities argue indigent care obligations

Editor's Note: The following story is reprinted by permission of The University Daily

By TOD ROBBERSON
UD Reporter

Local doctors, private hospital administrators and members of the Lubbock-Crosby-Garza County Medical Society appear to be increasingly at odds with Lubbock County officials concerning the county's obligation for providing medical care to the indigent.

The controversy resurfaced Thursday night when a committee from the medical society argued with county commissioners and administrators from the Medical School and Lubbock County Hospital District about the interpretation of the legislation creating LCHD.

In 1964, Tech applied to the State Commission on Higher Education for authorization of the Medical School. The 58th Legislature passed legislation in 1965 authorizing creation of the Tech Med School, but the bill was vetoed by Gov. John Connally because Lubbock lacked a charity hospital for use as a teaching facility.

To meet the governor's standards, local voters had to approve the creation of a county charity hospital. Proponents of the proposal executed a massive campaign to persuade voters that the Med School and teaching hospital would "add prestige to our area, produce opportunities for attracting other medically orientated facilities, aid in attracting other business and industry and add to the economic strength of the area," according to one of several pamphlets and leaflets circulated to voters at the time.

Medical Society doctors at Thursday's meeting said the literature was misleading in that it promised centralized medical care to the county's indigents, a promise which the doctors claim has not been fulfilled.

According to Dr. Norma Porres, chairperson of the medical society's Welfare Committee, the promises to centralize indigent medical care within the teaching hospital were made only for the purpose of fulfilling the governor's requirements. She charged that the promises made in the literature were never intended to be kept.

Porres' comments referred specifically to literature circulated by the Lubbock Chamber of Commerce, one of which state, "(LCHD's) creation will provide the funds necessary to build and operate a teaching hospital required for the medical school.

"The funds will also be used to adequately care for all medically indigent citizens of Lubbock County. The district will also immediately assume the hospital care of indigent citizens of Lubbock County. The district will also immediately assume the hospital care of indigents now being performed by the Lubbock City-County Welfare Department and by the City-County Health Department Outpatient Clinic.

All welfare services will be centralized and this should produce a more effective and economical operation," one booklet stated.

The booklet continued "(the LCHD Board of Mangers) will have the responsibility of planning and providing care for the medically indigent and also operating the hospital when built. The hospital will be both for indigent teaching patients and private patients."

Such wording, which is repeated in several other pamphlets, was a key factor influencing voter acceptance of the LCHD creation proposal according to Porres.

At Thursday's meeting, Porres and Dr. Ray Santos, chairman of the medical society's Ad Hoc Committee confronted county commissioners, LCHD administrators and Med School representatives with the question, "What is the county doing for its medical indigents?"

"Everything started to fall apart when LCHD took over the responsibility for the county's indigents," Santos told the commissioners.

Porres and Santos cited data from Methodist and St. Mary of the Plains hospitals indicating LCHD has not centralized care for the medically indigent.

"Before creation of the hospital district 1.5 percent of Methodist Hospital's patients were medical indigents," Porres said. "Since then, the hospital is taking 30 percent more indigents than before."

Porres said St. Mary's hospital is treating 150 percent more indigents than it treated before LCHD's creation. When questioned by the commissioners as to whether the indigents were "qualified medically indigent" under LCHD income and property ownership guidelines, or just "non-paying patients," Porres said the indigent patients met LCHD requirements for indigency benefits.

Porres said the figures indicate the hospital district has failed to centralize indigency care. She added the LCHD guidelines and procedures for indigents to obtain medical treatment discourage indigents to seek treatment at Health Science Center Hospital, the official designated charity hospital for Lubbock County.

Qualified medical indigents receive a yellow card which allows them to receive treatment at HSCH free of charge. Porres said these patients are required to go directly to the emergency room for treatment of any illness, regardless of whether it is an emergency situation.

Gerald Bosworth, LCHD executive director, said the patients do not necessarily have to go to the emergency room. "There are a number of ways indigent patients can receive care, one way is through the Medical School clinic at Thompson Hall," he said.

Porres said patients are only received at the clinic if they have previously been treated by one of the clinic's doctors.

Santos cited another problem of the restriction which disqualify many poor people from indigency benefits. He quoted a letter he received from a doctor in the Med School's pediatrics department which said "The hospital district is making a concentrated effort to disqualify as many people as possible from receiving indigency benefits."

Hack Flygare, member of the LCHD Board of Managers said "The board reviewed the indigency guideline as two months ago, then raised them to well above the median guidelines for all other major counties in the state. We didn't want to be the leaders in the state because the taxpayers wouldn't like it."

Flygare, Bosworth and the commissioners stated throughout the meeting that they were not trying to deny anyone the ability to seek medical care and they were doing everything they could to see that indigents receive whatever medical treatment they need.

"But I don't think you'll find anyone in Lubbock County who voted a 75 cent per $100 tax raise on himself to build a hospital just to care for indigents," said County Judge Rod Shaw. "WE have to abide by certain limits, and that means we can't foot the bill for every patient who isn't able to pay his bill."

But Porres and several other doctors in the county feel the hospital district is not doing everything it can for medical indigents. They maintain this failure has caused many indigents to seek treatment from private hospitals and doctors for which they are unable to pay.

Since the hospital district pays only for medical care provided to indigents at HSCH, these private physicians and hospitals have to write-off all care to indigents as "bad debts."

(Continued Page 6)

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El Editor, March 2, 1979 Page 6

Hassles, fears drive patients to private clinics

Local doctors, private hospital administrators and other officials who deal with indigent medical patients in Lubbock County are growing more vocal in their opposition to the indigency policies established by the Lubbock County Hospital District.

The LCHD Board of Managers revised its indigency guidelines at the January meeting to allow more poor people to qualify for free medical care supported by a county property tax. At the same meeting, the board voted not to continue paying for medical care given to indigents at any hospitals other than the Health Sciences Hospital.

Immediately following the meeting, administrators at Methodist and St. Mary of the Plains hospitals told The University Daily they were not satisfied with the revised policies, particularly considering that the board never consulted other hospitals before implementing the new policies.

Although Gerald Bosworth told the board members at the January meeting that both hospitals's administrators had been invited to address the board, nor did they feel their input would have any effect on the board's decisions.

Many local doctors and hospital officials have expressed similar opinions, saying that the board doesn't seek enough community input before it implements new policies.

The meeting on Thursday night with representatives from the Lubbock-Crosby-Garza Medical Society and the Lubbock County Commissioners was a final resort for the Medical Society to voice their dissatisfaction with the board's policies.

Dr. Rey Santos, chairman of the society's Ad Hoc Committee complained to the commissioners that the indigency qualification income guidelines are still too low and exclude too many poor people who cannot afford to pay for medical treatment.

The guidelines require that an indigent family can't own more than $500 in personal property. That means if a family owns a $500 car, it can't receive indigency benefits," Santos said. "I've seen cars worth $500 that could barely run, but nevertheless, transportation is a necessity for medical treatment."

Eldon Akin, vice president of finance at Methodist Hospital agreed with Santos complaint. "Everybody has a point on the financial scale where they can be considered indigent. If I were strapped with a $30,000 hospital bill, I know I couldn't afford it. So how can they (the LCHD board) expect poor people to pay such a bill?" Akin said.

"I don't think they should set the guidelines according to the number of people in a family," he said. "We've been urgin LCHD to adopt a sliding scale policy similar to those set by the Department of Health, Education and Welfare."

Although no official action has been taken by the board to further liberalize the indigency guidelines since the January meeting, Louis Martinez of the medical indigency guidance service at HSCD said his department is currently studying the personal property provision of the indigency guidelines.

He said the provision may be too strict, and his department will submit a revised proposal to the HSCH administrators in hopes of raising the maximum property allowance to more than $500.

"Working with both the indigents and the administrators, you see both sides of the issue," Martinez said. "I though the board was pretty lenient in the allowances it made for the indigency guidelines."

Both Martinez and Akin agreed that limits must be placed on indigency qualifications. "Eventually you have to draw a line somewhere," Martinez said.

Another problem with the indigency qualifications involves the paper work and bureaucratic procedures required of indigents before they can receive treatment at a county medical facility.

Communication barriers, bureaucratic paper work, impersonal relationships between doctors and patients and a general fear of institutionalized medicine are among the reasons indigent medical patients gave for seeking medical care from private clinics rather than from the Health Sciences Center Hospital.

Poor people who qualify for medical care benefits under the county-supported medical indigency health program are failing to take advantage of the program because private clinics offer more personal, compassionate care with fewer hassles, according to indigent patients interviewed by the University Daily.

According to guidelines established by the LCHD Board of Managers, certified medical indigents are required to seek medical treatment only at HSCH. Private hospitals and doctors are not reimbursed if they treat indigents without county approval.

Maria Rodriguez, a certified indigent from Wolfforth, said the requirements and procedures she had to follow when she sought help at the hospital made her reluctant to use the facility again.

"I had a bad cold and I just wanted to see a doctor about getting some medicine," Rodriguez said. "After I filled out all of the papers and gave the welfare people the information they wanted, they told me to go to the emergency room to see a doctor."

Rodriguez said she was referred to another doctor within the hospital after being told that she could not receive treatment for a cold in the emergency room.

"But that's where I was told to go," she said. "I had already spent several hours waiting and filling out the forms, and all I wanted was some medicine to ease my cold."

By the time the other doctor saw me and wrote me a prescription, I was too tired to care anymore. I just left after I got my medicine, and I don't ever want to go back," she said.

Another medical indigent, Maria Ramirez, related her experiences to the UD through an interpreter since she cannot speak English.

Like Rodriguez, Ramirez was referred to the emergency room at HSCD after she and her daughter filled out the required forms to qualify for indigency benefits. She said she "had problems with her veins," which was later diagnosed as high blood pressure.

"The doctor in the emergency room couldn't understand why I was asking him for help. He told me that I shouldn't come to the emergency room because it costs money to be treated there," she said.

"I told him that I was told to go there, but he said 'No, you understood wrong.'" Ramirez said the doctor started to get angry, but he still diagnosed her ailment and wrote her a prescription for medicine. She told the doctor her throat was sore too, and he told her to ask for some throat lozenges at the HSCH pharmacy when she went to fill her prescription.

"But the woman at the pharmacy told me I had to have a written prescription for anything at the pharmacy. We went back to the doctor but he told us it was silly to write a prescription for throat lozenges.

"We went back to the pharmacy, but the woman there insisted on having a prescription. She called the doctor, and they got into an argument," Ramirez said.

By the time she received her medicine, Ramirez said she never wants to go back to the hospital again. "We'll just get yelled at if we go there. I'd rather go to a private doctor who'll be nice to me."

Other cases involve language barriers between patients and doctors and an instance where a family of 12 was denied indigency benefits because its total income was slightly above the established limit. Such cases have caused local doctors to criticize LCHD's current indigency policies.

But local officials appear stumped to find a solution to the problem. They don't want to further burden the tax payers but they see no other way to liberalize the current indigency qualification guidelines.

One local doctor, who has worked closely with both the county officials and indigent patients, believes one solution is to lobby at the state level for more welfare support.

According to County Judge Rod Shaw, a proposal is being prepared for the Legislature which would encourage the state to underwrite care for medical indigents, thus easing the burden on the counties.

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STATEMENT OF ELMER CERIN, TRUSTEE AND WASHINGTON REPRESENTATIVE OF AMYOTROPHIC LATERAL SCLEROSIS SOCIETY OF AMERICA

I thank the chairman and members of the Senate Subcommittee on Health for giving me this opportunity to testify on S. 350 and S. 351.

My name is Elmer Cerin and I am a trustee of the Amyotrophic Lateral Scleroisis Society of America (ALSSOA) and its volunteer Washington Representative. ALSSOA is a non-profit health organization whch supports research on ALS and makes available educational and other information to assist ALS patients and their families to cope with this illness. ALS is a paralytic disorder in which the motor neurons in the brain and spinal cord cease to function and sometimes die. The muscles in the arms, legs, and bulbar area, activated by such nerve cells, go out of control and become paralyzed. When the bulbar area is affected, the breathing, swallowing and speaking functions are impeded and become inoperative. The following are the vital facts about ALS:

ALS strikes mature persons in the 40 to 70 age range but persons as young as 20 and as old as 80 have been diagnosed as having ALS;

Its cause is unknown and medical science has yet to develop a therapeutic treatment;

As the illness progresses, the ALS patient becomes dependent on a wheelchair and eventually becomes bedfast; and

The average course of ALS is three to four years from diagnosis to death although a small percentage of ALS patients may survive for longer periods.

It is estimated that there are between 10,000 and 30,000 cases of ALS in this country. The impact on ALS patients and their families is total devastation, both psychologically and financially. Until medical science finds a cure for this disease, most ALS patients prefer to remain at home and receive the warm and beneficial care that the home provides. Yet Medicare excludes such home health care from its benefits on the ground that such care is not "skilled." The rationale used is that such care is not rehabilitative or restorative but merely palliative and, therefore, does not require "skilled" nursing care. The fact that the home health care benefits the ALS patient and prolongs life is not relevant. So the ALS patient and his family must absorb all the home nursing care costs that the usual round-the-clock service demands.

Whereas ALS patients have been dying in the past due to the lack of symptomatic treatment, we now know that life can be prolonged for indefinite periods of time by such treatment. During the interval, when life is spared, the possibility exists that an answer will be found to treat and cure the disorder. However, should the ALS patient be sent to a hospital, the costs are far higher and the care less beneficial than in his warm, sympathetic home environment with far greater capacity to care for the patient. Because medical science has not yet found the answer to the ALS enigma, the use of registered nurses in not necessary. A licensed practical nurse can be trained to provide the special needs of ALS patients and the costs would be far less. For the present, this assistance would be adequate to provide the necessary care for ALS patients.

Now that a very aggressive research program to find the cure for ALS is under way, there is hope that the life of the ALS patient may be prolonged beyond that possible with symptomatic treatment. Can our country now do less than minimally help those families who wish to assume the burden of maintaining their loved ones at home, as opposed to hospitalizing them at a far heavier cost to the Federal government. The home is far more humane, more beneficial, and in many instances less costly. Furthermore, by providing one shift per week day, it is good economics to have Medicare absorb these costs and thus free the breadwinner to earn additional income to meet medical and household expenses.

I regret the introduction of a personal note, but I believe that it is appropriate in discussing the objectives of the subject legislation. Over two years ago my wife's illness was diagnosed as ALS. Since then I have set aside my legal practice to take care of her and to concentrate my time and efforts on obtaining both public and private funds for ALS research, trying to expand home health care services for the chronically disabled, and assisting ALS patients and their families.

I assume full responsibility for taking care of my very sick wife. Until 18 months ago I was able to provide all the required services. Since then, as my wife's condition has continued to deteriorate, I was compelled to engage one and subsequently two nurses' aides to assist me. On the third shift and over weekends and on holidays, I perform all the duties in caring for my wife. The current costs for these two nurses' aides and the physical therapist exceed $20,000 annually, none of which is reimbursable under existing Medicare regulations. As my wife' condition worsens,

I shall surely require additional assistance. I foresee the time when I shall be facing an increasingly insurmountable physical and financial burden.

In the statements accompanying S. 350 and S. 351, frequent references are made to the ruinous costs of prolonged illness wherein the lifetime savings and property of the patient and his family are wiped out. The sponsoring Senators seek, in these proposals, to develop a means of ssuring that all Americans will not be bankrupted by the devastating effects of a serious illness or injury. Moreover, the accompanying statements by the sponsoring Senators promise that the benefit provisions of this legislation will take care of "virtually every one" of the long-term cases. Finally, it is emphasized that the Congress has the opportunity in these proposals "to make health care a right for all Americans." This is to be accomplished by protecting them against rising health costs through the mechanism of placing a ceiling on every American's medical expenses.

The fact is that ALS patients and the many other chronically disabled patients suffering from serious diseases for which medical science has nto yet discovered a cure or treatment will receive not benefit at all form the proposed legislation. Since benefits excluded from Medicare would also be excluded under the provisions of this legislation, the home health care costs incurred for ALS and similarly disabled patients would not be reimbursable under the benefit provisions of either S. 350 or S. 351. This means that thousands of critically disabled Americans will continue to be denied any home health care benefits under the proposed program.

I am certain that the Senators who have introduced and cosponsored these programs desire to provide adequate protection for all Americans in meeting the rising health care costs. Accordingly, it is recommended that this proposed legislation be amended so as to place a ceiling on total medical costs incurred by every American. Perhaps, as was suggested above, a change in Medicare regulations authorizing the use of a professional nurse on one shift per day would be sufficient to ease the care and financial burdens so that all ALS families as well as the families of other chronically disabled patients can better cope with these dread diseases. In speaking with responsible Sante staff personnel, I have learned that this is precisely what the proponents of this legislation intend to provide. Less than this would fail to make helaht care a right which every American should be able to enjoy.

I thank you for permitting me to testify on this important legislation.

STATEMENT OF THE NATIONAL ASSOCIATION OF PRIVATE PSYCHIATRIC HOSPITALS

We welcome the opportunity to submit a written statement on S. 350, the Catastrophis Health Insurance and Mecical Assistance Reform legislation of 1979.

We, the National Association of Private Psychiatric Hospitals, representing over 180 free-standing (non-governmenal), speciality psychiatric hospitals, can appreciate more than other health organizations and associations any movement and direction which will improve the accessibility and availability of needed services. As providers of mental health care services, we know only too well the detrimental effects of poor or inadequate coveage. Coverage for psychiatric benefits, as you know, is sporadic and limited at best and non-existent at worst. Therefore, S. 350, in its attempt to federalize Medicaid and offer inpatient psychiatric services in any "accredited medical institution" as determined by the Secretary is certainly a positive step.

The introduction of this bill is certainly timely as the U.S. estimates that 45 billion dollars a year is spent on Medicare and Medicaie, yet 60 million Americans remain uninsured for any health benefits.

This bill does more to further and promote psychiatric care than any bill thus far introduced. The elimination of the 190-day lifetime limit on inpatient psychiatric care and the elimination of the $250 outpateint limit both presently part of the Medicare program, would, if apssed, do more to bolster and reaffirm the need for sound quality mental health care services than any previous peice of legislation. It would be a first step to parity.

We represent, as mentioned above, 180, free-standing hospitals. Our membership includes hsopitals having 15 beds to those having 500 beds. Both non-profit and proprietary hospitals are included; short-term and long-term care hospitals are also represented, with a large proportion of our membership offering the necessary multiple levwls of care—acute, intermediary, and long-term—as part of a basic, comprehensive, active treatment milieu. Our member hospitals include community mental health centers accredited as adult psychiatric hospitals, university-affiliated programs, residential treatment centers for children, and the few psychiatric units in general hospitals separately accredited as psychiatric facilities for the programs they offer. Our programs include comprehensive services for children, adolescents, adults, geriatrics, and persons with chemical dependencies. Our treatment philos-

phies and modalities are varied, but all hospitals, as a requirement for for membership, are accredited under the appropriate psychiatric standards of the Joint Commission on Accreditation of Hospitals.

While skeptical of any health insurance shceme because of the historical discrimination against the mentally ill and the providors who treat them, the thrust in S. 350 to eliminate limitations and recognize the need for equal treatment must be applauded.

We do, however, have some questions on both the inpatient and outpaitnent deductibles. As the bill presently reads, a person would be entitled to outpatient insurance upon satisfying a $2,000 out-of-pocket expense except that in the cas of outpatioent psychiatric benefits only $500 woudl be credited towards that $2,000 limit. It is inconceivable to us that a separation of expenses could be drawn. It is a known fact that outpatient psychiatric services, which are medically necessary and well documented, perform a service no other health benefit achieves. It maintains a person within their community, within their home environment, and most importantly on their job, which if without such treatment, a lesser level of functioning would almost be assured and perhaps hospitalization a necessity. Therefore, if the prescribed treatement is outpatient care and such treatment can be judged to be medically necessary and documented to be quality active treatement, why would a catastrophic health insurance program discourage such care and service?

As to the co-insurance after 60 days of inpatient care, we ask that the Committee take a close look at this provison as it applies to inpatient psychiatric care. Unlike most basic plans for physical health insurance which offer 90 to 180 days of inhospital care, most plans offer a limited 30-day to 45-day basic psychiatric inpatient hospitalization service. Therefore, while a co-insurance form day 60 onward is laudable, there exists a discrepency and perhaps a lapse of coverage between a private plan (as they exist todya) and the catastrophic plan from its point of departure.

Because of this limited coverage, many hospitals have been forced to discharge a more sickly patient than they would prefer. Many hospitals have begun outpatient, partial, and day and/or night programs to accomodate these persons while continuing to help them reenter the community. These programs, in addition to treating those persons who need a level of care somewhat more intense, controlled, and continual than outpatient, but less instensive than inpatient, are by necessity, because of limited inpatient resources, treating a person who truly should still be an inpatient. We hope, therefore, that in the Committee's deliberations to right some wrongs in the delivery of health care services a careful look be given to not perpetuating a wrong which has existed far too long.

While basic insurance coverage provides for at least 60 days for physical illness, many contracts fall short of that for inpatient psychiatric illness. Notwithstanding the trend to lower utilization and to discharge earlier, provisions must be assured for at least a 60-day inpatient basic benefit for those who need such care.

The last point to be made concerns the phrase "accredited medical insttitution" as determined to be appropriate by th Secretary for the delivery of mental health care services. We wish to point out to the Committee that the public is just now becoming aware of the dual standard of care found within the inpatient psychiatric community. They, the public, are not only recognizing it, they are objecting to it.

We hope that as the Secretary begins his surveys to determine which facilities are accredited appropriately to deliver psychiatric services, that he take a close lool at the standards promulgated by the Joint Commission on Accreditation of Hospitals for adult, children and adolescent, and alcohol psychiatric services as well as the standards for community mental health centers.

What is not widely known is that in 1972 a separate accreditation council was established within the Joint Commission to develop standards for psychiatric programs to maintain and upgrade the high degree of performance found in the specialty facilities. This council was established at the demand of the mental health community because it was strongly felt that the general hospital standards of accreditation held no mention of psychiatric programs and paid no attention to the sophisticated treatment needs of the psychiatrically ill patient. The National Association of Psychiatric Hospitals takes pride in being one of the ten founding organizations of the Accreditation Council of Psychiatric Facilities and one of the principal authors of the standards now in use for adult and children and adolsescent standards.

While all of our member hsoptials are accredited and surveyed for each and every service they provide, it is widely known that most psychiatric units in general hospitals escape separate review and survey, riding under the general hospital accreditation survey which has no specific criteria for psychiatric services or pro-

grams. In spite of this, and in spite of most third-party payors, government included, requiring accreditation as a requisite for payment, general hospital psychiatric units have been paid for services which in truth are not appropriately accredited. This situation has become aggravated because at the same time that general hospitals have been paid, specialty hospitals have been disallowed. It becomes all the more frustrating when one compares the cost per day between the general hospital and specialty hospital when it can be documented that general hospital psychiatric costs per day run at least 30 percent higher than that of a specialty hospital.

It has never made any sense that the less intense, less comprehensive, more expensive treatment setting has been the favored modality.

We ask, therefore, that the Committee in its accompanying report filled with S. 305 pay specific attention to this particular dilemma.

We thank the Committee once again for the opportunity to submit our statement for the record and are available to offer any further assistance or information as you continue this most important debate.

Statement of Edwin F. Flowers, President, American Public Welfare Association

The American Public Welfare Association (APWA), founded in 1930, is a private, non-profit organization composed of individuals and agencies concerned with publicly funded human services programs. Its membership is nationwide and includes all state and territorial public welfare agencies, over 1,700 local and federal agencies, schools, voluntary organizations, civic groups, and in excess of 7,500 individual members. One of the major ojectives of the Associaton is to promote the development of sound and progressive national social policies.

The American Public Welfare Associaton is pleased to present to the Senate Committee on Finace its views on legislation to implement a program of national catastropic health insurance protection and other related proposals. The clients which the membership of our organization seeks to serve are in the most disadvantaged segment of this nation's population—they are the impoverished, the disabled, and those in dire need of human services. From our intimate day-to-day contact with these people and their problems, we have become acutely aware of the cyclical relationship that often exists between illness and poverty—one condition can lead to the other with the result a hapless individual or family is inexorably drawn into a vortex of poor health and desitution from which there is little chance of escape. The Association therefore applauds attempts to break this cycle by assuring that individuals do not become impoverished as the result of paying for care to maintain or restore their health.

Because of the casual and synergistic effects of illness and poverty, APWA has long recognized the importance of including health care as a part of a coordinated, national policy of human services. Without adequate health care and health maintenance, national programs providing income maintenance and social services are blunted in their effectiveness. Ill health also has a serious financial impact on the provision of these services as well as other human service programs, for its presence only exacerbates and prolongs an individual's reliance upon these services for his well-being. Only an integrated national social policy which includes some type of health "assurance" is likely to prove effective in meeting human needs. "Access to comprehensive physical and mental health services is essential for all persons": a statement adopted by APWA in 1970, reflects this concern.

In 1976 an APWA Committee on National Health Policy built upon this important point and identified the necessary components of a health care system which could meet this broad goal—for our present fragmented, uncontrolled, and inequitable health care financing and delivery systems have proven that they cannot. I have enclosed as an attachment the report of this APWA Committee on Health Policy and, as I believe it contains much valuable information, I would ask that it be included in the record of these hearings as an essential part of our testimony.

The American Public Welfare Association believes that this nation must now enunciate a national health policy, a fundamental component of which must be a national health insurance program which meets the principles outlined later in our testimony. The NHI program should be enacted immediately, setting forth the long-range goal of adequate quality health care for all citizens. Implementation of the program, however, should be scheduled over a period of years in order to assure that the NHI program will:

Be financially sound and capable of controlling expenditures;

Be administratively feasible, with efficient management techniques and regulatory measures capable of implementation;

Build upon what now exists and works effectively within the health care system, including maintaining private and public financial support for existing programs until they are phased into NHI;

Be planned and implemented to anticipate the changes in demand on the health care system it will produce, and to develop the capacity of the system to respond to those changed demands; and,

Assure and preserve individual integrity and freedom of choice within the health care delivery system.

The American Public Welfare Association further recommends that any national health insurance enacted by Congress should:

(1) Provide coverage for all residents of the United States.

(2) Cover a comprehensive scope of essential health care services, including:

(a) Primary preventive care, which recognizes the importance of a national policy focusing upon assuring sound health for all as well as insuring against the cost of medical care when illness or accidents occur;

(b) Emphasis on health education so that the consumer has an active role in the maintenance of his own health; and

(c) Long-term care, including appropriate assessment, review, and placement services for individuals in need of such care.

(3) Impose no deductibles or co-insurance.

(4) Be financed through earmarked federal revenues to the maximum extent possible on a progressive basis.

(5) Be enacted immediately, setting forth the long-range goal of adequate health care for all citizens with phased implementation over a period of years.

(6) Be administered by an independent federal agency, newly established, which would be responsible for overall policy determination, budgeting and allocation of funds, supervision of program and health system performance and research and program evaluation.

(7) Authorize the use of regional, state, and local public and private organizations which, through contracts negotiated on a periodic and competitive basis, could be delegated the daily operation of the benefits payment process, including client and provider relations. In addition, contracts with public agencies would be negotiated to assure regulation of the delivery system performance and resource development.

(8) Utilize the budgeting appropriations process as the basic expenditure control in the program with appropriations planned on a five-year basis and subject to annual review. Within that constraint, adoption of a flexible management process through controls and incentives will assure adequate administrative performance, quality of care, cost control, and accessibility to appropriate services.

(9) Provide federal leadership and earmarked funding for research, planning, and development of resources to improve the capacity of the health care system to perform in relation to its financing, organization, quality, and supply of facilities, manpower, and services.

(10) Assure an open and participatory process of policy making at all levels, initially and on an ongoing basis, which includes participation from consumers, providers, and federal, state, and local public and private interests.

(11) Allow states a major role in administration of NHI, particularly in regulatory activities, but with no responsibility in the financing of NHI.

(12) Give priority in the first years of NHI to coverage of children and other vulnerable populations, as well as primary-preventive care while improving Medicaid, Medicare, and related programs until NHI is fully comprehensive.

While APWA supports a phased-in approach to implementing a national health insurance program which would extend over a number of years, the Association favors enactment of a single piece of comprehensive NHI legislation which includes authority to proceed to each successive stage. We are aware of the provisions in the bills currently under consideration by the Senate Finance Committee (S.350, S.351, and S.748) and their focus on providing protection against catastrophic medical expenses as well as standardizing and/or improving the existing Medicaid and Medicare programs. We are aware, too, of the Administration's anticipated strategy of seeking legislation to implement only the first stage of a longer-range national health plan. That first stage is expected to also include as a major component catastrophic medical insurance.

The American Public Welfare Association is concerned with this concentration on catastrophic health insurance protection. Certainly such a program would address a very real problem in our nation, one that is of great concern to the entire population—namely, the devastating effect that astronomically high medical expenses incurred as the result of a major accident or illness can have on an individual or family. Adequate protection against such occurrences should be provided to each

and every individual. However, the provision of such protection through enactment of a national program of catastrophic health insurance by itself is not without problems. Such an approach might accelerate the current inflation of health care costs by providing incentives for the provision of more expensive care, including longer hospitalization, while not providing any incentives for more cost effective preventative and ambulatory care. Further, the term "catastrophic" coverage is not entirely accurate, for none of the proposals being considered by the Committee protect the individual or family from the truly catastrophic expense of providing long-term care services, unless they pauperize themselves in meeting these costs to the point of becoming Medicaid-eligible.

Another important concern is the fact that focusing on a national catastrophic health insurance program might well divert public attention from serious consideration of a truly comprehensive national health insurance program. Catastrophic would effect, albeit significantly, only a small portion of the population. The Health Insurance Institute estimates that only one percent of claims made by those with private health insurance are for more than $5,000.

While it is important for the American people to be relieved of the anxieties and major upheavals in life style caused by catastrophic illness, such relieve should be provided within a broader framework. For this reason the American Public Welfare Association supports enactment of a truly comprehensive program of national health insurance that will address itself to meeting all the health needs of all individuals in an efficient and equitable manner. The Association stands ready to assist Congress in any way it can to develop and enact legislation which will achieve this goal of making access to adequate health care truly a right of all Americans in a manner which will not compromise the economic stability of this country. Please do not hesitate to contact us if we can be of assistance.

Attachment.

ATTACHMENT

AMERICAN PUBLIC WELFARE ASSOCIATION, REPORT OF THE COMMITTEE ON HEALTH POLICY

PART I: SCHEDULING PRIORITIES FOR NATIONAL HEALTH INSURANCE

A national health insurance program that meets the principles endorsed by APWA, cannot be put into operation at once. A careful plan following stated priorities must guide the scheduled implementation of the program. Before any of the population is covered by any scope of benefits, there must be assurance that the capacity of the health care system can respond to the new demands that will be placed upon it and that the management systems are in place and capable of assuring efficiency and cost effectiveness.

Therefore, the American Public Welfare Association recommends that the following priorities be taken into consideration in planning for the scheduled implementation of NHI:

(1) The capacity of the health care system to deliver the services must be developed in advance of creating new and additional demands on those services, keeping pace with the changes in NHI coverage over time. Funds must be available and planned for development of such resources e.g., facilities, manpower and services, and more importantly for their appropriate distribution and organization. A lead time of two (2) years should be allowed to carry out planned development and organization of resources, building upon existing capacity and expanding it in relation to the priorities of population coverage and benefits. Such investment in the system's capacity will continue until there is assurance that demand and supply are balanced within overall expenditure controls.

(2) The capability of the administrative management system to assure achievement of the program's objectives within expenditure constraints must be built and tested prior to full implementation of the program. Various mechanisms, some of them now in place or being demonstrated, may be appropriate. The new Federal agency for NHI must be established on enactment of the NHI legislation and given authority over and responsibility for all Federal programs that relate to the financing and delivery of personal health services, and to regulation and policy for personal health services. In this way, existing programs can be molded and modified to test out management procedures and all the programs that will ultimately be incorporated into NHI will come under one administrative agency during their phase-out—phase-in periods. Budgeting and forecasting techniques can also be developed and tested.

(3) After the two year lead time, the NHI program should begin operation with coverage of some benefits for all the population—something for everyone. However,

children, as a particularly vulnerable population, must receive special priority and offer the greatest potential rewards from preventive health dollars. Children should have initially the most comprehensive coverage, particularly covering pre-natal and post-natal services and comprehensive care up to age 6. Until more comprehensive coverage is available, the aged should continue to be covered by Medicare, supplemented where necessary by Medicaid.

With respect to the poor, Medicaid must temporarily be continued, but in modified form until comprehensive care is available including:

a. Simplification of existing regulations to stress less the process of administration and more the performance of state agencies, including more technical assistance by the Federal government, simplification of eligibility requirements, and 100% Federal funding of administrative costs that relate to federally mandated priorities, e.g. EPSDT, utilization review, fraud and abuse control, etc.

b. Federal assumption of total Medicaid costs for the SSI population.

c. Assuming a welfare reform proposal is adopted along the lines being recommended by APWA, then, until NHI assumes total responsibility:

1. Medicaid for those covered by the welfare reform measures should be totally financed by the Federal government.

2. States should be mandated to provide Medicaid coverage for the medically needy not receiving cash grants, within Federal guidelines and with Federal sharing in the costs.

(4) In scheduling priorities for benefit coverage, primary health care and preventive health services should be emphasized. Benefits should not be biased toward the high cost, institutional services except for those who require such.

APWA estimates that it may take up to ten years to fully implement NHI in a comprehensive fashion.

PART II: ADMINISTRATIVE STRUCTURE AND FUNCTIONS OF NATIONAL HEALTH INSURANCE

National health insurance will be an extremely complex program to administer. There must be centralized policy decisions based on consultation with the multitude of affected interests and implemented through a decentralized management structure, in order to accommodate the vast differences in regional capacities and capabilities. Existing bureaucracies and agencies at Federal and State levels, and traditional regulatory relationships between governmental levels, will not be adequate to carry out the administrative task.

Therefore APWA recommends the following approach to administrative structure and functions under NHI:

FEDERAL AGENCY STRUCTURE AND FUNCTIONS

Structure.—1. NHI should be administered by an independent Federal Board or Commission empowered by statute to carry out or delegate all appropriate program functions. The agency's independence and commission structure should assure that:

a. It will be less subject than a cabinet department to political changes in the Executive branch.

b. It will have statutory authority guaranteeing access to the Congress through a requirement for periodic independent recommendations and reporting by the NHI agency.

c. Its authority, powers and sanctions are sufficient to make its decisions effectively binding, and that judicial review is largely limited to constitutional policy issues.

d. A chief executive officer of the agency is responsible for implementation of policy established by the Commission/Board.

2. NHI administration must assure a broad representation from all interests in the policy making process. Advisory councils should be established including:

a. A strong general advisory council, representative of a wide range of viewpoints but not of organizations, and with independent staffing and funding for its role.

b. An interagency Council representative of all Federal agencies with an interest, direct or indirect, in NHI.

c. An advisory council of State and local governments.

d. An advisory council of contract administering agencies.

e. An advisory council of providers of service.

f. An advisory council of consumers.

Functions.—The NHI Federal agency would carry out the following functions:

1. Policy determination, through the rule making process as well as through the contracting mechanism, in the following general areas:

a. Establishing coverage and benefit definitions, which much evolve over time with changing medical technology and concepts of health status, and which may require modification based on expenditure control.

b. Establishing standards of administrative performance for contracting agencies, including determining the geographic areas for contract management, standards of administrative performance of decentralized functions, and standards for data processing.

c. Establishing standards for performance of the health care delivery system, including general parameters in such areas as: reimbursement methods, conditions of participation and performance by providers, quality of care and utilization, and accessibility to services.

d. Establishing policies and priorities for resource planning and development, including capital investment, manpower planning, and organizational innovation and development.

e. Establishing standards with respect to consumer and provider rights, responsibilities and relationships.

2. Budget planning and allocation of fiscal resources through contract negotiation with state or other public or private administering agencies.

3. Supervision, review and monitoring of decentralized management, including:

a. Monitoring of contractor performance.

b. Program evaluation in such areas as: administrative effectiveness, quality of care, access to services, control of fraud and abuse, etc.

c. Establishing of an internal review and grievance mechanism and appeals process to assure that consumers and providers receive prompt and adequate resolution of complaints. This will be supervised by the Federal agency, and adjudicated where necessary at the Federal level, including binding arbitration. Judicial review should be limited to constitutional issues.

d. Federal capability to undertake the State-local management and control processes, if no state agency is able or willing to do so. The Federal agency may maintain and operate model administrative areas for testing out techniques and to develop its capabilities to step into direct administrative management.

4. Authority to contract with other Federal agencies and with State and local agencies for specified functions that the other agencies are better able to carry out.

5. Conduct research in health services delivery systems, financing, and management techniques.

STATE/REGIONAL STRUCTURE AND FUNCTIONS

Structure.—The nature of the decentralized functions will require public accountability. Contracting with agencies would normally be within existing governmental jurisdictions, most usually state areas or substate areas of sufficient size. Contracts may be with either public or private agencies (including State government) for administrative functions. Resource development activities may only be delegated (by contract) to public agencies. Regulation would only be delegated to State or other government bodies. Contracts would be negotiated with agencies qualified within Federal standards, but to the extent possible a competitive bidding process would be used to select the most qualified agency. Contracts would encompass a five year span, consistent with the budgetary cycle adopted. Advisory council structures reflecting the scope of participation at the Federal level would be established at the State/substate level as well.

Functions.—The three basic functions to be decentralized include:

1. Management of the benefits payment process, including:

Client relations, information on clients, promotion of client education programs, information and services to clients,

Provider relations, information on providers and information and services to providers,

Claims payment, to the extent fee for service is used; institutional budgeting, prepayment, etc., to the extent these mechanisms are used,

Coordination with related organizations, and

Internal management controls, and collection and reporting of data to the Federal agency.

2. Application of controls and incentives to assure adequate performance of the health care delivery system (see related position statement).

3. Resource planning and development, including State area-wide planning of facilities, manpower and services, allocation of funds for development of needed resources and for improvement in the organization, quality, and distribution of existing resources.

PART III: FINANCING OF NATIONAL HEALTH INSURANCE—SOURCES, ALLOCATION, USES

National health insurance of the scope recommended by APWA, will be extensive and costly. It will represent, on the one hand, a large transfer of expenditures from the private sector to the public sector, and on the other hand will represent a

redistribution of income—from the well to the sick, and from the wealthy to the indigent. As a basic principle the method of financing NHI should treat all persons equitably, and should not impose any degrading or administratively complex test of financial resources, such as income testing used in welfare programs.

There are three alternative sources for the financing of NHI: premiums, payroll tax, and general revenue. (Deductibles and coinsurance are a method of controlling expenditures, not a source of income for NHI. They are controls that the APWA recommends not be used since they may discourage necessary services, delay treatment and add considerable complexity to the administrative process.)

Premiums represent a payment by the individual (family), usually in a flat amount in order to secure coverage. The term is usually applied to voluntary enrollment; if it is mandated to be paid, it constitutes a tax. Flat premiums would be unacceptable since they fall unevenly upon the poor and would constitute a disproportionate share of their income relative to the more affluent. Any premium subsidy approach would necessarily introduce a means test, which is an unacceptable procedure.

Payroll taxes usually take the form of a flat percentage of funds withheld from wage payments to cover the cost of the benefits. Most usually, the payments are shared between the employer and employed, but sometimes are paid totally by the employer. Payroll taxes would apply only to the wage earning population and thus would be limited in population coverage, requiring supplementation from other sources for unemployed. Payroll taxes are regressive, placing a heavy relative burden on those with lower incomes. The working poor would be particularly vulnerable to this unequal tax treatment. In addition, the payroll tax would not involve non-wage earners in the support of NHI.

Federal revenues, largely composed of income and related taxes, offer a broad-based, generally progressive, means of financing NHI. Such funds may also be earmarked to finance particular government programs.

Therefore, APWA recommends that:

1. NHI be financed from Federal revenues.
2. The basic expenditure control over NHI will be the budgeting-appropriations process, with appropriations planned for a five year period, subject to annual review.
3. Within the overall appropriations, funds would be allocated to state-substate regions, through the contracting mechanism. The allocation would be negotiated with each area, based broadly upon the number of people in each jurisdiction, and with consideration of regional needs and variations in costs, and taking into account administrative expenditures for the three functions being decentralized.
4. A percentage of NHI funds (up to 5%) should be earmarked for resource planning and development to improve the supply, distribution, quality, and organization of health resources, and to finance research and evaluation of the health status of the population health services, and health care financing system. Allocations of these earmarked funds would be made based on contracts with state and substate agencies delegated responsibility for the resource development function, with a portion of the earmarked funds reserved for national priority programs, and national research and evaluation.

PART IV: ASSURING PERFORMANCE OF THE HEALTH DELIVERY SYSTEM UNDER NATIONAL HEALTH INSURANCE

Under NHI the performance of the health care delivery system will be directed at four key objectives: Assuring adequate quality of care; achieving an optimal accessibility to needed service; curbing excessive program expenditures; and promoting appropriate utilization.

These are not new concerns and a variety of techniques designed to achieve such goals have been tested. So far the experience has been mixed. No one method or set of methods has been proven most effective in meeting the four program objectives. This has been the case for several reasons: policies are not flexible enough to account for the wide variations in capacity among geographical areas; they are implemented unilaterally, with little attention to their mutual impact (e.g. the effect of quality control measures on cost containment); and they tend to be adopted without sufficient planning, coordination, or evaluation to project their likely overall effectiveness.

The national health insurance program will ultimately impact every sector of the health care delivery system. It must have the means to influence appropriately the cost, quality, availability and utilization of services. However, given the lack of knowledge about present control mechanisms and the variability among regions and states, reliance on one or even a set of existing methodologies may not prove

adequate. Only when sufficient information becomes available from a working, comprehensive NHI program can the positive and negative effects of various control strategies be evaluated. And even then a method which proves effective in one region may be wholly inappropriate for another. Therefore, APWA recommends that:

1. Until adequate information is available concerning the effectiveness of certain controls and incentives, NHI policy should be flexible and cautious with respect to a system of regulatory controls.

2. The basic expenditure control should be the national budget, allocated to the States or region, through the negotiated contract.

3. A decentralized program of incentives and controls should be adopted. Each regional or state (public) contracting agency will negotiate a set of performance objectives relating to each of the four key program goals. Performance criteria would be formulated to reflect the variations in resources and expertise each agency area might demonstrate. The contract will specify which set of strategies will be undertaken to achieve the objectives. Should a jurisdiction be unable or unwilling to meet the performance objectives, the NHI agency should be empowered to implement necessary controls and incentives.

4. The NHI agency should monitor, through the contract mechanism, the performance of eah contracting agency and should take appropriate action to upgrade such performance as necessary.

5. Information regarding the effectiveness or lack thereof, of particular mechanisms, should be documented, analyzed and evaluated, so that effective methods can be used more widely.

6. Areas that controls and incentives will likely address include the following:

Capital expenditure control to assure that the appropriate supply of services is available (to curb those found medically unnecessary and encourage those that are),

Institutional quality control to assure that facilities meet appropriate physical plant and staffing requirements,

Provider reimbursement policies, to explore the use of financial incentives to curb inappropriate expenditures (would include prospective reimbursement, rate setting, capitation, fees, etc.),

Practitioner quality assurance to assure the level of provider qualifications and services (including certification, licensure, continuing education, utilization review),

Manpower planning to assure appropriate supply and distribution of physicians, nurses and allied medical personnel,

Interchange with claims processing systems to monitor and structure appropriate reimbursement policies, provider eligibility and fraud and abuse detection,

Consumer utilization review to provide enrollees with incentives to seek appropriate health services (e.g. immunizations, screening, pre-natal care) and practice good preventive medicine (e.g. moderation in smoking, diet, drinking). This would involve a great deal of consumer education (see Preventive Care Section),

Health product quality control to assure effectiveness of medical devices, foods, drugs, cost/benefits of technological advances. (This function would be largely administered by other Federal agencies in conjunction with the NHI agency.), and

Assurance of consumer involvement in all aspects of regulation and controls.

PART V: THE ROLE OF THE STATES IN NATIONAL HEALTH INSURANCE ADMINISTRATION AND FUNDING

The flow of funds for health programs between Federal, state and local governments has long been complex and largely disorganized. Myriad programs with similar objectives have frequently competed with one another for limited funds. Programs with required matching, the most prominent being Medicaid, have long been a source of controversy. Wealthy states have been able to spend more and thus capture greater Federal funds than their poorer counterparts. As a result, Medicaid is not uniform among participating jurisdictions. Some states have broad based programs, while others are fairly limited. As a result, indigent persons have not been treated equally.

States have, however, assumed major responsibilities in several areas: regulation, quality assurance, cost containment and resource development. Some jurisdictions have developed sophisticated administrative mechanisms under Medicaid. The key characteristic of states is, however, their tremendous variability. Therefore:

1. To assure uniformity of coverage and benefits, states and local governments should have no role in the financing of NHI. All present Federal categorical grant-in-aid programs should ultimately be eliminated, including Medicaid.

2. States should have major involvement in the administration of NHI. In particular, states should generally be responsible for regulatory functions under contract to

the NHI central authority. They may also have responsibilities in resource development and benefit management.

3. States should continue to finance services, e.g. Medicaid, or residual parts of them, until they are fully covered under NHI.

4. States should also continue to finance health services as they deem necessary which are eliminated under national health insurance (particularly those categorical grant programs), perhaps under a Federal block grant. Such services could include community mental health centers, migrant health programs, etc.

5. The states should maintain epidemiological and environmental health services.

PART VI: PRIMARY PREVENTIVE CARE UNDER NATIONAL HEALTH INSURANCE

Within the spectrum of preventive services, health care services are but one component. Adequate nutrition, housing and sanitation are more important factors in determining level of health status than is medical care. In addition, perhaps the most important single factor in preventing illness and disability is the behavior and life style of the individual consumer of health services. Here, health education can play a major role. National health insurance cannot finance all factors that affect the health of the populations. It must be limited to health care related benefits. Therefore, APWA recommends that:

1. National health insurance should place great emphasis on health education to assure the individual consumer assumes an active role in the maintenance of his health. This should be the responsibility of NHI contracting agencies but may be funded from Federal resource and development allocations. One appropriate locus for basic health education is the school health program, which should ultimately be financed by NHI.

2. Routine maternal and child health services should be among the first covered services for appropriate populations in the phased-in implementation of NHI, including well baby care, pre-natal and post-natal care, immunizations, and necessary examinations to assure appropriate growth and development. Adults should have equal access to preventive services.

PART VII: LONG TERM CARE UNDER NATIONAL HEALTH INSURANCE

There are among our citizens of all ages and all economic circumstances, a significant number for whom day-to-day life activities are limited due to disability: physical, mental, emotional, or developmental. A large number have adjusted to these limitations or have continued to function independently, sustained within their own environment with the support of family and friends. For other, however, external support services—economic, social, vocational, educational, housing, as well as medical—are necessary for the maintenance of life at a satisfactory level of quality. It is these persons who are the target population of what has come to be known as "long term care."

Three major areas of concern that arise out of the current situation must be addressed by any National Health Insurance Program:

1. For persons who require a combination of external support services, the most frequent choice tends to be a institutional setting. This occurs largely because of the inertia of the providers (it is easier to hide the person away in an institution), the paucity of organized services that can combine to maintain the individual in his or her own environment, and the availability of financing mechanisms which tend to deny payment for non-institutional services while paying for the higher cost of institutional care.

2. The major source of payment for long term institutional care is Medicaid. This source of payment further skews the delivery of long term care to the institution. Medicaid also tends to put the delivery of services into the medical model, which not only may be inappropriate to the needs of the individual but also more expensive than necessary. Because of the lack of financing from other sources, and because of the heavy reliance on nursing home and intermediate care facility services, payments for long term care now consume almost 40% of all Medicaid expenditures.

3. With the exception of a few experiments and demonstrations, there are no community-based organizations that have the authority to bring together the range of interrelated support services in order to focus on the needs of those persons requiring long term care. The problem of defining the population in the community that needs long term care is a difficult one. The problem of preventing unnecessary admission to institutions is even more difficult given the lack of coordinated support services and absence of payment sources. However, prevention of unnecessary admission—or control of entry into—institutions is a key element, because the individual tends to lose whatever resources of support might have sustained him outside, and once in the institution finds change or transfer to other settings traumatic.

The objectives of any long term care must be to:

a. Sustain individuals in their own environment to the extent possible.

b. Where the individual cannot or should not be maintained in his own environment, then assure the most appropriate institutional placement, with all service support systems paying their share of the costs.

Therefore, the APWA recommends that:

1. National Health Insurance be responsible for financing all of the medical-health services required by persons needing long term care. In addition to the services of physicians, other health care practitioners, hospital care and outpatient care, this would include such long term care-related services as: Home health aide services; nursing and medical services provided in the individual's residence, including medical devices and supplies for use in the home; therapeutic and rehabilitative health and mental health services required to maintain an optimal level of functioning; health related day care services, beyond those needed for socialization, including medical, nursing and rehabilitative services; transportation related to the need for medical care; institutional care, exclusive of hotel costs, for those whose disability or social condition do not allow maintenance at home and where the institution can provide a variety of levels of personal, medical, social and rehabilitative services.

2. Persons covered under NHI and found to need a combination of non-medical support services, should automatically be eligible for those services needed, with an appropriate co-payment as necessary.

3. NHI should finance appropriate assessment, review, placement functions for persons requiring long term care. Community agencies should be established which will carry out the following functions:

a. Identification of persons needing long term care services, and including referrals from all service support systems of persons they identify as needing such services;

b. Assessment of each person identified or referred to determine the range of support needed;

c. Assistance in securing the services needed and the financing for the services;

d. Continuing review and assessment of changing needs of persons using long term care services (both institutional and non-institutional) with recommendations to the various support systems of changes in services or financing required;

e. With respect to placement in institutional settings, no NHI payments will be made for care in institutions, including day care, unless and until the community agency has conducted an assessment and determined that such placement is the most appropriate needed by the individual; and

f. Advise the NHI resource development agencies concerning the community-based and institutional long term care services needed to be developed.

STATEMENT OF JAMES D. "MIKE" McKEVITT

NFIB, on behalf of its 565,000, small and independent business members, appreciates the opportunity to express its views on the catastrophic health insurance proposals now being considered by the Committee.

GENERAL POSITION

NFIB is opposed to any program of compulsory national health insurance including one covering catastrophic illness only. Our membership has adopted this position on two separate votes. In December, 1976, NFIB members voted 10 percent in favor of a broad mandatory national health insurance program, 34 percent in favor of catastrophic plan only, and 53 percent favored no plan at all. In January, 1979, the issue of a catastrophic program only was posed. It was voted down 39 percent to 55 percent with the remainder undecided.

These votes should not be shocking. Every opinion poll shows Americans more concerned about inflation than any other single problem.[1] Headlines scream with pleas and threats form Administration officials admonishing business and/or labor to review their actions in light of the anti-inflation program.

Small employers were stung in January with new minimum wage and Social Security tax hikes. The February Consumer Price Index increased by 1.2 percent, a four year high. OPEC just increased oil prices 9 percent. And Congress is again considering legislation to increase employer, for our purposes small employer, fixed

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[1] The "NFIB Quarterly Economic Report for Small Business" (January, 1979, data) finds 36 percent of all small businesses consider inflation to be their single most important business problem. Only in October, 1974, when it reached 41 percent, were more small businesses so concerned by inflation.

costs which must be passed along in the form of higher prices and/or lessened employment opportunities particularly for teenagers.

The catastrophic illness proposals now before the Committee are little more than another government ordered "head tax". They direct that an additional levy be placed on each employee simply because that individual happens to be working. Since the employer is expected to absorb this new head tax, the employer's payroll must increase with no commensurate increase in productivity. That means the employer must pay for this new fixed business cost by reducing profits, passing on costs, or reducing employment opportunities. Of course, the result is greater inflation and maintenance, if not exacerbation, of our teenage unemployment problem.

In effect, catastrophic health insurance proposals are "in kind" minimum wage increases. Most economists are now in agreement that increasing the minimum wage contributes to both inflation and teenage unemployment. And further, like the minimum wage, those employers which tend not to provide employee health insurance of any kind are the very smallest and most vulnerable.

Catastrophic health insurance rests on two interrelated fallacious assumptions: (1) Individuals cannot or will not obtain catastrophic insurance on their own initiative, and therefore the government must require it, and (2) health insurance, as distinguished from life insurance, homeowner's insurance, a parking space, warm lunches, and health club dues, is implicit in the employment relationship, requiring government intervention to ensure adherence. Neither of these assumptions are valid.

It is clear catastrophic insurance is being offered by the private sector. Numerous large carriers sell catastrophic policies (supplementary major medical) to individuals as well as groups. And, while "affordable rates" are obviously a function of income, premiums assumed by proponents are clearly within the price range of most Americans. Yet, many evidently choose not to carry such insurance.

While you and I may agree or disagree on the wisdom of such action, it is not the governments' right nor its responsibility to make those judgements for individuals. Clearly, this is another instance of Big Brother prying into the lives of its citizenry. It is, in effect, telling people—'you don't know what is good for you, so I will tell you.' If this were a matter that principally involved persons outside the immediate family unit, e.g. legitimate State requirements for automobile liability insurance, that would be one thing. But this is essentially a "victimless" act, except for the person(s) making the decisions and the immediate family.

The second fallacious assumption mystically relates a specified level of health insurance to a condition of employment.[2] In other words, the employer is forced, as a condition of employment, to provide a benefit not related to an employee's job. Why?

While labor and management may mutually agree that this benefit is a reasonable part of total employee compensation, why does government interfere with this decision? It is not related to working conditions, an employer's act harmful to an employee, e.g. a layoff, etc. Indeed the act is arbitrary at best and an unwarranted interference in private activity at worst.

LESSER EVILS

NFIB also asked its membership, if there were to be some type of national health insurance program, what parameters should be included? Overwhelmingly, small business would prefer, (1) a catastrophic program to any type of comprehensive program, (2) a program administered to the greatest practicable extent by private insurers, (3) a program paid for by premiums (the least favored alternative was a straight payroll tax) (see Table 1 for the reason), and (4) a program where employers are not required to bear the entire cost.

TABLE 1.—COSTLIEST BUSINESS TAX FOR SMALL BUSINESS, 1977

	Type of tax (in percent)				
	Payroll[1]	Business Income	Inventory, Property	Other	Undecided
Form of business:					
Proprietorship	43	37	16	2	7
Partnership	46	32	16	2	4
Corporation	61	27	7	1	4

[2] Why health insurance was chosen rather than a healthful hot lunch, or free parking space is not clear. It would be interesting to know the employees' priority.

TABLE 1.—COSTLIEST BUSINESS TAX FOR SMALL BUSINESS, 1977—Continued

	Type of tax (in percent)				
	Payroll[1]	Business Income	Inventory, Property	Other	Undecided
Annual gross receipts (in thousands):					
less than $50	31	42	21	2	3
$50 to $99	44	34	17	2	3
$100 to $199	50	31	14	2	4
$200 to $349	58	28	9	1	4
$350 to $499	61	26	9	1	3
$500 to $749	62	28	6	1	3
$750 to $999	60	26	8	2	5
$1,000 to $2,999	60	32	5	–	3
$3,000 and above	46	41	6	2	6
Sector:					
Retail	50	31	14	1	4
Wholesale	49	36	8	1	6
Manufacturing	32	57	8	2	2
Construction	66	27	4	1	2
Nonprofessional services	53	32	11	2	3
Finance	62	28	4	1	5
Transportation	65	22	26	2	6
Professional services	44	40	12	1	3
Agriculture	32	34	33	1	1
Unclassified	35	41	11	8	5
Total	52	32	12	1	4

[1] Includes any payroll tax, e g social Security and Unemployment Compensation.
[2] Includes State and local income taxes where applicable.
[3] Personal income tax for proprietors and partners; corporate income tax for corporations.

Source: Unpublished tabulations, National Federation of Independent Business, 1978.

HEALTH INSURANCE PROBLEMS PECULIAR TO SMALL BUSINESS

Employee turnover in small business is high, although layoffs appear relatively low.[3] This is the result of numerous factors including heavy utilization of teenagers, seasonal help, generally lower wage scales, etc. In fact, the "NFIB Quarterly Economic Report for Small Business" consistently finds approximately one in ten small firms has a net decrease in employment every quarter with an average of three to four employees per firm.[4] While these data do not capture the extent of turnover because they measure only decreases among firms registering net decreases in total employment, they are indicative of the situation. Corroborative indications of high employee turnover can be found in two additional pieces of data: 1. 38 percent of all small employers register as a common complaint about job applicants that they will not stay long,[5] and 2. 19 percent of those small firms not carrying employee health insurance indicate high employee turnover is a reason for not doing so.[6]

Another characteristic of the small business labor force is the large numbers of secondary wage earners employed. NFIB estimates 80 percent of all teenagers working are now employed by small firms. While all teenagers are not secondary wage earners, they are far more frequently secondary wage earners than adult males.

These two characteristics of the small business labor force have serious implications for the catastrophic legislation now under consideration. First, a period of

[3] The exception is the construction industry where layoffs are relatively high.

[4] The Bureau of Labor Statistics reports that separation in manufacturing industries averaged 3.8 per 100 employees per month in 1977. See "Monthly Labor Review," February, 1979.

[5] Only the lack of job skills was cited more frequently, "NFIB Employment Report for Small Business," (eds.) Bailey, Richard M., and Dunkelberg, William C., (National Federation of Independent Business: San Mateo, California), November, 1977.

[6] "NFIB National Health Insurance Report for Small Business," (eds.) Bailey, Richard M., and Dunkelberg, William C., (National Federation of Independent Business: San Mateo, California) September, 1978.

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employer paid insurance benefits beyond termination is unreasonable. It is conceivable that a small employer could pay for an employee's catastrophic insurance for more than twice the number of days an individual was employed (assuming eligibility after one month and termination three months after separation.) This situation opens the door to all manners of abuse and serves as as incentive for movement "in and out" of the labor force. But perhaps more importantly, it generates considerable paperwork and unnecessary premium payments. For example, if the separated employee immediately accepts another job unbeknownst to the original employer, that employer will ge paying premiums as will the second employer on the same individual. Further, those employers without computerized payroll systems, i.e. small employers, may well find themselves filing and refiling with their insurance companies as well as rearranging their bookkeeping procedures to ensure that a separated employee is removed from the covered list as soon as legal.

Second, seasonal employees, that is those employees hired for a specified period of time, e.g. Christmas season or summertime, should not be required to be covered. If they are covered, the incentive will be for employers to reduce the number of jobs for teenagers (particularly with coverage after termination) probably through overtime, or develop some "three weeks working and one week not working" mechanism to avoid the system. Neither are beneficial to the employer or employee.

Further, it is recognized by both parties that the employment is temporary, and not necessarily subject to identical pay or benefits of those employed full-time.

Third, you can expect all kinds of double coverage (other than that previously mentioned) resulting from secondary wage earners.[7] For example, a small employer could be paying for insurance on a teenager in his capacity as an employee, while the head of the household's employer will be paying for the teenager in his role as family member. As a result, NFIB believes an employer, after making his decision to hire, should be able to ascertain whether the employee is a secondary wage earner, and if so, be able to exclude that individual from coverage.

To illustrate, the following example is provided.[8] Small businessman Jones ownes and operates a nursery. Mr. Smith works for Mr. Jones and is covered by catastrophic insurance. During the spring and summer, business always picks up. So, Mr. Jones hires four teenagers including Mr. Smith's two sons, Tom and Dick. Two of the teenagers begin work May 15 and the Smith boys start June 1 and June 7. On June 15, small businessman Jones begins to pay catastrophic insurance on two of the teenagers even though it's well known both are sons of upper middle class parents. But on June 20, one of them quits to be followed by the second four days later. Two more teenagers are hired June 25 and July 4. The Smith boys leave the job to return to school on August 24 and September 1. The other teenagers leave September 14, but one of the two drops out of school in a week and takes a full time job.

Here is the result of summer employment for small businessman Jones: Nearly 18 months of work, nearly 30 months of catastrophic premiums paid, no additional coverage secured for any employee, and considerable paperwork. Costs are not estimated for it makes a considerable difference whether Mr. Jones' business is large enough to qualify for a group.

This raises another point—many small businesses don't qualify for a group. Nearly one-quarter of all small employers which do not carry any employee health insurance claim they cannot qualify as a group.[9] We have no means to verify the accuracy of that response or determine how diligently coverage was sought. Nevertheless, since the vast majority are annually grossing less than $200,000, authenticity can be attributed. This is the true "Mom and Pop" sector as well as that of many fledgling firms, but the overall contributions of these firms in terms of GNP and employment are surprisingly high.[10] In some manner, public or private (preferably private), these employers must be able to obtain insurance on a competitive cost basis. If not, their competitive positions could become untenable.

Finally, there is no reason for employers to be paying the cost of catastrophic insurance other than as a negotiated or otherwise agreed upon compensation arrangement. If compelling that portion of the citizenry who do not now carry cata-

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[7] There is a direct relationship between a small businesses' provision of employee health insurance and the percentage of heads of household employed. Those employing heavy percentages of heads of houlseholds are over 3 times as likely to provide employee health insurance as those employing no heads of household. "NFIB National Health Insurance Report for Small Business," op. cit.

[8] The example assumes required coverage 1 month after employment through 3 months beyond termination.

[9] "NFIB National Health Insurance Report for Small Business," op. cit.

[10] In 1975, establishments of 1-9 employers employed 15 percent the private non-farm workforce.

strophic to carry it is a worthy social and economic objective requiring government action, then certainly beneficiaries should help defray the cost.

The government never provides a free service; it always costs someone something. Catastrophic health insurance is no different. Disguising these costs in the form of an employer paid benefit only perpetuates the myth.

Additionally, there are large numbers of marginal small businesses who simply cannot afford paying this new fixed cost. We find that the median money income of self-employed persons, for example, is lower than the median money income for the population as a whole. The blanket assumption, therefore that all firms are capable of taking on this cost defraying in some manner just isn't valid.

You must recognize there is a direct relationship between firm size and the provision of any employee health insurance. The smaller the business the less likely it is to provide this benefit. For example, well over 90 percent of those firms annually grossing $1.5 million or more have it, while 43 percent of those firms annually grossing $100,000—$200,000 carry such insurance.[11] Further, a large portion of those small employers who do not have health insurance for their employees do not have it for themselves either.[12] The point is, there are large numbers of small firms that would severly be impacted by any catastrophic legislation.

Another sub-group hard hit will be those marginal firms relying on large amounts of part-time labor.[13] Not inconceivably, for example, a marginal small employer could pay 10 catastrophic premiums for the equivalent of 6 employees' worth of work.

Thus the higher proportion of part-time workers, the greater the relative cost. For those small firms already struggling, the disproportionate cost impact of the "part-time employee" problem could prove terminal.

CONCLUSION

NFIB, by vote of its membership, opposes government mandated catastrophic health insurance.

The legislation before the Committee could place a lesser burden on small business than it might ordinarily if the following is considered:

Exempting seasonal employees that would be "double covered".

Exempting mandatory coverage after severance.

Provision for those very small small employers who aren't eligible for group coverage.

No employer cost, unless otherwise privately agreed upon.

STATEMENT OF ANTHONY SCOTTO, COCHAIRMAN, NEW YORK STATE COMMITTEE FOR NATIONAL HEALTH SECURITY

The New York State Committee for National Health Security files this statement before the subcommittee on health of the Senate committee on finance, to express its views on S. 350 and S. 351, proposals for a catastrophic health insurance plan and medical assistance program.

The New York State Committee respectfully offers the following comments with respect to Title I and Title II, the catastrophic health insurance provisions of both S. 350 and S. 351, which provisions, in general, we cannot support.

I. Title I and title II do not provide cost protection for low and middle income workers

For many low and middle income working families, catastrophic health insurance—unless it is combined with a comprehensive national health insurance plan—would provide little needed care until after paying very high initial expenditures, which could mean financial disaster for millions of American workers. Provisions in S. 350 and S. 351 would focus health care expenditures, for the most part, on the most expensive and specialized kinds of care, rather than on preventive care, and early diagnosis and treatment.

By providing incentives for only the most costly and exceptional types of health care, catastrophic insurance will certainly boost rising health care costs.

Additionally, it will weaken efforts to institute a quality control system since catastrophic coverage, as we understand it, would not take effect until after the 60th day of hospital confinement and, consequently, any controls that may be

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[11] "NFIB Health Insurance Report for Small Business," op. cit.

[12] Ibid.

[13] Between 20 percent and 25 percent of all small business employees are part-time. See, "NFIB Employment Report for Small Business," op. cit.

included in the bill could not be developed until after the 60th day of hospitalization.

Further, catastrophic insurance will distort the distribution of national health care resources because of the high deductibles, the overwhelming emphasis on catastrophic disease, and the lack of early diagnosis of diseases, home health care, and other essential medical services.

And lastly, catastrophic insurance will require the poor and many working people to pay for a program that will largely benefit upper-income Americans.

With a 60-day deductible for hospital confinement, a $2,000 medical deductible, and a $1,000 co-insurance amount—all to be borne by the patient—it is quite conceivable that many Americans could virtually expend between $18,000-$21,000 before becoming eligible for catastrophic benefits. In simple terms, many working people, we believe, might find themselves in bankruptcy court before ever receiving such benefits as provided in S. 350 and S. 351.

And yet, recent government figures show that the first $2,000 of medical expenses and the first 60 days of hospitalization, in addition to other vital health expenditures, constitute over 99 percent of total expenses for personal health services in the United States.

If enacted, this legislation would provide essentially no protection for the working poor, that is, families with an annual income of $10,000 or less. According to statistics reported by the U.S. Department of Health, Education and Welfare, in 1977 there was a total of 15.7 million families (or 27.5 percent of all American families) with incomes less than $10,000. Of this number, some five million families would be eligible for Medicaid. In other words, about 10 million working families would have incomes above the present eligibility standards for Medicaid, yet would not earn enough to meet the out-of-pocket expenses of a $2,000 medical deductible, or a 60-day hospital deductible that is called for under the catastrophic insurance proposals. Moreover, these same working families could not afford even a basic insurance policy to cover these extraordinary deductible amounts.

In sum, it is our position that as long as needed health care is consequently denied workers and their families through deductibles and co-insurance, there may never be a truly effective health care program in the U.S., except perhaps for those who can well afford to pay the bills.

II. A piecemeal approach to national health coverage is highly inflationary

Of the many legislative measures now before the Congress, none is, we believe, quite as inflationary or as inequitable as the proposals for catastrophic health care insurance.

We believe that we must have a comprehensive national health care program with effective cost and quality controls. A fragmented approach simply cannot succeed. The myriad of federal and local programs, each with its own important and effective goals, has resulted in steadily rising costs, yet without any corresponding benefits. An overall approach, which might include merging many currently-established programs under a system of national standards with local implementation, can begin to serve those with inadequate health care coverage.

Any further delay in dealing with the need for a universal comprehensive health care system, we feel, will result in unremitting suffering for millions and increased health costs which will severely preclude the U.S. from encountering its number one domestic problem—inflation.

According to a recent report issued by the U.S. Department of Health, Education and Welfare, never before have Americans been so healthy—or spent so much to stay that way. The study shows that:

Americans are living longer. Life expectancy at birth in 1976 was 73 years—25 years longer than 80 years ago.

The death rate from heart diseases has declined in the last 30 years, but the cancer rate has risen slightly.

An estimated 32 million Americans—15 percent of the population—have mental disorders. Fourten percent are disabled by chronic diseases, such as arthritis, rheumatism, heart ailments and asthma.

Birth rates continue to decline.

And yet, health costs in 1977 rose to $163 billion.

The proportion of the gross national product (GNP) spent for health care, some 8.8 percent, was an all-time record.

In fact, medical care costs continue to escalate at about twice the rate of all other goods and services, as measured by the consumer price index (CPI), and those costs are nearly doubling every five years. We believe that catastrophic insurance would hasten the already unacceptably high inflation of health care costs. For the American people, this would mean greater taxes, higher insurance premiums, and costlier

out-of-pocket payments if catastrophic insurance is enacted. Indeed, medical care costs could easily double in three years, if an open-ended catastrophic proposal becomes law. And, as costs continue to escalate, more and more Americans will be denied adequate health care simply because they cannot afford it.

A recent Washington Post editorial addressed the deficiencies of a piecemeal approach to health insurance. The editorial stated, in part:

"To enact catastrophic-illness insurance by itself would turn a national health policy in exactly the wrong direction. It would also make cost control for the whole health system much more difficult—and would consequently make comprehensive health coverage more remote than ever. It would do those things because it would swing emphasis and funds to the most expensive and esoteric kinds of intensive hospital care—the desperate cases in which costs are genuinely almost impossible to restrict. The money would flow to the most specialized kinds of high-technology, high capital facilities.

"That would skew American health resources away from the areas where the largest and most important achievements can be accomplished. The quality of highly-specialized hospital care can be the difference between life and death for a critically ill patient. But further advances there can have very little effect on the health and longevity of the population as a whole—all 220 million of us, taken together. The general state of the country's health depends mainly on things that keep us from getting sick in the first place. It depends on the access that all citizens have to routinely competent care when troubles are still in their early stages.

"* * * Catastrophic-illness insurance offers valuable reassurance and protection to people already insured. But it does little to raise standards of health, and it brings the country no closer to the ideal of adequate health care available to every American."

The New York State Committee totally agrees.

There is just one answer, we believe: early enactment and the quickest possible implementation of a comprehensive national health insurance. This is the only way to gear health care costs to the nation's economy. It is the only way to assure good health care for every American.

III. New York State committee strongly supports comprehensive national health care program

Unlike the catastrophic insurance bill, the Health Care for All Americans Act would make quality health care, including catastrophic health services, a basic right of all Americans.

Year in and year out health care has been the fastest rising sector in the cost of living, and hospital costs have been a major contributing factor to inflation.

The Carter administration in recent weeks has announced that the Congress should enact legislation that will control soaring hospital costs under existing arrangements before tackling a national health insurance plan. However, it is our view that the existing arrangements are inherently inflationary. That is why we are convinced that only with comprehensive national health insurance will this country achieve lasting and effective control of health care costs.

The Health Care for All Americans Act, soon to be introduced by Sen. Edward Kennedy, will provide for physician and hospitalization benefits without limit and, therefore, include catastrophic insurance as an integral part of a total health care package. We strongly favor catastrophic protection for all Americans, as part of a comprehensive program with a mainstay of basic coverage that includes preventive and health maintenance benefits without any financial deterrents.

Thank you very much for giving the New York State Committee for National Health Security this opportunity to comment for the record on S. 350 and S. 351.

Statement of Dudley D. Flanders, New Orleans, La. for the Mental Health Association

Mr. Chairman and members of the committee, My name is Dudley Flanders. I am an attorney practicing in New Orleans, Louisiana. I am testifying in behalf of the Mental Health Association, the nationwide volunteer organization which speaks for the mentally ill.

I have been a volunteer for the Mental Health Association for the last 8 years. It was my privilege to work as a chairman of a committee to revise Louisiana's Civil Commitment Laws several years ago. I have been repeatedly impressed by an insidious prejudice against persons who are mentally ill and anyone who has ever been mentally ill. This prejudice exists in almost all aspects of our society. It is present in the law both written and unwritten. It is present in custom. The preju-

dice is practiced by lawyers, judges, legislators and this prejudice is one of the most pervasive limitations facing anyone who has ever suffered mental illness.

I am proud as a lawyer that the law took the first steps in the battle of confronting racial prejudice. As you know, that battle is not over but we are much further along than anyone could have envisioned 25 years ago. If we have National Health Insurance, I would like to see it lead the way in a battle toward ending the prejudice against the mentally ill, regularly treated as second class citizens in areas such as employment, housing and health insurance.

National Health Insurance proposals have either omitted coverage for mental illness entirely or limited it sharply. Justification for this action is embedded in several long held myths:

(1) that such coverage would be too costly,

(2) that outpatient care is slow and often requires years and,

(3) that psychiatric illness always requires long term inpatient care.

These beliefs lead some to conlude that coverage for mental illness in insurance plans causes rates to soar. Finding from various studies can help to dispel these myths and even show that in some cases inclusion of psychiatric coverage in insurance plans can reduce overall costs.

A six-year comparison study was made between 152 patients who received mental health services from the Kaiser Northern California Health Plan, and a carefully matched control group who were also under emotional stress but who received no mental health intervention.[1] Both groups were high medical care utilizers. Among the control group there was no significant differences in medical care utilization for the first three years, but in the fourth and fifth years the control group increased their medical care utilization significantly: 27.2 percent in the fourth year and 13.2 percent in the fifth year.

In the study group, however, there was a decrease in non-psychiatric outpatient medical care utilization of 21.4 percent in the first year, 48.2 percent in the third year, 52.3 percent in the fourth year, and 62.5 percent in the fifth year. Inpatient hospital utilization, the most expensive form of medical care, fell 52 percent after the first year, 69 percent after the second year, and then leveled off.

Eighty percent of this group required only brief psychotherapy, 1-8 sessions.[2] Medical utilization was reduced 60 percent over the next five years by those receiving only one session and 75 percent by those participating in 2-8 sessions.[3]

Cost-therapeutic-effectiveness ratios were developed from the data obtained in this study. The ratio for patients receiving 1-15 sessions of psychotherapy was 2.11, and the ratio for those needing long term psychotherapy (16 or more sessions) was 1.14.[4] Therefore, when psychotherapy is included in a health plan, the costs of providing the benefit are more than offset by the savings in medical utilization. Since a majority of patients need only brief psychotherapy, and there is such a high cost-therapeutic ratio, it is also economically feasible to provide long term psychotherapy to the patients who require it.

Blue Cross of Western Pennsylvania analyzed its experience of including an outpatient psychiatric benefit to a subscriber group made up of 1500 employees and their families. The study analyzed the impact of this benefit on the utilization and cost of fee for service medical services (medical and surgical care, inpatient and outpatient visits). The study group, 136 subscribers who had at least one outpatient psychiatric visit, was compared to all those in the subscriber group who had no outpatient psychotherapy. Utilization rates and costs for the study group were higher than those of the comparison group prior to this contact, but lower than average for the comparison group in the post-treatment period. Total cost per patient per month in the study group decreased 31%.[5]

A study was made of 256 patients who were members of Group Health Association, Inc. (GHA), a prepaid group practice plan in Washington, D.C., and were referred for outpatient psychiatric therapy.[6] The patients were members of GHA for a full 12-month period both before and after their utilization of physicians' services

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[1] Cummings, N., and Follette, W. "Psychiatric Services and Medical Utilization in a Prepaid Health Plan Setting," "Medical Care," January-February, 1976. Volume 5, Number 1.

[2] Jones, K., and Vischi, T. "Impact of Alcohol, Drug Abuse, and Mental Health Treatment on Medical Care Utilization—A Review of the Literature." February, 1976, p. A-3. Alcohol, Drug Abuse and Mental Health Administration.

[3] Cummings, N. "The Anatomy of Psychotherapy Under National Health Insurance," "American Psychologist," September, 1977.

[4] Ibid.

[5] Jones, K., and Vischi, T. Ibid., p. A-23

[6] Goldberg, I., Krantz, G., and Locke, B., "Effect of a Short-Term Outpatient Psychiatric Benefit on the Utilization of Medical Services in a Prepaid Group Practice Medical Program," "Medical Care," September-October, 1970. Volume 8, Number 5.

as compared to a 2 percent reduction by the GHA membership, and a 30 percent reduction in x-ray and lab procedures as compared to a 16 percent increase by the GHA general membership. This, along with the studies cited above, suggests that the provision of mental health services not only reduces the amount of non-psychiatric medical care provided, therefore costs, but even more important, results in provision of medical care which is more appropriate to the illnesses of the patient.

Looked at in the light of this data, the question is not whether we can afford to include mental health services adequately in a system of national health insurance, but rather, whether we can afford not to.

The Mental Health Association has taken no stand on National Health Insurance as such, but we feel that any plan of national health insurance that is adopted must include adequate mental health coverage. I would like to submit for the record, our formal position paper "A Plan of Coverage for the Mentally Ill in National Health Insurance," and describe it briefly now. It states that treatment for mental illness must be made as accessible as treatment for other covered illnesses, and that this treatment should be available in the least restrictive setting. Reimbursement mechanisms should encourage the development of a comprehensive mental health system with an emphasis on outpatient care provided in organized settings. Mental Health coverage must be designed so that appropriate treatment is available to every individual who needs it.

As we understand S. 350 and S. 351, they represent a step forward in that they would provide the same copayment for mental illness as for other covered illnesses, and they would recognize Community Mental Health Centers as providers of care with an unlimited number of visits under catastrophic health insurance. However, these bills do not conform to our requirements in other respects.

First, the reimbursement for outpatient care under Medicare is limited to $400. This amount is lower than was recommended by the President's Commission on Mental Health.

Second, Community Mental Health Centers and other organized care settings should also be recognized as providers of care under Medicare and the Private Basic Health Insurance Certification Program. These facilities provide the least restrictive setting for the patients, (80 percent of the care provided is on an outpatient basis) enable patients to remain active members of the community, and are less expensive than inpatient treatment which is presently encouraged by the reimbursement structure.

Third, only $500 of the $2,000 deductible may be for the diagnosis of mental illness. The substance of this testimony proves this is an unnecessary limitation and represents discrimination against the mentally ill.

S. 748, by contrast, does include provisions for mental health coverage that are compatible with the philosophy I cited. They include: (1) Raising the annual ceiling on outpatient care from $250 to $750; (2) making the copayment equal to that for other covered illnesses; and (3) recognizing Community Mental Health Centers as providers. We support these improvements.

If and when a national health insurance program is enacted in this country, non-discriminatory mental health coverage as outlined in our attached position paper should be offered. Mental health care is as important a component of wellbeing as physical health care. It can be provided on a cost effective basis, and as we've highlighted today, inclusion of mental health coverage can reduce overall insurance costs by reducing utilization of physical health services.

Thank you for letting us present our views. If the Committee has any questions we would be happy to answer them.

MENTAL HEALTH ASSOCIATION,
Arlington, Va., March 1977.

A PLAN OF COVERAGE FOR THE MENTALLY ILL IN NATIONAL HEALTH INSURANCE

The people of this nation are clearly moving to claim a right to treatment when ill, and a right to health if attainable.

Those leaders who will construct this claim and guarantee this right must, in their vision, and wisdom, and compassion, give solemn assurance to those citizens who suffer the pain, the anguish, and the despair of mental illness, that they, too, will receive equitable and appropriate access to these rights and benefits. It is quite frequently impossible for either a practitioner or a patient to distinguish or diagnose precisely between physical illness and mental illness. Therefore, it is to be hoped that neither legislators nor insurers will assume this awesome and arbitrary role. The only honest, appropriate and humane approach is to acknowledge that the misery of mental illness is as tormenting and unbearable to the individual, and as

destructive, debilitating, and costly to the nation, and as legitimate and treatable to the scientific community as any physical illness.

It is just and right and fair and reasonable to expect equal consideration for mental illness with physical illness, regardless of financial considerations or past patterns of discrimination. Neither cost, nor fear, nor ignorance, nor precedent should be allowed to cheat twenty million citizens of their right to treatment for mental illness, and their claim to mental health.—Hilda Robbins, National Chair, Public Affairs—Service Delivery Committee of the Mental Health Association.

Basic Principles

Mental illness is universal. At one time or another, and in one form or another, mild or severe, fleeting or persistent, it strikes almost every American family. Despite this, most health insurance policies—indeed, the government's own Medicare program—either severely limit the coverage of mental illness or exclude it altogether. This outmoded practice is a carry-over from a bygone era when virtually the only treatment for mental illness was expensive, long-term hospitalization.

The Mental Health Association deplores and condemns this discrimination. Not only is it obviously an injustice, but it is also unwarranted in the light of modern knowledge, available medicine, and progressive treatment modalities with their emphasis on out-patient care in community settings. The day of putting the mentally ill away and forgetting about them is past. The day of denying the mentally ill adequate insurance protection is in its twilight.

The framers of the coming National Health Insurance Act have the opportunity and the challenge to right this longstanding wrong, and to guarantee to anyone in America who has the misfortune of becoming mentally ill that his insurance will provide adequate financial assistance to help him share his burden. To assist in this, the Mental Health Association has formulated a number of guiding principles, aimed at providing an appropriate level of service at a reasonable cost.[1]

1. National Health Insurance (NHI) should serve a broader purpose than simply "paying the mental health bills." It should influence the development of a true mental health care delivery system in the United States.
2. Mental health coverage and benefits should be designed for the mentally ill and should be set forth separately; they should not be tied to the traditional patterns of coverage for physical illness.
3. NHI should provide incentives for the development of mental health services—especially for the underserved and high-risk populations—through Community Mental Health Centers (CMHCs)[2] and other Mental Health Service Organizations (MHSOs).[3]
4. The coordination and integration of the currently prevalent state institutional system, the comprehensive community system and the private psychiatric system for mental health services should be facilitated and accelerated by NHI to insure continuity of care and maximum choice of modalities of care.
5. NHI reimbursements should encourage the use of out-of-hospital services which are the least restrictive and least disruptive of the patient's normal living pattern; they are also least expensive.
6. There should be accountability—for program, fiscal, and procedural performance—directly to the general public at all levels and in all aspects of the mental health care delivery system and the health insurance administrative system.
7. There should be a guarantee of privileged communication and confidentiality throughout the mental health care delivery system and throughout the insurance reimbursement and administrative systems.
8. There should be no discrimination against clients in coverage and no discrimination by providers based upon sex, age, race, creed, economic circumstances, previous physical or mental conditions or diagnoses, or patient's location in any institution such as special schools, residential facilities, court-designated settings, etc.
9. Individual Patient Service Plans (IPSP) should be prepared, in conjunction with the patient, for each person who receives treatment.
10. Preventive mental health services should be covered without deductibles or coinsurance, to encourage early treatment.
11. NHI should be seen as a means of expanding mental health services, not reducing them. Therefore it should not be used by government bodies as an excuse for reducing or eliminating financial support for necessary mental health services.

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[1] Information on the cost of providing insurance coverage for mental illness can be found on page 12.

[2] See page 6 for a definition of a CMHC. Also see "A Layman's Guide to the Community Mental Health Center Amendments of 1975," available from NAMH at $.25 a copy.

[3] See page 8 for a description of an MHSO.

12. Every disability—whether psychological or physical or both, or undetermined—should be covered in the most appropriate way by National Health Insurance. The concept of delaying mental health coverage in NHI, or requiring higher co-payments for the mentally disabled segment of the population, is arbitrary, discriminatory, possibly unconstitutional, and therefore totally unacceptable.

MENTAL HEALTH BENEFITS

1. Services provided on an unlimited basis when approved by an independent mental health utilization review panel (IMHURP), including services provided by contract

A. Outpatient Services provided by an MHSO.—No limit should be placed on outpatient services provided by an MHSO. Each client case which has continued for 90 calendar days should be reviewed by an IMHURP. Subsequent reviews should be made every 90 calendar days.

B. Partial Hospitalization Services provided by an MHSO.—No limit should be placed on partial hospitalization services provided by an MHSO. Each client case which has continued for 60 calendar days should be reviewed by an IMHURP. Subsequent reviews should be made every 60 calendar days.

C. Psychotherapeutic Medications.—No limit should be placed on psychotherapeutic medications prescribed by a licensed physician. Use of medication should be included in utilization review procedures.

D. Residential Services for Children.—No limit should be placed on services for children (18 years and younger) when the child is living in a hospital, school or similar residence other than home. Each client case should be reviewed monthly by an IMHURP.

2. Services provided on a limited basis when approved by an IMHURP

A. Outpatient Services not provided by an MHSO.—Outpatient services not provided by an MHSO should be limited to thirty (30) consultations per one-year benefit period. The first seven consultations should be covered in full. Private professional consultations may be provided by private practitioners in categories designated by the Secretary and who hold a valid license issues by an appropriate government agency, and are certified by the appropriate national professional organization to provide diagnostic or therapeutic services. Such services should be subject to a periodic review by an IMHURP. The review should be based upon a random sample.

B. Partial Hospitalization not provided by an MHSO.—Partial hospitalization services provided by facilities other than an MHSO should be limited to 90 days per year.

C. Inpatient Services for Adults.—Inpatient services for adults should be limited to 90 days of active treatment per one year benefit period in an MHSO, or 30 days of active treatment per one year benefit period in a facility other than an MHSO. No continuous stay of more than 20 days should be permitted without approval by an IMHURP. Those client cases found by the IMHURP to need treatment for more than 30 days in a facility other than an MHSO, or more than 90 days in an MHSO, should be eligible for NHI inpatient coverage under provisions for long-term care.

3. Services for long-term and/or chronic mental illness

NHI should provide for medication, health and health supportive services required to meet the needs of persons with long-term and/or chronic mental illness who may be in day care, extended care, intermediate care, foster homes, small group homes and other alternate living arrangements. Home health care provided through follow-up services of MHSOs should be covered. Room, board and other maintenance costs, transportation, vocational counseling, special education and other rehabilitative services are necessary parts of an integrated system of care for persons with chronic disabilities and should be supported through financing arrangements other than NHI.

In no way should the long-term treatment and maintenance benefits for the mentally ill be less than the most favorable coverage provided for any chronic physical illness.

Interviews with clients and review of case records should be conducted at least twice annually by an IMHURP to determine the nature and necessity for continued treatment and maintenance.

4. Continued support for CMHCs

The National Association for Mental Health remains convinced that the basic concepts inherent in Community Mental Health Centers are fundamentally sound. These include:

A. designated responsibility and accountability on a geographic basis for mental health needs of all persons within a geographic area;

B. placement of ultimate governance and accountability with citizen boards within the community;

C. provision of multiple services by multiple disciplines within the community;

D. requirements for preventive as well as treatment programs.

We strongly urge that CMHC programs continue to be supported by federal start-up funds so that the remaining two-thirds of the country may be served. And we further recommend that additional incentives for the continuation of present centers and the stimulation of new centers be developed and built into National Health Insurance.

Definitions and Descriptions

1. Accountability

The development of effective methods of assuring accountability in all aspects of the mental health care delivery system and the health insurance administrative system should be established by NHI. Basic standards for accountability should be set by NHI. As a further aid to placing accountability, NHI should require the development of standardized, unified, automated information management systems to improve quality and coordination of health service, cost control and audit procedures. This would also provide reliable and comparable data for certain research purposes. Basic requirements for assurance of confidentiality, at all levels of services, should be set by NHI.

2. Active Treatment

Active, preventive, diagnostic, therapeutic, supportive, or rehabilitative services should mean that all treatment modalities consist of a planned and written program of daily activities or services based upon diagnosis and designed to prevent regression, improve adaptive capability, or maximize ability to live independently. Such services may include, but are not limited to: family therapy, drugs, testing, nursing, psychotherapy, home visits, counseling, group therapy, casework, and other professional and paraprofessional services, which are a part of active care.

3. Community Mental Health Center (CMHC)

Title III of PL.94-63 defines a CMHC and identifies the services it must provide in order to qualify for Federal funding. A center which meets all these requirements would be eligible to receive special NHI funding, whether or not it is receiving, or has received, Federal funding. All CMHCs would qualify as MHSOs.

4. Independent Mental Health Utilization Review Panel (IMHURP)

IMHURPS, of not less than seven persons, should be established to serve specific geographic areas.

IMHURPS should be comprised of at least three disciplines of the mental health professionals, and also include para-professionals and informed laypersons. Participation on an IMHURP should be limited to three years. In no instance should members of the IMHURP be employees, or Board members, of the organizations being reviewed. Access to information upon which judgment can be made, and authority to enforce this judgment, should be provided by NHI administrative regulations. Such regulations should protect the confidentiality of individual patients' records. All services, no matter where they are delivered, should be subject to IMHURPs, using approved monitoring procedures. The purpose of the utilization review process should be as follows:

A to determine the nature, necessity, and frequency of continued treatment;

B. to safeguard the rights of clients receiving treatment, including the rights of confidentiality;

C. to assure quality care of the most effective and appropriate kind;

D. to assure adherence to Individual Patient Service Plans.

IMHURPs have a responsibility to inform a patient of a finding of inappropriate or unsatisfactory services.

5. Individual Patient Service Plan (IPSP)

Each patient, regardless of the service setting, should have an IPSP, which is prepared and authorized by one or more mental health professionals. Each IPSP

should stipulate clear service objectives within designated time intervals, indicating procedures to be used to attain the objectives, and mental health providers who will carry out the procedures.

The IPSP should include systematic, periodic, progress summary reports, directly related to the agreed upon objectives. Preparation of the IPSP should be done with the concurrence of the patient and should be accessible to the patient at regular review intervals. IPSPs for clients of MHSOs should be approved and monitored by mental health professionals of three or more disciplines.

Frequently, more than one member of a family must receive mental health services at the same time for maximum benefits. This practice should be recognized and encouraged by NHI. Each person should have an IPSP.

Many persons receiving mental health services move back and forth from one setting and/or mode of therapy to another. Some patients receive multiple therapies provided by a variety of professionals and paraprofessionals simultaneously. IPSPs should reflect this practice and be designed to facilitate its use.

6. Mental Health Service Organizations (MHSOs)

I. To be eligible for reimbursement under NHI, an MHSO must meet the following criteria:

A. have the capacity to provide, directly or by contractual arrangements, a coordinated range of mental health services which assure a variety of therapeutic modalities and also assure continuity of care for the patient;

B. employ a staff, including the full-time services of a physician and at least two other mental health professionals such as: psychologists, psychiatric nurse, psychiatric social worker, marriage counselor, or pastoral counselor;

C. provide treatment pursuant to an IPSP approved and monitored by an interdisciplinary team which should consist of a minimum of three different professional disciplines;

D. be approved by the Health Systems Agency in the Health Service Area (under PL.93-641) in which it is located;

E. be licensed under any applicable state or federal law, if this is a requirement in the state;

F. be eligible for funding under state or federal law if applicable;

G. meet the following criteria for coordination of client care:

i. provide for cross consultation and accessibility of all case information subject to applicable laws related to confidentiality;

ii. establish a system for planned and coordinated transfer of clients and their records among providers of service;

iii. maintain a uniform record system.

II. The Boards of Mental Health Service Organizations should meet the following criteria:

A. A MHSO should have a Citizen Advisory Board of no less than nine persons with responsibility for advising in the following areas:

1. establishment of and adherence to priorities for services with special emphasis on high risk and/or underserved populations;

2. personnel policies, including selection of chief administrator of the MHSO;

3. financial policies, including approval of the budget, cost controls, receipt and disbursement of all funds;

4. management and administrative policies;

5. operational structure of the MHSO;

6. procedures for auditing service programs, personnel performance, and fiscal affairs;

7. appropriate action following a review of the findings of IMHURPS and other review organizations;

8. coordination of services of the MHSO with other delivery systems to assure continuity of care;

9. protection of patients' rights and maintenance of patient care standards.

B. The membership requirements of a Citizen Advisory Board should stipulate that at least three quarters of the members be neither health providers nor have a financial interest in the MHSO, and that all members should be residents of and closely representative of the geographic area served. The primary responsibility of such Citizen Advisory Boards should be to the consumer public; all meetings should be open to the public; and a procedure for annual reporting to the public should be developed. Minutes should be recorded. Separate reports should be made to the Health Systems Agency. Where specific recommendations are made by the Citizen Advisory Board, written responses should be required.

7. Other Mental Health Services Not Funded by NHI

A. Funding for Consultation and Education, provided by a CMHC, should be provided on a capitation basis.

B. Mental health research has produced significant areas of knowledge of the causes, diagnosis and treatment of mental illness. Continued, and indeed expanded, research is essential to assure further progress in finding effective treatment methods and ultimately finding means of preventing mental illness. Mental health research should be funded separately from NHI, through categorical funds or project grants.

C. Mental health manpower training and development should be continued and funded separately from NHI, through categorical funds or project grants.

8. Partial Hospitalization

"Partial hospitalization" is a mode of care widely used for severely mentally ill persons receiving intensive treatment for several hours each day and for several days each week, but it does not entail twenty-four hour in-hospital arrangements. NHI should specifically recognize this service and encourage its use.

9. Preventive Mental Health Services

Due to a lingering stigma, fear, and misunderstanding of mental illness, many persons are reluctant to seek mental health services. Mentally ill persons are more likely than those with physical illnesses to delay or to reject early treatment. There should be encouragement and incentives for the public to use preventive services such as crisis-intervention and early diagnosis. NHI should remove financial barriers to early treatment of mental illness.

10. Privileged Communication and Confidentiality

The assurance of confidentiality is an especially important factor in mental health services. The necessity for adequate precautions and protective controls regarding names of specific patients, as well as therapists' comments on IPSPs must be recognized and vigorously enforced in both the mental health care delivery systems and the insurance administrative systems.

11. Residential Services for Children

Treatment modalities and settings (both residential and non-residential) for mentally ill and emotionally disturbed children are frequently unique and innovative, not fitting more typical models. NHI should reimburse for such services when approved by appropriate bodies.

12. Services Provided by Contract

When certain services needed for a client cannot be provided by the regular staff of a MHSO, such services should be provided by a qualified mental health practitioner through a contractual agreement. IPSPs, as described for all MHSO clients, should be required and the same schedule and method of utilization review should prevail. Client billing and NHI reimbursement should be through the MHSO. Contracts with mental health practitioners, other than regular MHSO staff, should be renewable yearly, and should be reviewed by the Citizen Advisory Board.

Information on Cost and Utilization of Mental Health Care

The social and financial costs of mental illness are high. It is estimated that ten percent of the population have emotional problems of sufficient seriousness to warrant professional help. Two and one-half percent of this country's population, 5.25 million persons, are receiving treatment for mental illness. The cost of mental illness in 1974 was $36.786 billion. Over half of this figure ($19.82 billion) was due to income losses resulting from deaths, disability and productive time lost by persons receiving treatment for mental illness. The cost of direct care was fourteen percent ($14.88 billion) of all health care expenditures in the United States. Supportive services accounted for the remaining $1.72 billion. Clearly, the mentally ill and their families need assistance in bearing the financial burden of mental illness.

The currently high cost to the nation caused by mental illness—both treated and untreated—can be substantially ameliorated by more extensive and more appropriate insurance coverage. Experience has shown that earlier intervention, wider use of out-of-hospital treatment, and more appropriate distribution and use of various personnel can lower costs. The position of NAMH would facilitate change and accelerate the expansion of such services.

There is a widely held belief that there would be overutilization, and therefore exorbitant costs if mental illness were adequately insured. However, there are

abundant actual figures regarding costs and utilization, to allay this fear and dispel this myth. The most recent data based on experience is as follows:

1. In the Federal Employees High Option Plan, covering 5.6 million persons, the per-person cost (1973) for virtually unlimited outpatient and inpatient mental health benefits was $6.60 annually for an individual, and $45.52 annually for a family. The Plan includes a $100 deductible and 20 percent co-insurance for outpatient care.

2. In the Canadian Federal-Provencial Health Insurance programs, which provide care for mental conditions to the same extent as physical illness, payments for outpatient services ranged (1971 through 1973) from $.43 annually to $3.15 annually per covered person.

3. The Health Insurance Plan of Greater New York found that it could provide mental illness coverage for a family of three or more for $2.70 per month, in 1972.

THE FACTS ABOUT UTILIZATION

1. Data available on a large number of employees utilizing mental health services is provided by the United Auto Workers Blue Cross Plan of Michigan. In 1973, 2.4 percent of the 2.4 million participants utilized an outpatient psychiatric service. The plan requires no co-payment for the first five out-patient visits.

2. The Federal Employees Health Benefit High Option Program requires a $100 deductible and 20 percent co-insurance. .63 percent of the total enrollees received an outpatient benefit and .13 percent received an inpatient benefit in 1973.

3. Both the Health Insurance Plan of Greater New York, and Group Health Association of Washington, D.C., are Health Maintenance Organizations which limit mental health benefits to those who have acute psychiatric conditions amenable to brief therapy. There has been a utilization rate of 1.1 percent by their adult members.

4. Those receiving benefits for mental illness were 1.1 percent of the total population covered by the Federal Employees Health Benefits program in the years 1971–1973, or about 2.5 percent of the number receiving any benefit in each year.

5. A comparison of benefits paid by Blue Cross/Blue Shield for all conditions, and for the treatment of nervous and mental disorders in 1975, shows that mental health benefits paid were 7.5 percent of the total—or just over $90 million.

6. Mental health services account for a small part of the health care paid for by Medicare. This is explained by the fact that the mentally ill are discriminated against by Medicare. In fiscal year 1973, psychiatric hospital care accounted for less than 2 percent of the $6.6 billion spent on hospital care.

7. In contrast to Medicare, the Medicaid program is a major source for payment of care of elderly patients in mental hospitals. In 1974, Medicaid expenditures in mental hospitals accounted for 10 percent of the total Medicaid expenditures for hospital care, a sharp decrease from the 23 percent figure in 1967. (Source of data: "The Financing, Utilization and Quality of Mental Health Care in the United States", April, 1976. Office of Program Development and Analysis, National Institute of Mental Health.)

8. The Kaiser Foundation Health Plan, in Northern California, in a study of service utilization, determined that patients, after brief psychotherapy (2–8 visits) reduced their utilization of medical services, in the five years following their therapy, by 75 percent.

DELTA DENTAL PLANS ASSOCIATION,
Chicago, Ill., April 9, 1979.

Hon. HERMAN E. TALMADGE,
Russell Senate Building,
Washington, D.C.

DEAR SENATOR TALMADGE: As it was not possible for the Delta Dental Plans Association to give testimony at the recent Senate Finance Committee Hearings on catastrophic health insurance (S-350, S-351), I am taking this opportunity of providing you with a copy of the statement that was prepared by Dr. F. Gene Dixon, President of the Delta Dental Plans Association.

May I particularly call your attention to the enclosed spiral-bound material which describes a unique and successful program in the state of California which provides dental care benefits to 2.8 million Title XIX Medicaid recepients. The program which is underwritten and administered by California Dental Service, the Delta Dental Plan of California, has been in effect for five years and has successfully blended the fee-for-service system with HMO cost containment incentives.

The "Denti-Cal" program as it is known has been responsible for the delivery of dental care to both children and adults on a broader basis, has increased accessibility to dental provi 'ers for eligibles and, at the same time, actually lowered the cost per beneficiary receiving care. The California Delta Plan administrative rate is 5.5 per of the program's total dollars, a remarkably low rate for a dental program.

It is our contention that any national program that provides health care benefits for poor people should include a dental component. The Delta system has demonstrated that an effective, cost-controlled, quality program can be provided to the poor through a partnership of government and the private sector. We urge your close examination of this material and its potential in proposed national legislation. If you or your staff would like any additional information or data, please let us know.

Sincerely,

JAMES BONK,
Vice President.

STATEMENT OF THE DELTA DENTAL PLANS ASSOCIATION

Mr. Chairman, I am Dr. F. Gene Dixon, of San Mateo, California. I am the President of the Delta Dental Plans Association with headquarters in Chicago, Illnois. With me is Dr. Erik D. Olsen, the Executive Vice President of California Dental Service, the Delta Dental Plan of California. We are here representing the Delta Dental Plans Association, the national coordinating agency for the country's not-for-profit dental service corporation system which today provides prepaid dental care programs on a group basis to 15 million subscribers in both the private and publicly funded sectors.

We are aware that the bill under discussion is comprised of three main sections relating to Catastrophic Health Insurance, a Federal Medical Assistance Plan for Low-Income People, and Private Basic Health Insurance Certification. Our testimony today is related to the second section on Medical Assistance for Low-Income People and specifically to the provision of dental services as listed under "health care expenses" as Item (J) on page 72, line 23 of the Bill.

We wish to provide the members of the committee with information on the activities of the Delta Dental Plan system in the area of providing dental benefits under publicly funded programs at the federal and state levels, and specifically, information on a successful 5-year program in California which is presently serving 2.8 million Title XIX Medicaid eligibles in that state.

Following my brief introductory remarks, Dr. Olsen will provide a concise summation of the results of the Title XIX "Denti-Cal" program in California. As we will be providing sections of our report in this hearing, we would like to request that the text of our full statement be included in the published record of these hearings.

The Delta Dental Plans Association is the national coordinating agency for the country's not-for-profit dental service corporations. It was incorporated in 1966 in the State of Illinois as a not-for-profit trade association.

The object of the Delta Dental Plans Association as defined in its Bylaws and Membership Standards is "to increase the availability of dental services to the public by encouraging the expansion of dental prepayment programs administered through nonprofit dental service corporations, and providing the means for active or associate members to cooperate with this Corporation in providing multistate and national group coverage."

More than 25 years ago, the American Dental Association and individual state dental societies, aware of the massive needs of the American public for dental treatment, began encouraging the formation of dental service corporations to provide group programs in the various states. Since then, dental societies in nearly every state have taken steps to incorporate and activate dental service Plans.

These Plans, formed in 47 states and the District of Columbia which adopted the "Delta Dental Plan" name and symbol, are presently underwriting or administering dental care programs for an estimated 15 million Americans under both private and publicly funded programs in all 50 states. The Delta system annual premium volume has been projected to reach $640 million during 1979.

While formed and supported by the organized profession, Delta Plans are separate prepayment organizations under the jurisdiction or regulation of state insurance commissioners or attorneys general. As such, Delta Plan boards of directors are highly cognizant of their multiple responsibilities to program purchasers and subscribers in addition to the providing dentists who have contracted to deliver care under the terms of Plan programs. Evidence of this concern can be seen in the composition of Delta Plan boards, all of which include significant consumer representation.

Delta Dental Plans, as a result of their support by the dental profession and their unique contractual relationships with private dental practitioners, provide "service" benefits to covered subscribers, in contrast to indemnity dollars or fee schedule payments to cover the cost of care.

Delta Dental Plans design their programs to provide maximum dental care benefits to subscribers at reasonable cost. No portion of the Delta income dollar is held for dividends to shareholders. All funds received by Delta Plans are used to pay for services rendered to covered subscribers and their eligible dependents and for administration of the program.

Moreover, the Delta system successfully pioneered such innovative cost containment and quality assurance procedures as a fee concept based on filed and verified fee profiles of individual participating dentists, "predetermination" of proposed treatment and pre- and post-treatment review of proposed or completed cases.

Delta Plan administrative techniques, which have evolved from a first-hand awareness of the "elective" character of most dental treatment, embody a cost-containment philosophy most visible in the determination of covered benefits by Plan dental directors and consultants. Basing their claims processing policies on professionally accepted standards of dental care, Plan professional supervision personnel are able to control effectively areas of program over-utilization, non-essential and repeat services and areas of potential abuse, exercising a level of cost-effectiveness not presently available from other carrier entities.

These characteristics of the Delta Dental Plan system have captured the interest and attention of informed purchasers in private industry, organized labor, as well as governmental agencies at the local, state and federal levels. The Delta system presently provides group coverage for more than one of every four Americans with prepaid dental benefits and is the largest single carrier system for dental coverage in the United States.

In addition to serving millions of Americans under private programs for corporate employees, union members and their dependents, the Delta system has also been responsible for the administration and delivery of care to eligible recepients of public assistance under a variety of tax supported health care programs.

For many years, the Delta system has been the fiscal intermediary for numerous publicly funded programs throughout the country. These programs administered by state Delta Plans have made possible the delivery of dental care to the medically indigent, particularly the child population, on an efficient and cost-effective basis, in the private office setting. These programs have demonstrated the ability of a non-governmental system to deliver needed health care services to this sector of the public, with provider involvement and cooperation, without necessitating the expenditure of tax dollars for the construction of costly clinical facilities by federal or state government.

Delta Dental Plans in some 23 states are presently covering nearly 5 million Americans for dental benefits under federal and state programs including over 3 million under Title XIX Medicaid, and others under Veterans Administration programs, the Indian Health Service, Project Head Start, migrant worker programs, Job Corps, state employee programs and host of others.

In addition to providing benefits under publicly funded programs, the Delta system, nationally, covers an estimated 10 million Americans under private programs, including more than one million United Auto Workers and their dependents, hourly and salaried employees in the Aerospace, Tire and Rubber, meatpacking, and other major industries. Delta subscribers constitute a cross section of Americans from all walks of life, and fields of endeavor as employees of major corporations or medium or small companies or service organizations.

DENTI-CAL PROGRAM

In terms of size and unique administration, the Title XIX Medicaid Program for the state of California (Denti-Cal) underwritten and administered by the Delta Dental Plan of California, represents the most dramatic example of how not-for-profit service Plan can organize the resources of the private sector in providing care to those covered under tax supported programs.

At present, 2.8 million Californians are eligible for dental benefits under the "Denti-Cal" Program (Title XIX Medicaid) developed on a pilot basis in 1973 by the California Delta Plan. In recent years an estimated $100 million annually has been provided for dental care treatment for children and adults.

The Denti-Cal Program, as a model, has been the subject of close observation over the past five years by the health care industry, and by many state and federal agencies including the Department of Health, Education and Welfare, with respect

to its potential for future cooperative ventures between the private prepayment sector and government in the financing and delivery of needed health care services.

THE DELTA SYSTEM AND PRIVATE PROGRAMS

Over the past quarter century the Delta Dental Plan system has been the choice of a number of major corporations and international labor organizations as the underwriter and administrator of group dental programs for their employees and members. These programs, many of which evolved through the collective bargaining process, incorporate benefit designs, cost and quality assurance mechanisms, and other administrative procedures pioneered by the Delta system over the years.

An outstanding example of a successful dental program covering a large number of subscribers is that which was negotiated in the auto industry in 1973 by the United Auto Workers. Today, well over a millon UAW members and their families receive dental benefits under Delta programs purchased by General Motors Corporation and Chrysler Corporation in the states of Michigan, Missouri and California. The UAW-Auto Program has become a prototype for similiar dental programs in a number of major industries and has been responsible for elevating the level of oral health for literally millions of Americans.

Other major corporations and unions that have selected Delta programs include Rockwell International, Kaiser Steel, Lockhead Corporation, McDonnell Douglas Corporation, Armour & Company, Western Greyhound Lines, Northrop Corporation, Crown Zellerbach Corporation, Goodyear Tire and Rubber Company, the International Association of Machinists, the United Rubber Workers, Oil Chemical and Atomic Workers and others.

SUMMARY

The Delta Dental Plans Association believes that the proposal embodied in S-350 and S-351 to "federalize" the provisions of health care services for the poor offers a significant opportunity to the government to develop a program of dental services that would emphasize the preventive aspects of dental care and thus derive a greater impact on the health of this population in relation to the funds expended.

The following proven characteristics of the Delta system are presently available for use as part of a health care program for the poor under government auspices:

More than 25 years of experience in providing prepaid group dental benefits under both private and publicly funded programs;

Programs based on "service benefits" rather than indemnity payments;

A reliable and inflation-minimizing reimbursement system to providers based on verified customary fee filings;

Accessibility to participating providers of services;

Proven and workable cost-containment procedures;

Quality of care assurance systems;

An economic administrative system; and

National program capability.

The Delta Dental Plans Association appreciates this opportunity to provide testimony and information to the members of the Committee. The Association would be please to meet and work with the proper persons designated by the Committee for the development of such a program.

DENTI-CAL

A Pilot Program Which Uniquely Blends the Fee-for-Service System With HMO Cost Containment Incentives

Erik D. Olsen, DDS
Executive Vice President
California Dental Service

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San Francisco, CA 94120
(415) 864-9800

Is it possible to operate health care programs that are effective and economical and still provide quality care?

The question reflects general disenchantment with many health care programs Early enthusiasm is often dampened by administrative red tape, runaway costs and complaints that care is below desired quality standards

Denti-Cal is the dental segment of the federal Medicaid program, Title XIX, operated as a joint pilot project of the California Department of Health and California Dental Service, a member of the nationwide Delta Dental Plans system of dental service corporations The success of the program demonstrates that government-sponsored programs operated by the private sector can produce effective, quality care at reasonable costs In fact, after a lengthy evaluation the Department of Health recently concluded that, "Based on its findings, the department takes the position that CDS has done a satisfactory job of meeting the stated contract objectives"

Because of its achievements, Denti-Cal has been studied by many state and federal agencies as well as representatives from foreign countries Most observers of the program are impressed by its potential as a model for future cooperative ventures between the private prepayment sector and government agencies in the delivery and financing of needed health care through the private practice delivery system

THE PROGRAM

When the Denti-Cal pilot program was initiated over four years ago it had these objectives

1 Broaden use and create a better dental care system for the Medi-Cal (Medicaid) population This goal was to be achieved through participation by more dentists and therefore increased accessibility for the beneficiaries
2 Establish effective quality assurance mechanisms
3 Develop an efficient, cost-effective administration
4 Produce a measurement of the "risk" effect in a government health care program

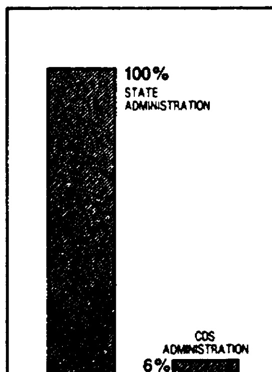
PROGRAM REFINEMENTS

When these goals were established, the State recognized the need to improve the dental portion of its Medi-Cal program As the pilot Denti-Cal project evolved, three basic refinements were made to increase care to beneficiaries and to improve the plan's overall effectiveness

1 The benefit structure for children was expanded to emphasize preventive care and provide coverage available to mainstream dental patients
2 New reimbursement levels were established to make them more closely approximate usual fees A recent study conducted by the University of California, Davis, showed that for the most part, reasonable fees were an important factor in widening accessibility of the Denti-Cal program (It must be pointed out that, though significant fee improvements are being achieved, reimbursement levels still remain below the average fee charged by the state's dentists)
3 Most of the prior authorization requirements of previous programs were eliminated This step had two effects. a) Reduction in authorization requirements eliminated the "paper hassle" to make the program more economical for the dental office, b) Instead of the dental office seeing a patient, doing the paper work and then, some time in the future, providing the care, it could in most cases examine and provide routine and/or necessary services in one appointment

Fig. 1

Elimination of Bureaucratic Red Tape
Required Prior Authorization
(excluding diagnostic and emergency procedures)



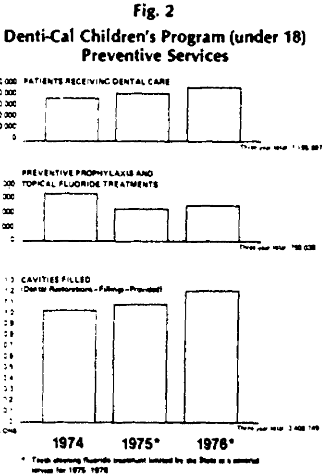
IMPRESSIVE INCREASES

In the first year of operation, utilization of benefits by 2.1 million eligible recipients increased 40 percent for children—with children's utilization in the critical 6 to 12 year age category increasing 47 percent.

During its first three years, nearly 1.2 million children received dental care. There were 750,000 preventive cleaning and fluoride treatments and more than 3.4 million restorations placed.

Fig. 2

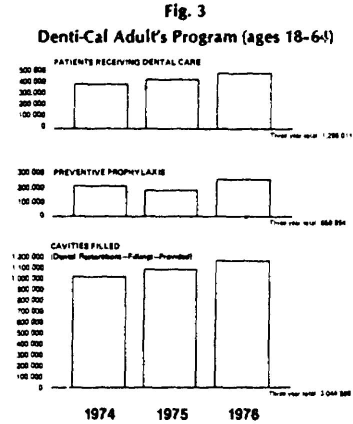
Denti-Cal Children's Program (under 18) Preventive Services



Figures on adults receiving care are similarly impressive. Utilization increased by more than 20 percent in the first year. In the 18-64 group about 1.3 million people received care.

Fig. 3

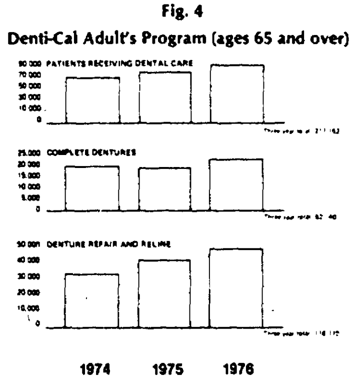
Denti-Cal Adult's Program (ages 18-64)



Denti-Cal also focused on the needs of the elderly, providing full coverage for complete dentures and their repair. For the three years, 62,100 dentures were provided with needed denture repair service provided to over 116,000 patients.

Fig. 4

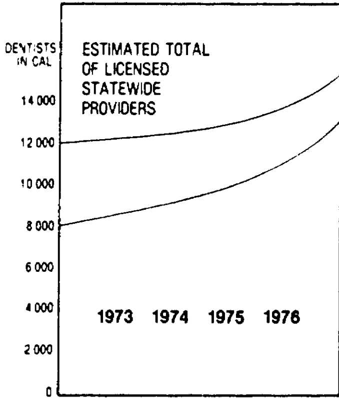
Denti-Cal Adult's Program (ages 65 and over)



The number of dentists participating in Denti-Cal has increased from an estimated 8,000 in 1973 to more than 12,500 in 1976 (with the number of non-participating dentists decreasing)

Fig. 5

Dentists Providing Care to Medi-Cal Beneficiaries



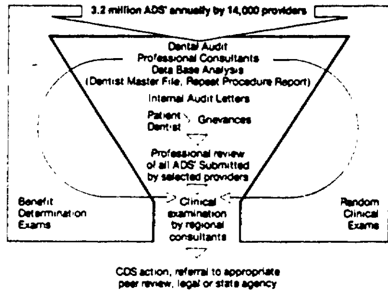
With greater accessibility and more participation it was incumbent on CDS to assure that the dollars expended for care were reasonable and that care met accepted standards under both law and contract To do this, CDS developed a multi-layer processing and quality assurance system

QUALITY ASSURANCE

Each year Denti-Cal receives in excess of 1 5 million Attending Dentist's Statements, or claims Routine processing includes extensive computer cross-checking to determine which procedures are being repeated and whose utilization may fall outside the norm

Fig. 6

Quality Assurance Mechanism
Provider Identification



Each procedure is computer captured in a master file which is then used to build, among other things, a profile of services Profiles and deviant patterns are analyzed for further examination and follow-up

About 10 percent of all claims, attending radiographs and prior patient treatment history are reviewed by a full-time staff of dentist consultants who check for appropriateness of services under the contract as well as any services previously provided the patient These consultants represent general practice and all major specialty areas

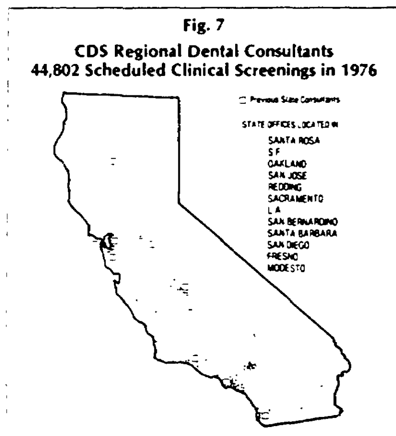
The CDS review system identifies previous procedure failures and any patterns of high failure rate by providers who are then "flagged" for closer scrutiny through clinical examination of patients Providers who have exhibited a history of poor quality service are placed on "hold" to assure that all claims submitted by them receive professional review

Another in-house function that is part of our total quality assurance activity includes a random as well as selective letter audit of patients receiving care to solicit comments regarding impressions of care received CDS sends out thousands of letters each year and analyzes replies to identify any areas of concern The analysis is reviewed quarterly by the seven-member Standing Committee on Public Policy which forwards its recommendations to the CDS Board of Directors

CDS maintains close liaison with the CDA Council on Dental Care and the ADA to continually monitor accepted dental practice and procedures As part of this monitoring function, all dentists providing service under the Denti-Cal program are included in a random selection which requires them to submit all claims for prior authorization This is done so practices and procedures may be evaluated both by CDS' in-house consultants and our network of 250 regional consultants

Fig. 7

CDS Regional Dental Consultants
44,802 Scheduled Clinical Screenings in 1976



This is a statewide network of practicing dentists who are available to clinically examine patients in their private offices This peer review-type system, operated by CDS, gives the Denti-Cal program a critical flexibility, especially involving a "second opinion" in our denture program

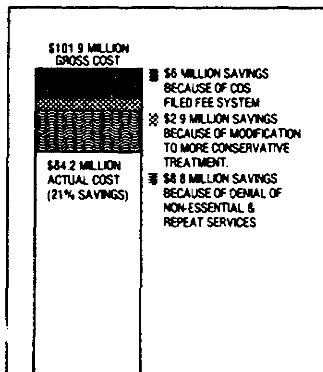
Sometimes such clinical review may produce a request for refunds or a request for evaluation through the California Dental Association Peer Review system, or State Board of Dental Examiners action or other action

COST-EFFECTIVE ADMINISTRATION

What is the net result of all these activities? In 1976, the actual cost of services provided was $84 2 million Had there not been any effective quality and cost assurance mechanisms in the program, the service cost for 1976 would have been $101 9 million—a savings of 21 percent

Fig. 8

Denti-Cal Dollar Savings
Through CDS Administration (1976)



Savings were achieved three different ways First, over 90 percent of all practicing California dentists file their usual fees with CDS These filed fees assure the State that a dentist is not paid more under the Denti-Cal program than he would charge a private patient As a result, in 1976, CDS adjusted submitted fees which exceeded individual dentists' usual, customary and reasonable prefiled fees by $6 million, in accordance with its contractual obligation Second, the professional review process modified allowances for services determined to be beyond the scope of the contract This modification brought savings of $2 9 million Third, the program and review system are designed to deny allowances for less critical and repeat services This savings amounted to $8 8 million. During 1976, CDS, through expertise and experience, saved the State a total of $17 7 million, or 21 percent

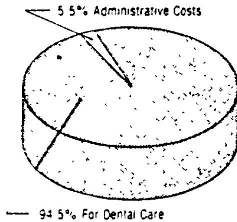
One might expect that overwhelming administrative costs would naturally accompany such extensive efforts Denti-Cal has proven this does not have to be the case

ADMINISTRATIVE COSTS

CDS is proud that its Denti-Cal administrative rate is 5 5 percent of the program's total dollars Usually, dental programs are expensive to administer and most carriers charge from 10 to 20 percent of dues income

Fig. 9

Cost to Administer Denti-Cal Program

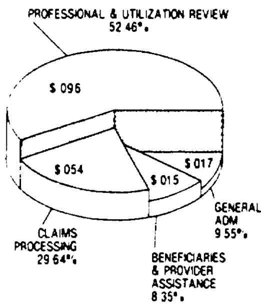


Our single service administrator concept means that one entity is responsible for all activities—authorization, payment, provider and beneficiary relations, data source, etc., thus the costs are centered at one source

How are administrative dollars spent? More than half go for professional and utilization review For this, CDS spends roughly $3 million a year to save the State and taxpayers more than $17 million This is a return of almost six times the investment

Fig. 10

Cost to Administer Denti-Cal Program



ADDING THE RISK CONCEPT

When it refined portions of its pilot Denti-Cal program, CDS made some unique changes which included adding the concept of risk By definition, risk is the contractual guarantee by a party, in this case CDS, to fulfill terms of a contract in providing services to beneficiaries at an agreed reimbursement to providers at a stipulated rate per eligible

Denti-Cal broadened the risk element to include not only CDS but the providing dentists as well This was and still is done through a temporary retention of 5 percent of the dentist's payment in a "Participation Fund" If the program does not show a loss, those funds are returned to the dentists During the early days of the program, losses precluded full return of the Participation Fund However, by 1977 the program had reached a self-sustaining level and continued full repayment is anticipated Denti-Cal is believed to be the first program to apply this risk concept to a major publicly funded service on a statewide basis

The advantages are several and considerable

1 The State has limited its liability for service and administration costs because the financial risk is in the hands of the health care administrator The only factor that increases the dollars spent during the contract year is an increase in the number of eligible recipients Thus the State can budget with a high degree of confidence that the contract will not exceed the budget

2 The financial risk places a very strong incentive upon the administrator to do everything possible to monitor, within law and contract, the service and administrative cost

3 The organized profession has a financial incentive to support program objectives, including fair cost containment mechanisms

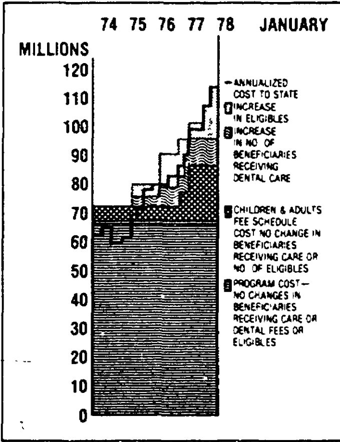
4 The individual dentist has the advantage of a significant government dental program being provided through the private practice system The provider-risk incentive is uniquely blended into a fee-for-service delivery system

Of course, success of the concepts that make up the Denti-Cal program can't be judged totally on the financial aspect Obviously, the State of California also must know if its dollar is buying more and better dental care for its Medicaid recipients

CARE DOUBLED

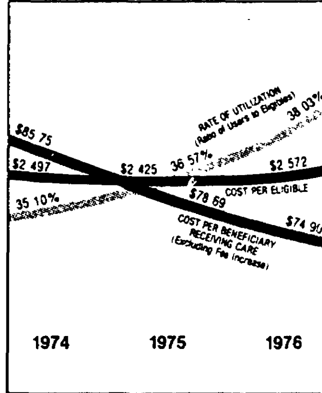
The amount of dental care delivered has almost doubled between 1973 and 1977 Total program costs have increased due to three factors First, more equitable reimbursement levels have resulted from annual fee increases which have approximated the increase in the cost of living Second, there has been the aforementioned increase in utilization by the beneficiaries Third, the largest increase in total program costs has been due to the dramatic increase in the number of people eligible for Medicaid Yet, actual cost to the State for each eligible has not changed very much over the four years of the project even though program utilization by eligibles has gone up dramatically

Fig. 11
Denti-Cal Program Costs



During 1974, Denti-Cal's first year, CDS paid $85 75 for each patient receiving care *Through effective administration, dental review and accumulation of patient treatment histories, the cost per patient has since decreased to $74 90.* These figures illustrate that more beneficiaries are receiving more services while CDS' professionally oriented administration is reducing the cost of care

Fig. 12
Utilization and Cost Controls



ACCOMPLISHMENTS

The decreased cost per patient not only underscores the effectiveness of the system but demonstrates the effects of the risk incentive This is the most successful accomplishment of the pilot project

A number of accomplishments for the pilot program can be listed

1 Increase in use by beneficiaries
2 Creation of an effective review mechanism to assure service quality
3 Increase in participation by the dental profession which produced broader access to services for beneficiaries
4 An advanced and cost-effective administrative system which keeps service costs at a reasonable level
5 Effective cost assurance procedures
6 A limit to financial liability for the State
7 A measure of the full risk concept in a government health program

SUMMARY

The CDS-administered Denti-Cal project proved to be an excellent example of how more care can be delivered to more individuals through cooperation between government and the private sector with the result that an increased proportion of dollars are expended for care and less for administration

Denti-Cal demonstrates the feasibility of a not-for-profit service corporation working with a government agency to provide an extremely effective method of delivering dental care, using the strengths of the current delivery system

This observation is not solely made by CDS As mentioned earlier, the State Department of Health's recently completed evaluation of the pilot project arrived at the same conclusion In speculating on the best course of action concerning future Medicaid dental programs the department concluded, "In our opinion, the objectives of this program can best be realized through contracting with a dental specific, prepaid, at risk fiscal intermediary "

We believe the success of the pilot project is due to the combined efforts of CDA, CDS and the profession The State of California has recognized this past combined commitment and its beneficial effects and we are certain it will strongly influence any future decision on an administrator

STATEMENT OF SERVICE EMPLOYEES INTERNATIONAL UNION AFL-CIO

The Service Employees International Union AFL-CIO, welcomes this opportunity to present our opinion on the Catastrophic Health Insurance and Medical Assistance Reform Legislation of 1979 (S350 and S351).

The Service Employees International Union (SEIU) represents approximately 600,000 workers throughout the United States, one-third in the service fields, one-third healthcare workers and one-third in public sector (local, state and federal workers). This statement represents our position on this proposed legislation, as employees, union members in the healthcare field and as consumers.

Some of our members have chosen to have their outpatient healthcare provided at comprehensive health clinics sponsored by our joint local and employer Health and Welfare funds, others by Health Maintenance Organizations and others as their alternate method of healthcare delivery, by fee-for-service providers reimbursed by private group health insurance plans, for which their employers pay all or part of their premiums. Unfortunately, fee for service plans reimbursed by private insurance are the only forms of group health insurance available in most of the country. The latter plans have deductible and coinsurance provisons. Most of all of our union plans cover the employee, his and her spouse and children.

HEALTH CARE FOR ALL AMERICAN ACT

From the outset, let us make it clear that the SEIU, along with most of organized labor, support the Healthcare for All Americans Act to be introduced in detail by Senator Edward Kennedy in the middle of this month. This bill sets out in one law, to be implemented in major steps (or phases), a comprehensive, universal national health insurance program with a target date of 1985 for full implementation. The bill calls for the administration of the legislation by a Federal Public Authority, to be comprised of consumers, providers, and members of the health insurance industry. Consumers will constitute a majority of this authority. Our members would welcome an opportunity to participate, as many already do in the State and local Health Planning agencies. The Public Authority would establish and use a State structure to administer the program.

Healthcare for all Americans calls for a combination of financing mechanisms. Employer/employee health insurance premiums are supposed to cover a maximum 25 percent of the costs. (These premiums are to be income-related, not a flat percent per person, as private health insurance is presently administered). Unions will have the right to negotiate with employers, in order to retain the present existing employee/employer benefit packages. Ultimately, it is anticipated that the Bill will phase out the entire employer contribution; as the employer contribution, under the act, would be less than it is at present and there would be no provisions requiring employers to negotiate, with unions regarding distribution of any cost saving. In the long run, this bill will require no means test for participation, no coinsurance and no deductibles. Premiums for the unemployed and near-poor would be paid from general federal revenue. Most of this funding for these improvements would come from the insurance premiums and not from taxation. Public and private insurers would be strictly regulated to make certain they conformed with the requirements of the law.

The benefits proposed will be phased in, as follows:

I. As soon as the legislation is enacted; a strong hospital cost controls and physicians fee schedule would be established.

II. Two years after the anniversary date of the legislation's enactment, benefits would be provided for outpatient and inpatient care, with emphasis on preventive services, home health-care, and supplementing the basic general benefits, a catastrophic plan for the entire population; prescription drugs for elderly and disabled, who are currently covered by the Medicare[1] program. Prospective budgeting of hospital costs and geographic physician fee scheduling are to be introduced in this phase. (Cost controls would be put into the hands of physicians and hospitals, the groups most responsible for excessive utilization.)

III. Prescription drugs reimbursement for all participants and those in nursing homes will then be phased in.

Implementation of Phase I would cost from $5 to $7 billion, the same as in the Long-Talmadge Bill. It is estimated that when the entire program is put in place the cost will be between $30 and $32 billion, mainly to overcome Medi-gaps.

When the legislation is finally implemented, the poor and elderly will receive the same level of services provided to the private group health participants. Health Maintenance Organizations and organizations which deliver similar levels of care

[1] Title XVIII of the Social Security Act

will comfortably fit into this structure. There will be no distinction as to the type of recipient as far as the provider is concerned, except as to age. As to reimbursement, no different levels of care will be provided.

CARTER ADMINISTRATION'S PROPOSED NATIONAL HEALTH PROGRAM

It is difficult to determine exactly what the Administration's proposed health plan is to be, as it has not formally been introduced as yet.

According to HEW Secretary Joseph Califano, Phase I of the Administration's program will include the following:

The aged will remain in the Medicare program. Limitation on hospital day deductibles will be removed and physicians will be required to accept assignment from the aged and poor. Children, pregnant women in the low (near poor) income standard (LIS) will be added to Medicaid.[3] Mandatory spend-down for the medically eligible will be added to Medicaid with the Federal government absorbing the cost. Hospital and physician cost controls will be mandatory. Grants for HMOs and National Health Service Corps Providers will be fostered in underserviced areas. There will be continued capital controls and strengthened health planning. All employers are mandated to cover full-time employees with catastrophic health coverage with a $2,500 ceiling. Employers must pay at least 50 percent of insured premium share.

HEW estimated the cost of Phase I at $10 to $15 billion. There are to be no payroll tax increases required. Additional federal expenditures will be financed by general revenues.

No one is quite certain whether the President will place this limited emphasis on Catastrophic Health Care when the Administration's plan is presented. Even if Secretary Califano's Phase I is accepted, there is no guarantee there will ever be a Phase II, with the present hard line philosophy of the Administration's economic advisors. The Secretary emphasizes that this is a National Health Plan not National Health Insurance.

CATASTROPHIC HEALTH INSURANCE AND MEDICAL ASSISTANCE REFORM LEGISLATION OF 1979—S. 350 AND S. 351

The SEIU strongly opposes Title I of both S350 and 351 which provides for Catastrophic Health Insurance. We feel that would provide an inefficient, ineffective and extremely cost-inflated health insurance program.

The Ribicoff-Long Bill, S350, is more concerned with the health needs of the poor and needy, along with the rest of the population. S350 would avail Medicaid benefits to all individuals and families with incomes at or below the following levels:

(1) a single person with less than $3,000 annual income.
(2) a two-person family with an income of less than $4,200
(3) a four-person family with an income of under $5,400

For each additional family member over four, eligibility would be increased $400. No person presently eligible for Medicaid would lose his/her benefits.

The Talmadge-Long Bill, S351, emphasizes the Catastrophic Coverage advantages to the middle and upper classes which have little or no need of such assistance in our present medical structure.

We can lend our support to part of Title II of S350, and Title III of S351 and Title IV of S350. These titles should be separated from the Catastrophic Legislation and introduced as separate bills.

Title II of Section 350 replaces Medicaid with uniform national program benefits for those in the low-income brackets. Allowances for healthcare crises for the near-poor are not included in enough of the State Medicaid provisions.

Different states have different criteria for defining Medicaid populations.

We applaud the effort of the bills to Federalize Medicaid reimbursement.

The inequitable delivery of health care services in Medicaid has been one genuine shortcoming of that program's recipients. For example, one state, Arizona, has no genuine compulsory Medicaid program. Twenty states implement the basic eligibility requirements covering medical assistance for only the poor receiving Federal financing assistance (the categorically needy): (1) Those age 65 years or over; (2) the blind; (3) the permanently and totally disabled; (4) members of families with dependant children. Thirty-three other states and territories include the financially needy, in certain age categories, in administering their Title XIX programs. In many of these states, these people will receive the same services as the categorically needy groups.

A number of SEIU families have incomes slightly higher than $10,000. Fortunately, as part of organized labor, their contracts include fringe benefits providing for

[3] Title XIX of the Social Security Act.

health insurance coverage. According to 1977 data, there are 15.7 million or 27.5 percent of all families with annual incomes of less than $10,000.

Unfortunately, even in some low-income employment situations, employers offer group health insurance, requiring participation sometimes as high as 60 percent employee contribution to 40 percent employer contribution to the premium.

These workers look on health protection as a luxury. They barely have sufficient income for the basic necessities and payment for health insurance is in the Cadillac class. A basic insurance policy to cover deductibles provided for the catastrophic provisions of these two bills would be beyond their means. Not too many of these families would be able to reach the $2,000 out-of-pocket expense for the Medical deductible or the 60-day hospital deductible.

FEDERALIZATION OF HEALTH INSURANCE

Federal standards for insurance companies have been a long time in coming, particularly health insurance.

The SEIU has prepared earlier testimony protesting the various abuses of supplementary Medicare coverage in different states sold by unscrupulous agents and companies, sometimes victimizing our retirees. It is sad that at a time in their lives when they are no longer employed, they become easy prey to these shocking opportunists. Only ten states have made any effort to attack this problem, some more effectively than others. The minimum benefit package of Title XVIII of the Social Security Act does not provide for coverage of pre-existing conditions, long term nursing home care, excessive provider charges, eye-glasses, prescription drugs, private duty nursing when needed, routine check-ups, orthopedic appliances in many cases, hearing aides, routine foot care, long term custodial or mental health care, services provided by most skilled health personnel other than physicians, particular therapists, nurse practitioners and physicians' assistants under special circumstances. And neither do these supplementary plans or these two Bills provide coverage for their Medi-gaps. However, S350 does have provisions for picking up the $8.20 monthly Part B Fee, now paid by Social Security Medicare participants as well as Medicare deductibles and coinsurance.

OTHER AMENDMENTS, S. 350 TITLE IV AND S. 351, TITLE III

The SEIU can support the proposed immunization packages of both bills until the passage of the Healthcare for All Americans Act.

Immunization for childhood diseases should be encouraged and emphasized.

Federal funding should be available for all children, whether covered by Medicaid or not.

HEW, with its various resources, is the logical agency to determine the techniques for scheduling such a program.

In light of the increasing inflationary level, it is essential that additional funding be appropriated for outpatient mental health care for the poor.

It is vital that there be as many people as possible with mental disabilities stabilized in their normal or out-patient environments. Expenditure of these funds would hardly put as great a strain on public funding as institutionalization.

Increasing reimbursement for payment for extended care services have been long overdue. It is appalling to observe that the nursing home beds meeting Medicare and Medicaid standards are not available to these populations, because it is the policy of the public reimbursing agencies to pay providers such low fees that basic costs cannot be met. Adequate funding should be continued for the Renal Disease Program, legislation in place since 1973, as thousands of Americans are depending on those services.

Healthcare providers should be encouraged to accept offers from the philanthropic arena. If efforts were made to support this industry, our nation's third largest, solely by public funds, we would be opening the floodgates for another effort to drown ourselves in the inflation whirlpool.

TITLES I OF S. 350 AND S. 351—THE CATASTROPHIC HEALTH INSURANCE PROPOSALS

A catastrophic health program without the backup of a basic healthcare insurance plan would lead to an excessive inflation such as we have never seen in this country before.

Alone it would be an open invitation to unnecessary expenditure in high-cost technology, long-term hospital and nursing home bed use, increase in testing, laboratory services, etc. Without an exhorbitant expenditure for oversight agencies, little savings would be realized from the implementation of such a program. Experience has proven to us that medical and insurance fraud and abuse is a very expensive proposition. The hospital deductible provided in the proposed legislation

would be triggered in after 60-days of utilization. According to data provided by the Health Resources Administration of the Department of Health, Education, and Welfare, the average length of stay for all general hospital patients in 1977 was 7.3 days and for individuals in the major age groups, as follows: Under 15 years, 4.2 days; 15–44 years, 5.3 days; 45–65 years, 8.5 days; and 65 years and over 11.1 days.

From this data, it appears that few patients would be able to take advantage of the after 60-day hospital stay. If another catastrophic health event occured during the same calendar year, the patient would once again be subject to the 60-day hospital deductible clause to be eligible for benefits. The bills are not specific enough as to whether hospital days can be cumulative during a calendar year to satisfy the deductible, if there are additional admissions.

A $3 copayment would be required on visits to physicians' offices, but there cannot be more than a total of $30 in copayments for any individual. These copayments would not apply to family planning services or well baby visits.

There is a great deal of controversy over the impact of copayment charges and their relationship to healthcare utilization for people in low income brackets.

After considerable study in the U.S. and Canada, State Medicaid administrations tend to veer away from copayments relating to physicians, but copays are heavily utilized in the administration of prescription drugs, eyeglasses and other appliance programs, items with high elasticity of demand.

The passage of these bills would favor the more affluent and play havoc for the poor. Many low-income families would have to resort to Medicaid or welfare to meet excessive medical expenses, but they would continue to be contributing taxes to meet the catastrophic coverage of their more affluent fellow Americans.

Catastrophic coverage alone might appear to be economically responsive, but it is socially irresponsible.

An example of this social irresponsibility is that these bills make no provision for Health Maintenance Organizations (HMOs). There has been a concerted effort on the part of HEW, labor, industry, some providers, and some segments of the insurance industry to implement HMOs in every section of the country.

HMOs represent the first effort at hospital and physician cost containment and often, through their emphasis on preventive medicine, are a proven technique for limitation on the use of high-cost hospital stays.

Even though the bills mention group health insurance, Health Maintenance Organizations are not insurance in the usual definition. As a matter of fact, the legislation as currently proposed will discourage the expansion of HMOs, with the possibility of unlimited reimbursement to the providers after the deductibles are reached.

The catastrophic payroll tax is the cornerstone of S351. It would impose an additional one percent tax on employers. Employers who chose private insurance coverage instead of the public Catastrophic Health Insurance Program would be entitled to a 50 percent tax credit or rebate against their overall one percent tax liability. This would certainly favor large employers. With this approach, additional payroll taxes are eliminated and eventually the use of private insurance will mandate greater coverage for the employed in contrast to unemployed, aged and disabled.

Both bills have split the deductibles, one for physician services and one for hospital services. Even if a family triggers in the $2,000 medical deductible, in order to achieve the hospital deductible, there must be the 60-days of hospital utilization, mentioned earlier. An example of the inequity of this combination would be if a family member dies in the hospital after 40 days of occupancy, but has accumulated hospital bills of $15,000 and physician bills of $5,000. S351 would help the family with reimbursement of $3,000 of the physician bill, but would not provide any reimbursement of the $15,000 of the hospital charges as the required day-stay would not be in excess of the 60.

S351 limits State financing to the Medicaid acute care services and would require States to maintain that low level of financing. This would penalize those states which had utilized Medicaid to its fullest potential and reward those states which had done the least.

It is estimated that this program will cost $7 billion if S351 is implemented and $21 billion if S350 is adopted.

END STAGE RENAL DISEASE PROGRAM UNDER MEDICARE

A number of experiments in catastrophic health insurance are already under way in the United States. The End-Stage Renal Disease Law passed in 1973, (included in Medicare coverage), is administered under the aegis of HEW. The program, has already been amended. In 1973 the program cost the U.S. taxpayer $250 million for

the first year. Last year the charges rose to close to $1 billion, in 1973 dollars. Congress finally had to impose a type of cap legislation to prevent this figure from rising to an estimated $23 billion by 1982 (in 1973 dollars).

Prior to the passage of the legislation, the majority of the patients were treated at home on home dialysis, which cost between $7,000 and $14,000 individually annually, depending on the severity of the illness and areas of residence. After the passage of the law Medicare required that all patients be treated in Dialysis Treatment Centers, a number of which functioned on a for-profit basis. The charges skyrocketed to $25,000 per annum per patient. The number of dialysis Centers more than doubled between 1972 and 1977. Presently, there are 860 such centers providing care.

Congress itself was struck by this first national experiment in catastrophic reimbursement. In the last Congress passed PL 95-292 which stipulated that home care for renal dialysis might now be covered by Medicare funds as well as care in the Centers was passed by an overwhelming majority.

STATES WITH CATASTROPHIC HEALTH PLANS

A number of States, including Rhode Island, Hawaii, Connecticut and Minnesota have adopted Catastrophic Health Plans. None of these is more than four years old and they bear careful scrutiny and evaluation before this type of program is made national law. The motivating force behind these, for the most part, seemed to be a need for some form of health insurance coverage for the uninsurables—the unemployed, those who do not qualify for a group health plan, government coverage, or are considered too great a physical risk by private health insurance standards.

It is estimated that this program will cost $7 billion if S351 is implemented and $21 billion if S350 if adopted.

CONCLUSION

We welcome your renewed effort to help solve the nation's health problems and we applaud the Long-Ribicoff's concern for the near-poor. But it is our hope that your committee will move to the implementation of a comprehensive national health insurance program, which will provide equal access to care regardless of economic, physical status or age.

STATEMENT BY THOMAS G. DORRITY, M.D., CHAIRMAN, LEGISLATIVE COMMITTEE, AND FRANK K. WOOLLEY, EXECUTIVE DIRECTOR OF THE ASSOCIATION OF AMERICAN PHYSICIANS AND SURGEONS

Mr. Chairman and members of the Committee, the AAPS is pleased to submit this statement on various proposals concerning government controlled health care programs.

The Association is a free, independent, non-governmental voluntary organization of members of the medical profession. We are united for the purpose of analyzing the profession's problems and formulating action programs to solve them. Our goals include improvement of medical care for all Americans, preservation of freedom of choice for patients and doctors, and protection of the practice of private medicine.

Our aim is also to educate physicians and the public to recognize and defeat schemes that would weaken or destroy our free choice system of medical care. Founded in 1943, AAPS operates nationwide. We have membership in all 50 states, Puerto Rico, and the District of Columbia. We are non-partisan, non-sectarian, and non-secret in character.

Members of the Association are committed to America's traditional values of individual freedom and family responsibility. We are committed to providing patients with the highest level of health care within a free-market competitive society. We are also committed to the encouragement of the medical profession to provide assistance to needy patients, even when they are unable to pay.

We believe that the federal government's influence and growth into the health area is destroying quality care and fouling our economy with high taxes, inflation, and regulation.

To the initiated and uninitiated alike the proposals before you are complicated. However, a number of common denominators run through them all. We believe that if citizens generally, that is, your constituents and the doctors' patients, understand what these proposals mean, none of them will be enacted into law. Because obviously all contain ideas contrary to the basic economic and political principles which the great majority of us believe in and cherish. Most of us would like to build on our system of individualism. AAPS believes that the proposals before you or any combination of them are, in principle, against the interests of us all.

Obviously, based upon attacks on our medical system, there is misunderstanding of our economic and political system. Medicine is an integral part of this system. Therefore, if the proposals before you undermining our system are to be understood, the system must be understood.

Simply stated it is this: A system within which every individual is free to work as hard as he pleases to produce and to save as much as he can to take care of his present and future needs and those of his family. Since each individual is incapable of producing everything he needs and wants, he should be free to exchange willingly with others what he produces so he can get what he wants. An economic system like ours is, in a sense, knit together by efforts, talents, skills, and desires for income of countless individuals and enterprises. Each seeks to further his own interest, yet somehow this works for the benefit of all.

We have no general central economic planning by government fiat or edict. Yet the willing uncoerced exchange of goods and services for other goods and services—in a vast almost incomprehensible network—brings orderliness to our lives. The customers determine the value of our services and products by the prices which they are willing to pay in the open market. What could be more democratic? Each of us selects where and at what we will work, and then exchanges what we have earned for what other equally free persons offer in exchange. Money, which is the medium of exchange has been called an economic vote, but we really work primarily for what money will acquire for us.

By preserving this system of exchange, free and open to competition with millions of separate and independent, but highly interdependent establishments, economic power is widely dispersed and diffused. Monopoly and coercion are at least effectively minimized and in most instances, avoided. Thus men, money, and materials are devoted or allocated to what the millions of free citizens choose by their individual "votes with money" in the market places every day. To the extent government interferes by such devices as arbitrary taxation of producers for the benefit of non-producers, or artificially sets prices, or wages, the market economy is confused and prohibited from doing the finest job possible.

This system produces a vast diversity and variety of goods and services and an enormous variety of employment, investment, and productive opportunities. No society in history has enjoyed a large degree of political and personal freedom without a free market, "willing exchange" economy to organize and control its economic activity. Thus, political and economic freedom are inextricably interrelated.

Our political system was developed to facilitate this willing exchange. The U.S. Government was established as an impartial referee among us and to deal with matters involving other countries. The U.S. Constitution was adopted to establish a limited government to serve individual citizens. It was not intended to become their master.

This system has helped Americans to develop their talents better than any other place in the world. Under it our economy has flourished, and we have produced and delivered the most and the best goods and services.

As a humane society we have recognized that some individuals are not able to produce or exchange what they need to subsist. These individuals are our "poor". The "poor" have been cared for in this country by family, church, voluntary charitable organizations, and local government. The medical profession was second to none in serving mankind on a charitable basis until some were lured into accepting centralized government payments with red tape attached.

In the past, when government has been used to aid less fortunate citizens, we have followed the rule that the closer a unit of government is to the individual, the more desirable it is to have that unit of government help solve problems, whenever it is reasonably possible to do so. However, increasingly the central government has arbitrarily taken more and more production from citizens to help the "poor". At first it was a small percentage of total production, but now the "take" is becoming a sizeable portion of the total.

For example, today local, state, and federal government units are taking more than half of everything everyone earns. The total take of government for taxes, regulation, and inflation is more than $790 billion while citizen earnings are $1,501 billion.

[In billions of dollars]

Federal expenditures	464.5
State and local expenditures	228.3
Federal regulations	97.9
Total	790.7
Total personal income	1,731.7
Minus transfer payments	–230.4
Total earned income	1,501.3

NOTE.—Data from survey of Current Business, December, 1978, pp. 8 and 9. Public & Private Expenditures for Federal Regulation of Business, Washington University, St. Louis, August, 1978.

The Department of Health, Education, and Welfare alone is now spending nearly $200 billion per year. Obviously, there has to be a halt to accelerated central government spending or our system will be destroyed. Even though destruction is obvious if we continue such irresponsible spending, the proposals before you would greatly increase government spending.

With HEW spending such huge sums to stoke the fires of inflation, more nationalized health insurance schemes would make inflation worse by spending many more billions for "health care". Approaches suggested by members of this Committee range in cost from $3–7 billion. President Carter's Phase I approach ranges from $10–15 billion. Last year's Kennedy bill ranged upward from $130 billion.

It is now reported that Sen. Kennedy will have a bill this year that will start out at a cost of $30 billion. A prudent person knows how unreliable guesses are of government and its allies seeking to squander the central Treasury. The guesses the government sold this Committee on Medicare and Medicaid were downright fraudulent.

Congress was forcefully warned before Medicare and Medicaid were enacted about their true costs and the inevitable damage to the patient-physician relationship and to the economy. This was prior to 1965. Congress paid no attention. Instead, it listened to the bureaucrats and others who had an interest in misleading the people. Bureaucrats told Congress in a most solemn way that the cost of hospitalization the first year would only be $900 million, but it turned out to be $3.4 billion—over three times as much as the bureaucrats said. They also said that in 1975 it would only cost $1.7 billion. It cost $10.6 billion, more than six times what the bureaucracy said.

Costs skyrocketed, as every reasonable person expected. The bureaucratic answer has been to blame doctors and hospitals publicly for their miscalculations and to apply controls on the medical profession to force a reduction in costs. This, of course, was impossible because of general inflation resulting from deliberate policies of government. Demand has increased due to government Medicare and Medicaid promises. Also costs have continued to mount, because demand is insatiable, particularly if that service or product is thought to be free.

It is important to note that with the advent of Medicaid and Medicare the already straining health market was immediately forced into a state of marked economic disequilibrium. In this instance, vast sums of unearned and hitherto unavailable dollars were suddenly poured into the demand side of the health care ledger.

The immediate effect was not just an increase in demand. Demand was psychologically hyper-inflated. The consumer was released from all the restraints imposed by "cost" and "afford." Rather quickly he developed a whole new spectrum of complaints which demand attention—a huge new group—the "worried well". Chronic ailments which were not disabling, with which the consumer had lived and been productive for many years without seeking medical aid, now became more and more emergent.

The consumer begins to demand attention for increasingly trivial complaints. The consumers calls upon the physician became more frequent and hospital admissions were more frequent. The consumer demanded more sophisticated and more luxurious services and facilities than he was willing and/or able to pay for before.

The physician once had difficulty keeping the consumer in the hospital long enough; more and more the problem became getting him to leave. As we have already proved, with the vast and never-ending expansion of welfare programs over the past 40 years, there is no end to the growth of needs and demands when they are unrestrained by the person seeking the service.

As long as the government continues to stimulate demand, and supply remains inelastic, acute shortages will continue, and prices and wages will continue to rise.

Attempts to improve efficiency further by more mechanization and increased paramedical personnel will only increase capital investment and operational costs. Physicians and hospitals, who must pay their bills or close their doors, have no choice but to increase fees and to continue increasing them with each new spiral of general inflation, regulation, and tax increase. This, in general, is the situation in the medical market today.

As long as general inflation continues, which is caused by central government deficit financing, this situation will remain. No combination of managerial talent under the sun can do anything constructive about it.

What happens when the medical market, as seems likely, becomes a government-controlled monopoly, administered by a politically-oriented bureaucracy? It seems unlikely that the situation will improve under the least competent and least efficient form of administration which man has yet devised—government bureaucracy.

Government intervention means a drastic reduction in the overall quality of medical care at a tremendous increase in cost to the consumer. The program will be entirely dependent on a continuation of inflation in spite of massive increases in taxation for the already overburdened taxpayer, and in spite of the proposed hospital price controls.

The demise of competition, the eradication of "fee for service" contract between the physician and the individual patient, the court-created malpractice problem, and the distortion of freedom of action and freedom of choice, are having a disastrous effect on physician motivation and incentive. The art of medicine under these circumstances must degenerate into a sterile and grossly distorted caricature. There may, for a while, be luxury care but the element of quality will, all too often, be lacking.

Further study and evaluation of these fundamental problems is imperative. No useful purpose can be served by minimizing a serious situation. Just how serious our situation is becomes immediately apparent when we realize that the problems of medicine are but one set of symptoms of a disease which threatens our entire social structure.

In the face of the colossal blunders of Medicare and Medicaid, it is now proposed to pile another catastrophe upon them many times worse. This is the real "crisis" and the people had better be told the truth now. Costs of government, not medical care, is the problem America must solve.

As the public sector is bloated with more and more spending, with more and more waste and less and less performance, the private sector is becoming weaker and weaker. As resources are appropriated by government they are denied to the non-government sector.

All of the legislative proposals on health care pending before this Committee ask you to usurp power through the central government which would violate the intentions of the Founding Fathers and the U.S. Constitution. Specifically, you are being asked to authorize increased taxation and government control over all individuals demanding and supplying goods and services related to health and medical care.

This would give less competent people (government clerks) authority to push around competent people! This is a tragedy! Because first you have the apparent power to grant the request. Second, individual liberty, here of all places in the world, is being so abused that power seekers think the time is ripe to nail shut its coffin lid as has been done elsewhere.

Third, the legislative situation is so confused and obscure that few individuals understand what is being done to their individual liberty. Much emphasis is being placed on what is being done for people through governmental promises of benefits impossible of delivery. So the people are confused about what is being done to their responsibility and freedom upon which their happiness depends.

If the central government has power to subsidize and control medical service for everyone then by the same reasoning, it can do the same for food, clothing, housing, autos, recreation, and any other goods or services. Obviously, such an absurdity negates any limitation of the central government to destroy our system of willing exchange.

The proponents of this tragedy are asking you and your constituents to believe in a piecemeal fashion that: (1) All of the citizens can get all of the medical care which they wish without cost to themselves; (2) The American system of individual responsibility through which goods and services are willingly exchanged without government coercion has failed; (3) You should substitute for the brilliant success of the decentralized, flexible, and innovative American system, the failures of the centralized rigid and stagnant European system.

The proponents assert there is a "crisis" in health care in the U.S. This language is an effort to scare citizens into supporting drastic central government intervention

into areas not delegated to it by the U.S. Constitution. If there were a real crisis, people would be waiting for weeks and months to get into hospitals or days to see physicians—as they do in other countries having politicalized medicine such as Britain.

We believe you should reject the requests, and explain to your constituents, as we shall do, why the requests are against their interests.

The HEW bureaucrats have consistently stuck with a strategy to nationalize health care under a compulsory socialized system. If they cannot accomplish their goals in one broad comprehensive sweep of the entire medical field, they have demonstrated their intent to accomplish their goals incrementally by foot-in-the-door techniques. Some call it gradualism. This year you have already had enough testimony before your Committee from Secretary Califano to substantiate this not as a claim or assertion on our part but as a fact.

Secretary Califano has said that with the already existing regulations forced under the Medicare, Medicaid, PSRO, H.M.O. and other federal public laws, HEW has enough data to institute price controls on the hospitals if given the authority by the Congress. Did anyone on this Committee at the time of the passage of these particular laws intend to establish a basis for the operation of hospital price controls? Of course not.

Secretary Califano has said that he wants these price controls to help curb the inflation we are now experiencing. Yet he has admitted that any savings resulting should be spent on President Carter's Phase I of a "national health plan". It's pure and simple, the Secretary wants to make the decisions of where some of the health dollars are to be spent instead of allowing the individual to make that decision. That is not all. There is clearly more. This is only Phase I. Phase II will be the step toward acceptance of a Kennedy-style takeover of health care. At that stage the government bureaucrat would be given complete control of how all health dollars are to be spent.

Unfortunately, some well-meaning members, even of this Committee, have looked at the scope of the so-called crisis and concluded that more government intervention is, in fact, required. They, however, are attempting to demonstrate that they do not want Califano or Kennedy-style intervention. They indicate that they would sidetrack the HEW goal of federalizing health care while solving a crisis.

Most of these approaches are in the form of some type of catastrophic health insurance. But isn't it obvious that that is exactly what HEW wants? Once such a proposal is in place the lowering or dropping of deductibles could be legislatively accomplished easily.

Thus, the federal government would pay for and control all medical care. The passage of a catastrophic bill would be a castrophe. It would establish the principle that the federal government has the responsibility for everyone's medical expenses. All that would be left would be the haggling over price.

The consequences of more government involvement has many aspects. Two in particular must be emphasized. First, more government involvement makes more constraint on free choice inevitable. The U.S. Solicitor General argued in AAPS vs. Weinberger (395 F. Suppl. 125, 1975) that anyone whose medical care is paid for by government has no right to free choice of a physician. "Patients whose medical care is provided by public funds have no constitutional right to . . . obtain that care 'from a physician of their choice'." The U.S. Supreme Court did not disagree with the Solicitor General's position.

Second, from the experience of other countries that have tried socialized medicine, from our own experience with Medicaid, Medicare and other government health programs, and from a Rand Corporation study on NHI ("Commitment", Abbott Laboratories, Spring, 1979) we know there will be a significant increase in demand for medical services. Since the supply side is very inelastic, something will have to give. Services will, out of absolute necessity, have to be rationed by bureaucratic dictates.

We do not believe that this is the intent or judgment of this Committee or the Congress. AAPS recognizes that there is supposed public sentiment growing that something must be done about health care costs and insurance coverage for catastrophic illness. We believe that there are problems in this area but we also believe that a "crisis" has been contrived by HEW bureaucrats. This takes the heat off their own inflation engine and shifts the focus to the private medical profession in order to justify, at the very least, nationalized compulsory catastrophic health insurance, which is another foot-in-the-door effort to a complete federal takeover.

In The American Spectator (April, 1978) William Simon said, "Califano's most basic assertion is that health care costs are spiraling out of sight. He would have us believe that this cost increase is outstripping the cost increase of all other commod-

ities. But according to the Consumer Price Index medical costs for the past decade have not risen nearly as rapidly as the cost of many other essential services. The following list showed what you paid at the end of 1978 for certain products and services that cost only a dollar in 1967.

Medical care	$2.23
Auto maintenance and repair	2.24
Home financing, taxes, and insurance charges	2.69
Gas and electricity	2.38
Home repair and maintenance	2.37
Water and sewer services	2.35
Postal fees under Government supervision	2.57

"Consider, as well, the Social Security tax bite: From 1967 through 1978, the maximum Social Security tax increase rose twice as fast as health care costs.

"But Califano is not interested in figures that undermine his case—especially apparent in his assaults on pharmaceuticals. Among all major industries, pharmaceuticals have been one of the most successful at keeping prices down. In terms of real dollars we pay considerably less for prescription drugs now than a decade ago. Between 1967 and 1978, according to the Bureau of Labor Statistics, prices for all goods rose 99.3 percent. The price of prescription drugs, however, rose less than 34 percent.

"That figure is especially remarkable when we consider the effect of Food and Drug Administration regulation of the drug industry. In the early 1960s, it cost $1.5 million, after basic research had been completed to develop a new drug and win federal approval to market it. Today, that cost has risen to at least $15 million. Yet in 1978, when all costs were rising 8.3 percent, drug prices rose 7.6 percent.

"One wishes, before Califano nationalizes medicine, that he would reassure us all by pointing to just one instance in which government intrusion into the private sector has resulted in a less expensive product—or for that matter, a product of higher quality. To my knowledge, that has never happened, and it would be highly unlikely that it happen in the complex field of health care."

Rather than a crisis in the health insurance coverage for our citizens Mr. Califano could have presented an entirely different picture to this Committee. The fact is that more than 207 million Americans—that's over 92 percent—have health insurance coverage today or have the income available to buy it.

The fact is that more than 150 million Americans under age 65—that's over 75 percent—have private catastrophic protection defined at benefit levels of $10,000 or more. In 1960 only 25 million Americans had this coverage. After Medicare, Medicaid, veterans programs, renal disease coverage, etc. are considered with the existing private coverage, it should be clear that only a small number of those who do not have this coverage cannot afford it.

According to a report of the National Center for Health Services Resources, Human Resources Agency, Department of Health, Education, and Welfare, only 4 out of 10,000 population who are not institutionalized, will have out-of-pocket expenses of $5,000 or more for catastrophic illnesses. That would mean that for 10 million Americans without catastrophic coverage, 4,000 could be in need of assistance.

Why shouldn't the family, church, other organizations and/or local and/or state government be expected to deal with this problem? Just this past year Americans gave more than $38 billion to charitable organizations. Almost $5.5 billion of that went to the health arena alone.

Why should we remove the responsibility for one's own health from the individual to the federal government? Why should we jeopardize our entire medical care system for all Americans by adoption of a national catastrophic health scheme? It just doesn't make sense!

At this time. there is no crisis in medical care in the United States. Private enterprise medicine is still producing the highest quality of medical care found anywhere in the world.

In fact, ample evidence is available to the Committee that the quality of medical care deteriorates when national health insurance and other socialized medicine schemes, similar to those proposed, are put into action. Even in the U.S., Medicare and Medicaid have placed a tremendous burden upon our system of care by forcing the private patient to pay extra when the government reneges on its obligations. PSROs and other expensive invasions of the patient-physician relationship, instead of helping resolve the problem only tend to aggravate it further.

Add to this the fact that our up-to-now profligate Congresses always seem to finance these programs by going into debt, and a real crisis does face us—not of medical care, but of bankruptcy and general inflation.

Perhaps the Committee should give consideration to returning the Medicare and Medicaid patient back to providing his own care where he can afford it, or to local charity, county and state government where he cannot, instead of digging even deeper into the morass by trying to provide medical care for all.

Why are Medicare, Medicaid and other compulsory federal schemes the most expensive way of providing medical care? For these reasons, among others:

1. Desire for medical care is all but inexhaustible. The federal government has no way of sorting out desire from need as effectively as an individual can himself.

2. To try to resolve the first problem, the government piles on regulation after regulation. The regulations fail to correct, but rather aggravate the problem by diverting time and energy away from the physicians' primary concern—caring for sick patients—while at the same time repressing any creativity that might have helped ease the difficulty.

3. Bureaucracy is by its nature inefficient, since it is spending someone else's money and does not watch carefully how to conserve. Funds are diverted from the taxpayer-patient so that he cannot control the use of funds. This tends to over-utilize the system.

In summary then, in the interest of preserving high quality medical care, the private practice of medicine and the personal patient-physician relationship, we request that you:

Recognize the inefficiencies, destructiveness, and inflationary tendencies of federal medicine programs, whether Medicare, Medicaid, national catastrophic health insurance or other so-called national health insurance proposals.

Study methods of gradually repealing the Medicare and Medicaid laws and place the responsibility for medical care back where it belongs—with the individual, the charitable institution and the local government.

Avoid getting deeper into the morass of bankruptcy and inflation by soundly rejecting all schemes of national health insurance and steps to national health insurance such as catastrophic and cost control schemes.

Statement of the Optical Laboratories Association

Mr. Chairman, I am Ed Sutherlin, President of Sutherlin Optical Co., Inc., Kansas City, Mo. With me is Mr. Keith West, president of Benson Optical Co., whose headquarters are in Minneapolis, Minnesota. We appear here today in behalf of the Optical Laboratories Association.

The OLA represents 375 firms operating from over 700 business locations (laboratories) employing approximately 15,000 persons. These firms are principally small businesses. Their size ranges from a two-man partnership in a single location to over 1,300 employees spread out over more than 100 locations. Of the 375 firms, about one-third have 10 or fewer employees, another one-third have 25 or fewer employees and the remaining one-third employ 25 or more persons. While the vast majority of firms operate from a single location, the larger employers have multiple business locations (branches). Narrowly defined, the "optical laboratory" is a full service prescription ophthalmic laboratory with the capability to grind lenses to prescribed powers, and to form lenses to fit styles of frames selected by patients.

We understand that Senate Bill 350 proposes three major changes to the Social Security Act. Our purpose is to discuss certain aspects of Title II which proposes to replace the Medicaid program with a Federal Medical Assistance Plan for low-income people.

The bill in specifying the "health care expenses" for eligible beneficiaries includes eyeglasses prescribed by physicians skilled in diseases of the eye or by an optometrist. The Optical Laboratories of the country are thus directly involved as providers for services prescribed in the legislation. We deeply appreciate this opportunity to discuss the provision of eyeglasses and to make recommendations which we believe will facilitate this purpose. We do so in the belief that this committee and the Congress desire to see that those individuals for whom eyeglasses are prescribed are benefited by having easy accessability for the fitting and any needed future servicing, assurance as to quality, and that the eyeglasses may be provided in an economical manner.

We realize that many of the details of a procurement program involving eyeglasses, as well as other goods and services furnished to eligible individuals under medical assistance plans, must necessarily be left to administrators. However, the statutes and regulations which have governed such programs heretofore have not

recognized the existence of an independent optical laboratory industry; nor have such programs been designed to take advantage of the quality factors and cost savings which a proper utilization of that industry would provide to federally assisted programs. The state Medicaid programs and the Federal Veterans Administration program are examples. For that reason we beleive that this is an appropriate forum in which to state our views as to the proper structure of federally assisted eyeglass procurement programs.

At the outset, we believe that no program can be properly structured unless the administrators of that program understand the essential components of the total procurement price of eyeglasses and address each component properly. Those components are:

I. An examination and refraction by a professional—ophthalmologist or optometrist.

This cost should be met by separate professional fees.

II. The cost of materials: To identify these costs as a separate component the completed device should be fabricated by a qualified laboratory independent of professionals and dispensers.

III. The cost of furnishing the completed device to the patient-user: This cost—usually called a "dispensing" fee—covers measuring, fitting and other services provided to the ultimate eyeglass wearer. This fee should be separately stated and paid—not as a part of the cost of materials.

The separate functions set out above have been hard to explain to persons outside the industry, including many program administrators, because of a common confusion between the functions of the refractionist and the dispenser, and because of a general lack of knowledge of just where the materials originated. This confusion occurs because practically all optometrists (O.D.'s) and about half of the ophthalmologists (M.D.'s) dispense completed devices in connection with their professional offices and most employ an assistant or optician to perform the dispensing function. They make an overall charge to the patient which consists of a combination of a professional fee, a dispensing fee, and a charge for the materials. There is little knowledge of the fact that there is an independent laboratory business which fabricates the eyeglass device on the prescription order of the professional and delivers it to the dispenser ready to be fitted to the user. The dispensing optician who operates his business separate from the refractionist also has most of his prescriptions fabricated in an optical laboratory. The general pricing structure of the independent optician is to mark up products and services over his cost of materials.

The independent laboratory industry does exist. We fabricate most of the devices not produced in retail operations (doctor owned or independent) that have a finishing shop in conjunction with their retail outlet; the laboratory industry is used by practically all O.D.'s and M.D.'s in providing for their private patients; and it is extremely competitive as to prices and services. If this competitive factor is recognized and properly used, it can help to provide public programs with quality materials at competitive prices. It is our position that the industry can be properly used—to the advantage of the public programs—only if materials are properly recognized as a separate component.

The quality of the eye examination is recognized as being of basic importance to any vision care program. This quality is assured by the required educational preparation of the professional conducting the examination, their licensure, and by the peer review process in effect. However, it is less realized that to the wearer of the eyeglasses, the quality of the skilled laboratory preparation of the lenses is also of major importance. In recognition of this fact, the Association has undertaken a program of established standards to qualify laboratories. Following is a description of that effort.

The proposed program utilizes accreditation as a means of conducting non-governmental, voluntary peer review evaluation of optical laboratories. The functions of accreditation for the OLA Qualified Optical Laboratory Program are to:

1. Certify that an optical laboratory has met established standards.
2. Assist ophthalmologists, optometrists, dispensing opticians and third party payers in identifying optical laboratories that have met established standards.
3. Create goals for self-improvement of optical laboratory operations and stimulate a general improvement in optical laboratory quality control standards and methods.
4. Involve optical laboratory management and personnel comprehensively in optical laboratory quality control evaluation and planning.
5. Establish criteria for providing a standard of knowledge and competence in optical laboratory quality control.

Once it is recognized that a separate industry exists and that materials should be separately treated, a program could be easily shaped. While we realize that details may properly be left to administrators rather than included in legislation, our position can be well illustrated by the outline of a plan which we submitted to the Health Care Financing Administration on October 16, 1978, in response to a Federal Register Notice of August 31, 1978. That program is as follows:

I. The program would establish separate charges for:

A. Professional fees.

B. Dispensing fees.

C. Cost of materials fabricated into a finished device.

It is suggested that these fees and/or charges be prefiled for thoroughly defined benefit coverage and that a percentile cut off establish the maximum charges allowed within a geographic area, but with each provider assuring his prefiled charges for one (1) year.

II. The program would specify what materials it would pay for.

A. Frames could be specified by: (1) Specific names, (2) maximum prices, or (3) a maximum percentile of the prices found in current, standard, domestic frame catalogs.

NOTE.—Cost savings could result from restricting the the number of frame styles available to the more popular domestically available frames that most retailers and laboratories already stock. This would allow for a reasonably broad selection.

B. Lenses could be specified by: (1) Brand names, (2) quality descriptions, or (3) Specifications on color, size, lens style would maximize cost savings.

C. Time and conditions of delivery need be spelled out in the program design.

III. Charges for materials fabricated by a properly qualified laboratory into a completed device—of lenses, surfaced, edged, rendered impact resistant and tested, and assembled into a frame would be determined from the appropriate percentile of current prices submitted for the defined or specified lenses and frames by laboratories operating within the applicable market.

IV. Completed eyeglasses could be ordered by any dispenser participating in the program from a laboratory of his choice.

A. Assuming that the laboratory had agreed to furnish materials of the specified quality at the price specified, under the prescribed time and terms of delivery.

B. The laboratory's submitted price for the defined eyewear would set its maximum charge. Our experience supports the benefit of such an approach.

The Veterans Administration has tried lowest bidder single contracts on eyewear with little success for various reasons:

1. The savings between quoted prices and the competitive market are minimal compared to the inconvenience and lack of control of service and quality. The only savings that can be made without a subsequent reduction in service and quality is in sales and inventory costs which are minimal in the optical industry.

2. Lowest bidders are always laboratories not generally preferred by the professions for quality workmanship and service and are generally located where the lowest labor rates are or are vertically integrated lab-marketing companies.

3. Eyecare and eyewear is a personalized service that requires laboratory participation in the delivery system. Lowest bidders are not set up conveniently for consultation or correction of errors.

4. The training requirement is long for personnel to properly fabricate prescription eyewear to acceptable quality levels. The investment personnel, in equipment, in space, and machinery is high. No companies are set up to properly train personnel for a contract, then let them go if they lose the contract the next year. Few are financially able to add facilities to take on lowest bidder contracts and add the necessary equipment and space to perform satisfactorily under the contract term.

The proposal being considered by HEW on lowest bidder laboratory contracts for Medicaid recipients ignores the following facts—eyewear is a personalized medical and cosmetic device made one at a time by skilled craftsmen:

1. A broad base of refractionists and dispensers will participate in these programs if realistically reimbursed for their services.

2. The separate treatment of reimbursement schedules between refractionist, optician and laboratory will result in a system of checks and balances on quality which will work to the consumer's advantage.

3. Specification of frame styles already proven popular will satisfy most appearance needs as well as fit and comfort needs. These styles are universally available from opticians and laboratories.

4. Specification of the lens style, size and color will simplify the program and keep it cost effective.

5. Consumer will be able to use doctors and opticians of their choice and doctors and opticians can use laboratories of their choice.

Our suggested program would be least disruptive to the existing structure of the industry while giving good quality and service to the publicly funded programs. It comes squarely within the requirement of Section 1903(i)(1) of the Social Security Act that reasonable charges "may not exceed the lowest charge levels at which such services * * * are widely and consistently available in a locality." In addition, it meets the generally accepted administrative rule that procurement policies should not diminish the quality and availability of services but, if possible, should expand both.

Finally, it is submitted that an important segment of the existing industry—the independent optical laboratory segment—should not be deprived of the opportunity to participate in public procurement programs so long as it can provide quality materials and workmanship at competitive prices. We would welcome the chance to assist in devising appropriate legislative language which would make this objective possible.

STATEMENT OF THE AMERICAN OCCUPATIONAL THERAPY ASSOCIATION, INC.

The American Occupational Therapy Association is pleased to submit comments on S. 350, the Catastrophic Health Insurance proposal introduced by Chairman Russell B. Long and Senator Abraham A. Ribicoff, in conjunction with the Finance Committee's public hearings on this bill. We applaud the Committee's initiative in addressing the tremendous financial problems which many Americans face because they suffer from an extended illness or disability. Occupational therapists are especially aware of these problems because they specialize in helping people who have experienced a catastrophic disease or accident to return to as normal a life as possible. In addition, occupational therapists have found that financial fears or hardships often undermine this rehabilitative process.

Formed in 1917, the Association represents over 27,000 members who include registered occupational therapists, certified occupational therapy assistants, and students of occupational therapy. Occupational therapy is a health profession which has its foundation in the medical management of patients. The service is provided to persons of all ages who are physically, psychologically, or developmentally disabled. It includes the functional evaluation and treatment of several different types of patients, including those suffering from strokes, heart attacks, cancer, arthritis, diabetes, serious burns, spinal cord injuries, and psychiatric disorders. The purpose of occupational therapy is to direct these patients to achieve a maximum level of independent living by developing those capacities which remain after disease, accident, or deformity.

The treatment modalities used by occupational therapists are those which, in addition to reducing specific pathology or impairment, will simultaneously help the patient learn to apply the newly restored or impaired function to the demands of daily living, thus speeding recovery and an early return to a more independent life.

Occupational therapists provide services in rehabilitation centers, through home health agencies, and in acute care hospitals, long and short term psychiatric facilities, skilled nursing facilities, outpatient clinics, community mental health centers, tuberculosis hospitals, day care centers, and private and public school systems.

TITLE I OF S. 350

Title I of S. 350, as currently worded, incorporates existing Medicare coverage provisions into a catastrophic health insurance program. In so doing, it perpetuates a serious problem for many beneficiaries who require occupational therapy treatment. This is especially true for individuals who are intended as the primary recipients of the benefits of the Long-Ribicoff approach. These victims of catastrophic type illness frequently require occupational therapy as part of their medically prescribed treatment program. The current Medicare restrictions on coverage for outpatient and home health occupational therapy, however, severely limit these persons' access to needed care, or force the service to be provided in the costliest setting possible. We, therefore, seriously urge the Committee to correct these problems in the course of developing its catastrophic national health insurance plan.

Specifically, we ask the Committee to permit coverage for occupational therapy in approved outpatient settings, as physical therapy and speech pathology services are now covered. We also ask that occupational therapy be included with skilled nursing, physical therapy, and speech pathology services, as a primary home health care service. Attachment I contains the specific statutory references where amendments are required to implement these recommendations.

Under the present Medicare law, occupational therapy services are reimbursable when provided to inpatients in hospitals and skilled nursing facilities, to outpatients in clinics attached to approved hospitals, and to recipients of home health care if they also require either intermittent skilled nursing or physical therapy or speech pathology services. Occupational therapy is also covered on an outpatient basis when provided "incident to a physician's professional service."

The Department of Health, Education, and Welfare has defined occupational therapy and established coverage criteria for Medicare purposes in the intermediary manuals for hospitals (Ch. II, Sec. 2101.9), skilled nursing facilities (Ch. II, Sec. 3133 3c), and home health agencies (Ch. II, Sec. 3118.2). These manuals require that occuaptional therapy be prescribed by a physician, be performed by a qualified occupational therapist or assistant, and be reasonable and necessary for the treatment of the individual's illness or injury. Occupational therapy is considered reasonable and necessary when "an expectation exists that the therapy will result in a significant practical improvement in the individual's level of functioning within a reasonable period of time (Ch. II, Sec. 3101.9 B)."

The current Medicare program certainly recognizes the important role of occupational therapy in the provision of quality health care. The existence of specific coverage criteria further safeguards against abuses in the delivery of this service. Yet, the law remains seriously deficient as long as the restrictions on outpatient and home health coverage of occupational therapy are maintained. These restrictions are neither cost-effective, nor do they promote the delivery of proper treatment. Rather, they encourage over-utilization of hospitals and nursing homes and they support decisions to terminate prematurely necessary treatment solely because coverage for the service is no longer available. In the latter case, the beneficiary's risk of recurring disability and eventual return to the institution increases dramatically. Ultimately, a shortsighted attempt to save money results in nothing more than higher costs occasioned by poorer care.

Several brief examples can be cited to show how Medicare beneficiaries can benefit from these amendments.

In the outpatient setting the occupational therapist might treat a burn patient by providing progressive splinting and an active program to increase range of motion and muscle strength of specific muscle groups in order to improve function. For the cardiac patient the therapist would plan and assist the individual to implement a program to increase cardiac expenditure based on a careful balance between the person's cardiac tolerance and the vocational, physical, and psychological demands of his or her life style. The occupational therapist might also initiate a program for a person with spinal cord injury. The program would include treatment to develop muscle tone, increase range of motion, improve circulation and substitute new muscle patterns for those which have been lost. The therapist might also design special adaptive equipment to increase functional use of remaining muscle strength.

Frequently in the home setting, only an occupational therapist is needed to train persons in essential activities of daily living, such as feeding, dressing, and personal hygiene, or to teach individuals with sensory or visual perceptual loss safety techniques to avoid accidental injury. In this context the occupational therapist might treat a stroke patient with residual arm paralysis. The treatment program would include remedial tasks to increase range of motion, maximize muscle tone, promote sensory integration and coordination, and decrease painful and debilitating contractures. Or, the therapist might assist a person who has severe arthritis with a program involving manual tasks to decrease contractures, muscle atrophy, and joint degeneration, so that the person can perform crucial tasks of daily living. The therapist might also teach energy conservation and joint protection, and provide instruction in the use of assistive devices to minimize the stress on joints and, thereby, develop greater independence.

These examples illustrate the type of services which occupational therapists provide in freestanding outpatient settings and as a sole service in the home. These services are a recognized part of proper medical treatment and appropriately fall within the scope of coverage which Medicare is intended to provide. It is difficult to understand, then, the rationale for the Medicare limits on coverage for these services. Surely, only an arbitrary distinction would prohibit coverage for occupational therapy in the freestanding outpatient setting, but yet permit coverage for the same service provided under the same coverage criteria to a patient with the same medical need, as long as the patient can make it to a hsopital's outpatient clinic. Apart from attempting to ensure that the elderly beneficiary make a determined effort to receive the service, it is difficult to understand the wisdom of a requirement which forces this older person to travel 45 minutes to a hospital when an approved rehabilitation facility might be across the street.

There is, likewise, no reasonable justification for Medicare's failure to classify occupational therapy as a primary or "skilled" service under the home health benefit. Nowhere else in the Medicare program or other accepted health care practice is the service placed in the "unskilled" category. The law itself, moreover, is inconsistent with regard to this restriction in that it does permit coverage for the patient who needs only physical therapy or speech pathology services. Yet, the level of care required for the patient who needs only occupational therapy is the same as that due the patient who needs only physical therapy or only speech pathology services. The occupational therapist treats the same types of disabled patients, at the same or a comparable time in the treatment process, as does the physical therapist or speech pathologist. No one can support the claim that this service is anything other than "skilled" as this classification is used in the Medicare context.

The Association's recommendations regarding Title I of S. 350 have frequently had a favorable hearing in both the Finance Committee and the full Senate. In 1970 the Committee heard testimony on these amendments. In 1973 and 1975 it unanimously adopted these proposals. Likewise in 1972, 1973, and 1975, the full Senate approved these amendments. The current Title II of S. 350 also includes the outpatient component of these amendments as part of the modification of the Medicaid program. A substantial need for enactment of these proposals relative to Medicare continues to this day, and we urge the Committee to reaffirm its past decisions and incorporate these changes into Title I of S. 350.

TITLE II OF S. 350

Our Association strongly supports S. 350's proposals to standardize and federalize the Medicaid program. The current variations in Medicaid coverage are both inequitable and inefficient. The constant crises, moreover, which arise each year as states renew their budget trimming efforts, are debilitating for the system, the individuals it is intended to serve, and the providers of service. Title II of S. 350, we believe, is an important step towards alleviating some of these problems.

We were especially pleased with the emphasis placed on home health and mental health services as part of the Medicaid benefits. To the extent, however, that the Medicare limit on home health coverage for occupational therapy is continued in the Medicaid program, we recommend the same amendments as discussed above.

We also strongly support the inclusion of outpatient rehabilitation services among the Medicaid benefits. This provision represents a realistic, cost-effective improvement in the health care services which Medicaid beneficiaries will recieve. As we mentioned above, this same amendment, especially as it relates to occupational therapy, should also be incorporated into the Medicare plan.

We would also strongly urge that occupational therapists who meet licensing and other standards prescribed by the Secretary be permitted coverage for services provided in their offices or the individual's home. As currently worded, Section 1946 (a)(4)(B) allows this coverage only for physical therapists and speech pathologists. The equal role played by occupational therapists with physical therapists and speech pathologists in the provision of rehabilitative care certainly justifies inclusion of occupational therapists in this section.

Attachment II contains our specific recommendations for changes in Title II of S. 350.

The American Occupational Therapy Association appreciates the opportunity to offer these comments and recommendations relative to S. 350.

ATTACHMENT I

AMENDMENTS TO TITLE I OF S. 350

(Catastrophic Health Insurance and Medical Assistance Reform Act)

Sec. 2103(c)(2)(c)

The last sentence of section 1861(p) of the Social Security Act should be amended by inserting "and occupational therapy services" after "speech pathology services".

Sec. 2104(e)(1)

Section 1814(a)(2)(D), which is referred to in Section 1812(e), should be amended by inserting, ", occupational," immediately after "physical".

Section 1835(a)(2)(A)(i) should be amended by inserting ",occupational," immediately after "physical."

Section 1835(a)(2) should be amended—

by striking out "and" at the end of subparagraphs (B) and (C);

by striking out the period at the end of subparagraph (D) and inserting in lieu-thereof ";and"; and

by adding after subparagraph (D) the following new subparagraph: "(E) in the case of outpatient occupational therapy services, (i) such services are or were required because the individual needed occupational therapy services, (ii) a plan for furnishing such services has been established and is periodically reviewed by a physician, and (iii) such services are or were furnished while the individual is or was under the care of a physician.".

Sec. 2105(a)

Section 1814(a)(2)(D) should be amended as stated above.

Sec. 2106

Section 1861(p) should be amended as stated above.

ATTACHMENT II

AMENDMENTS TO TITLE II OF S. 350

(Catastrophic Health Insurance and Medical Assistance Reform Act)

Sec. 1932(b)(1)(K)

Add "occupational therapy," after "physical therapy,".

Sec. 1946(a)(4)(A)(ii)

Add "occupational therapists," after "physical therapists,".

Sec. 1946(a)(4)(B)

Add ", occupational therapist," after "physical therapist".

STATEMENT OF THE NATIONAL COUNCIL OF COMMUNITY MENTAL HEALTH CENTERS

This statement is presented on behalf of the National Council of Community Mental Health Centers, representing providers of mental health services at the community level. NCCMHC's membership includes over 650 community mental health programs and over 100 other agencies providing services. The Board of Directors of NCCMHC includes individuals from both the staffs of member agencies and the community governing boards of these agencies. The Board is thus composed of lay people and professionals from various mental health disciplines (psychiatrists, psychologists and social workers).

NCCMHC welcomes the opportunity to comment on catastrophic health insurance legislation. We have reviewed S.350, S.351 and S.748, and we offer the following comments on the proposed benefit packages as they pertain to coverage of mental health services. This statement does not address other aspects of the bills.

INSURABILITY OF MENTAL ILLNESS

It is becoming increasingly obvious that mental health care is indeed insurable. Studies have shown that costs and utilization are not excessive and that failure to treat mental health problems results in expensive, unnecessary utilization of other medical services. The compelling accumulation of utilization and cost information is forcing health insurance companies to reassess the role of mental health coverage. Although the extent to which health insurance plans meet the cost of psychiatric services is still limited, it appears to be expanding.

Since the 1950's, dramatic developments have brought mental health care into the mainstream of general medical care. These changes include the development of psychiatric units in general hospitals, the effective use of psychotropic medications, and the shift in locus of care away from the remote long-term custodial institutions and back to the community. This trend is documented by Steven S. Sharfstein, M.D., Acting Director, Division of Mental Health Service Programs at NIMH, in a recent American Journal of Psychiatry article in which he states: "Data from recent studies of health insurance plans and the community mental health centers program indicate that the fears of insurance companies about the utilization and costs of mental treatments are groundless."[1]

For instance, data from the federal employee Blue Cross/Blue Shield plan, with very generous psychiatric coverage, indicates that the proportion of mental and nervous health to total health benefits has stabilized at around 7.5 percent for the

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[1] Sharfstein, Steven S., M.D. Third-party payers: to pay or not to pay. "American Journal of Psychiatry," 135:10, October 1978, p. 1186.

past five years.[2] Data from the Canadian provincial program of medical care indicates that the proportion of psychiatric care to total medical payments is between 1.4 percent and 5.4 percent in various provinces, depending on the availability of psychiatrists.[3]

Data from the CMHC program also indicates that long-term care is much more the exception than the rule. Throughout the program's history, lengths of stay have been low despite unlimited availability of the service. Over the five-year period 1971-75, inpatient stays averaged between 15 and 17 days; average length of stay in partial hospitalization units ranged from 23 to 35 over the same five-year period; and outpatient visits averaged 10 or less.

There also have been numerous studies of the efficacy of psychotherapy and counseling for the mentally ill. In 1977 Mary Lee Smith and Gene V. Glass published a summary of their review of 400 such evaluations which were coded and integrated statistically.[4] The findings provide convincing evidence of the efficacy of psychotherapy: On the average, the typical patient is better off than 75 percent of untreated individuals.

An extensive follow-up of patients who had had analytic psychotherapy or psychoanalysis was conducted in West Germany by A. Duehrssen and her colleagues.[5] They developed a system for evaluating patients at the onset of treatment, at the end of treatment, and after a five-year interval. Only 17 percent of the nearly 1,000 patients studied five years after treatment were judged to have had at least one relapse during that period. Importantly, of the 845 patients for whom follow-up data was available, the hospital rate was 0.78 days per year, compared to a pre-treatment average of 5.3 days per year and a general average for the insured population of 2.5 hospital days per year. (This included hospital days for any illness.) Prognostic measures built in at the onset of treatment also had a high degree of validity and reliability: Patients with favorable prognoses had excellent outcome measures at the termination of treatment and at the five-year follow-up. This research helped preserve and extend the national health insurance benefit for the mentally ill in West Germany and led to a more efficient and effective prior authorization and peer review system throughout the country.

Several other studies indicate that effective mental health treatment reduces the utilization of all medical services significantly, particularly in organized settings (community health centers or health maintenance organizations). In these studies, reductions in utilization of medical services ranged from 5 percent to 85 percent after a mental health intervention (generally outpatient). Some studies have calculated the dollar amounts of these reductions and found savings of $0.34, $1.33, and over $2.00 for each dollar spent on mental health treatment.[6]

Various studies indicate that as many as 15 percent of patients seen in general medical settings may be diagnosed as having a psychiatric or emotional disorder. According to NIMH data, significantly higher rates of psychiatric disorders have been found for specialized medical settings such as hospital-based clinics and emergency rooms.[7] Nicholas Cummings estimates that "60 percent or more of the physician visits are made by patients who demonstrate an emotional, rather than an organic etiology for their physical symptoms."[8] Additional available evidence supports the view that funding of somatic medical care currently pays for a significant amount of care for emotional or mental problems, even though they are not defined or reported as such.[9]

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[2] Reed, L. S. "Coverage and Utilization of Care for Mental Conditions Under Health Insurance—Various Studies, 1973-74, Washington, D.C." American Psychiatric Association, August 1975.

[3] Id.

[4] Smith, Mary Lee and Glass, Gene V. Meta-analysis of psychotherapy outcome studies. "American Psychologist," September 1977.

[5] Duehrssen, A. "Katamnestische ergebnisse bei 1004 patienten nach analytischer psychotherapie." "Z Psychosom Med," 7:2, 1972.

[6] Jones, Kenneth and Vischi, Thomas. "Impact of Alcohol, Drug Abuse and Mental Health Treatment on Medical Care Utilization—A Review of the Literature." ADAMHA/OPPE, February 1979.

[7] DHEW/NIMH. Draft Report: "The Financing, Utilization, and Quality of Mental Health Care in the United States." April 1976, p. 27.

[8] Cummings, Nicholas. The anatomy of psychotherapy under NHI. "American Psychologist," Vol. 32, No. 9, September 1977, p. 711.

[9] Report of the Task Panel on Financing, President's Commission on Mental Health, Appendix to Report of President's Commission on Mental Health, 1978, Vol. II.

PROPOSED LEGISLATION

(a) Medicare amendments

All three bills (S.350, S.351 and S.748) would amend Title XVIII of the Social Security Act (Medicare), changing the mental health benefits and making Medicare benefits applicable through the catastrophic insurance programs to individuals who have incurred a certain level of expenses for medical care.

However, S.350 and S.351 differ significantly in mental health coverage as compared to S.748, in that they make very minor changes to mental health outpatient benefits and generally continue the current Medicare policy of reimbursing for primarily institutional services for the mentally ill.

In contrast to the current emphasis on providing mental health care in the least restrictive setting, Medicare promotes inappropriate and unnecessary institutional care. Present law severly restricts development of community alternatives, discourages and complicates—if not precludes—family care of the mentally ill, and reinforces public stigmatization of mentally ill persons. The fact that 80 percent of Medicare expenditures for mental health services are for institutional inpatient hospital care, is evidence of the emphasis on institutionalization. Lack of adjustment to federal, state and local deinstitutionalization efforts and strategies to promote ambulatory services has contributed to the abandonment of many elderly and disabled Americans who are inappropriately placed in hospitals and nursing homes.

Community mental health center programs provide an entire range of services for the mentally ill, including many beneficial social services which are not reimbursable through a medical insurance program. CMHCs provide inpatient care, partial hospitalization (primarily day treatment) and outpatient services using many modalities of treatment. Services are provided by a team of professionals and nonprofessionals, including psychiatrists, other physicians, psychologists, psychiatric nurses and psychiatric social workers.

Currently, however, CMHCs have particular problems in collecting Medicare reimbursements for their services. Medicare has no category of provider suitable for all CMHCs. The 16 percent of federally funded CMHC programs which are directly operated by hospitals are being reimbursed as providers under Title XVIII through the sponsoring hospital. Inpatient services provided by affiliated hospitals on behalf of another 62 percent of the CMHC programs are also being reimbursed in this manner. Yet outpatient services of free-standing CMHCs are not reimbursable—despite the fact that these same services are reimbursable to hospital-operated CMHCs.

As a result, CMHCs have been forced to collect Medicare outpatient reimbursements through physicians on their staff. The physicians bill Medicare, using their own Medicare number, on the basis of customary fees and then reimburse the CMHC. This is not a sound business practice; nor is it programmatically sound since CMHCs provide a full range of mental health services in addition to physician services.

Other clinic settings can now be reimbursed as providers under Medicare. Rural health clinics not providing mental health services are eligible for cost reimbursement, as are "physician directed" clinics. CMHCs cannot qualify as physician directed because the presence of a physician is required in all facilities of the center at all times. CMHCs must utilize numerous facilities in the catchment area in order to make services accessible, and it is economically impossible to maintain physicians in all facilities. Furthermore, the shortage of psychiatrists and of physicians generally in many parts of the country, particularly rural areas or inner cities, prohibits many CMHCs from hiring any full-time physicians. Instead, these programs operate with one or more physicians working on a part-time basis.

Currently, by law, federal CMHCs must collect all available third-party payments, specifically Medicare payments, in order to receive federal grant funds. Federal funds are intended to initiate CMHC programs and to fund part of the costs of services for the first eight years of operation, after which alternative funding mechanisms must take over. Changes to Medicare to make Title XVIII more compatible with other federal efforts to promote deinstitutionalization and ensure provision of effective, available community alternatives are urgently needed.

S.748 would begin to address these problems by enabling federally qualified CMHCs to receive provider status and reimbursement on a cost-related basis. Services provided by or under the supervision of a mental health professional would be reimbursable when furnished under the case management of a physician. This is a major improvement for the centers and one which we hope the Committee will adopt.

Another long overdue change to Medicare is provision of partial hospitalization services as an alternative to 24-hour inpatient stays. However, none of these bills

includes coverage for such services, despite evidence of the effectiveness of partial hospitalization.

The Aetna Life and Casualty Company in Hartford, Connecticut, recently conducted a pilot study to determine the impact of including partial hospitalization coverage in insurance plans.[10] The study included 31 patients who would otherwise have been hospitalized, most of whom had histories of severe psychiatric disorders and extensive treatment. Using the measure that the day hospital patients would have been hospitalized for the same number of days as they were in day treatment, the authors estimated that the use of day treatment saved the insurer more than $255,000 for these 31 patients. They recommended that day hospitalization be reimbursed on the same basis as inpatient care if a day hospital can meet stringent criteria ensuring that it provides active, appropriate treatment.

There is some indication, moreover, that lengths of stay in partial hospitalization programs are not the same as inpatient stays, as assumed in the Aetna study, but considerably shorter. In a controlled study of lengths of stay and readmission rates, Marvin Herz and his colleagues demonstrated that the average length of stay for inpatients was 119 days while day patients had an average stay of 49 days. The readmission rate for day patients was 22 percent compared with 42 percent for inpatients.[11]

According to F. Dee Goldberg,[12] there are several factors which contribute to this clinical efficacy and cost-effectiveness of partial hospitalization:

It discourages the excessive dependence and regression which often occur with inpatient hospitalization;

It avoids the isolation and dehumanization of inpatient hospital facilities;

It encourages higher expectation levels for each patient because patients must maintain all of those independent activities of which they are capable, despite their mental illness;

The patient remains within the family, which forces the patient and family to work through family problems;

Flexibility of the schedule allows the program to meet the patient's needs;

There is much less social stigma than for inpatient hospitalization;

Fewer staff must interact with the patient and each other, making information processing and treatment planning more effective.

NCCMHC urges the Committee to enact legislation which makes changes to the mental health benefits under Medicare so as to enable community mental health center outpatient and partial hospitalization services to be reimbursed on a cost-related basis. Legislation to make such changes has been introduced by Senators Stafford and Leahy (S.458), and S.748 includes much the same provisions as S.458 but pertains only to outpatient benefits.

Attached is a copy of S.458, together with two new, revised definitions, not included in this bill, to define partial hospitalization services and the term "case managed by a physician." Such language should be incorporated into any Committee bill establishing CMHCs as providers and reimbursing for partial hospitalization services. While NCCMHC believes no limits on services are necessary if effective quality assurance and stiff external utilization reviews are required, limits have been included in S.458 which would enable the great majority of patients to receive all the care they need. S.748 requires HEW to set specific limits on services, in which event we would urge the Committee to give HEW general guidelines regarding the recommended extent of coverage.

(b) Catastrophic insurance: Limit on mental health costs

S.350 and S.351 include a provision which is highly discriminatory against the mentally ill and their families. Under these bills, only $500 of expenses for mental illness can be considered when calculating the level of expenditure on medical care which entitles an individual to catastrophic coverage. Yet, as the studies cited above demonstrate, mental illness is insurable; costs and utilization are not excessive under insurance plans.

Moreover, rather than a limitation on the amount of benefits to be paid for mental illness, this provision is a blanket restriction which means that expenditures for mental illness should not entitle an individual to catastrophic insurance for any

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[10] Guillette, William; Crowley, Brian; Savitz, S. Alan, and Goldberg, F. Dee. Day hospitalization as a cost-effective alternative to inpatient care: a pilot study. "Hospital and Community Psychiatry," Vol. 29, No. 8, August 1978.

[11] Herz, Marvin I.; Endicott, Jean; Spitzer, Robert L., and Mesnikoff, Alvin. Day versus inpatient hospitalization: a controlled study. "American Journal of Psychiatry," 127, 1971, pp. 107–18.

[12] Goldberg, F. Dee, M.H.A. Funding Partial Hospitalization Programs. In press, chapter in R. Luber (ed.), "Partial Hospitalization: A Current Perspective," May 1979.

mental or physical illness. It clearly implies that costs for mental illness are somehow not legitimate.

S.748, on the other hand, contains no such restriction but treats expenditures for mental health in the same manner as expenditures for other illnesses. This is by far the better approach, and NCCMHC urges its adoption.

(c) Standards for health insurance policies

The problems cited above regarding mental health benefits under Medicare also apply to the standards for basic health insurance policies in S.350 and S.351. Coverage of community mental health center services is not required, and such policies may impose a limit of $400 on the charges for services of psychiatrists (both in CMHC programs and in other settings).

NCCMHC urges that the benefits available under all parts of these proposals include services provided by community mental health centers, as defined in S.458.

(d) Programs for low-income individuals

Title II of S.350 provides a program of health care coverage for low-income individuals; S.748 requires state Medicaid plans to include a catastrophic component under which the mental health benefits would be the same as for other individuals.

Title II of S.350 provides excellent coverage for mental health services for low-income individuals. The contrast between the proposed benefits for low-income individuals and the benefits proposed for others under S.350 is striking. NCCMHC believes that the elderly and disabled, as well as those who qualify for catastrophic protection, are in need of mental health services and entitled to this protection.

CONCLUSION

Focusing on the mental health benefit provisions in S.350, S.351 and S.748, NCCMHC urges prompt enactment of changes to Medicare. Whether part of a more comprehensive bill or a separate piece of legislation, such changes should permit appropriate reimbursement of community mental health center services. NCCMHC endorses the Medicare improvements in either the Stafford-Leahy bill (S.458) or the Dole-Danforth-Domenici bill (S.748) with the addition of partial hospitalization services.

ATTACHMENT 1

By Mr. STAFFORD:

S. 458. A bill to amend title XVIII of the Social Security Act for the purpose of including community mental health centers among the entities which may be qualified providers of service and for other purposes; to the Committee on Finance.

COMMUNITY MENTAL HEALTH ASSISTANCE ACT OF 1979

S. 458

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. This Act may be cited as the "Community Mental Health Assistance Act of 1979."

SEC. 2. (a) Section 1812(a) of the Social Security Act is amended by striking out "and" in paragraph (2), by striking out the period at the end of paragraph (3) and inserting in lieu thereof a semicolon and by adding the following two new paragraphs at the end thereof:

"(4) outpatient services provided by a community mental health center for up to 25 visits during a year; and

"(5) partial hospitalization services by a community mental health center for up to 60 visits during a year.".

(b) Section 1812(b) of such Act is amended by striking out "or" at the end of paragraph (2), by striking out the period at the end of paragraph (3) and inserting in lieu thereof a semicolon, and by adding the following two new paragraphs at the end thereof:

"(4) outpatient services furnished to him by a community mental health center after such services have been furnished to him for a total of 25 visits during a year; and

"(5) partial hospitalization services furnished to him by a community mental health center after such services have been furnished to him for a total of 60 visits during a year.".

(c) Section 1812(c) of such Act is amended by adding the following new sentence at the end thereof: "In determining the 190-day limit with respect to any individual

under subsection (b)(3), the Secretary shall include one day for every three partial hospitalization visits to a community mental health center by such individual.".

(d) Section 1812(e) of such Act is amended by inserting "outpatient mental health services and partial hospitalization services furnished by a community mental health center," after "extended care services,".

SEC. 3. (a) Section 1814(a)(2) of the Social Security Act is amended by striking out "or" at the end of subparagraph (D), by inserting "or" after the semicolon at the end of subparagraph (E), and by adding the following new subparagraph after subparagraph (E):

"(F) in the case of outpatient services or partial hospitalization services furnished by a community mental health center, by or under the case management of a physician, such services are or were required for the mental health treatment of an individual, and such treatment can or could reasonably be expected to improve the condition for which such treatment is or was necessary;".

(b) Section 1814(a) of such Act is amended by striking out "and" at the end of paragraph (6), by striking out the period at the end of paragraph (7) and inserting in lieu thereof a semicolon, and by adding the following two new paragraphs at the end thereof:

"(8) with respect to services furnished by a community mental health center in connection with a partial hospitalization visit, such center shall make available to the Secretary a statement, in writing and signed by the individual or his representative (pursuant to regulations issued by the Secretary) before receiving such services, indicating that the individual understands that three partial hospitalization visits will reduce by one day the number of days of inpatient psychiatric hospital services to which such individual is entitled during his lifetime under this part; and

"(9) with respect to services furnished by an inpatient hospital in connection with inpatient psychiatric care, such hospital makes available to the Secretary a statement, in writing and signed by the individual or his representative (pursuant to regulations issued by the Secretary) before receiving such care, indicating that use of inpatient hospital services will reduce on a daily basis the lifetime inpatient entitlement under this Act, and that the individual understands that.". one day of inpatient psychiatric hospital care will reduce by three the number of partial hospitalization visits to which such individual is entitled during such spell of illness.".

(c) Section 1814(b) of such Act is amended by adding the following new paragraph at the end thereof:

"( ) The amount paid with respect to community mental health center services shall be equal to the costs which are reasonable and related to the cost of providing such services or on such other tests of reasonableness as the Secretary may prescribe in regulations, including those authorized under Section 1861(v)(1)(A).

(d) Section 1814 of such Act is amended by adding the following new subsection at the end thereof:

"(K) Payments for partial hospitalization services by a community mental health center on behalf of an individual, which are rendered for visits in excess of 10 visits per year shall be made only after a treatment review committee of a community mental health center has certified prior to the eleventh visit during a year and an external utilization review committee (as defined in section 1861(ee)) has certified prior to the thirty-sixth visit during such year, that such services are necessary and appropriate.".

SEC. 4. Section 1861 of the Social Security Act is amended by adding the following new subsections at the end thereof:

"OUTPATIENT SERVICES BY A COMMUNITY MENTAL HEALTH CENTER

"(bb) The term 'outpatient services by a community mental health center' means the following items and services furnished to an outpatient of a community mental health center by such center in accordance with a treatment plan:

"(1) active diagnostic, therapeutic, or rehabilitative mental health services, including crisis intervention outside the facility and home mental health visits, when provided by a physician or by another qualified mental health professional under the case management of a physician as prescribed by the Secretary;

"(2) such other related services necessary to the mental health of an individual, when provided by a physician or by another qualified mental health professional, under the case management of a physician, which are ordinarily furnished to outpatients in such center; and

(3) drugs and biologicals which cannot be, as determined by the Secretary, self-administered.

"PARTIAL HOSPITALIZATION SERVICES BY A COMMUNITY MENTAL HEALTH CENTER

"(cc) The term 'partial hospitalization services by a community mental health center' includes—

"(1) active, professional treatment (with at least 75 per centum of the time of attendance in active therapies) of a person with acute mental or emotional disabilities, with such treatment being based upon an individualized treatment plan which is regularly updated;

"(2) coordination of related services to assist treatment, and

"(3) demonstrated capacity to respond to crisis and emergencies of persons in treatment on a 24-hour basis, 365 days during a year (including medical emergencies while the person is in attendance at the facility).

"The treatment plan for such services may include, but is not limited to, diagnosis and evaluation (including psychological, physical, and nutritional assessment), formal and informal psychotherapy (individually or in groups or families), chemotherapy, and other modalities designed to improve the condition of the patient.

"The services of this section are limited to persons not requiring 24-hour inpatient care or 24-hour supervision in noninpatient care entities.

"COMMUNITY MENTAL HEALTH CENTER

"(dd) The term 'community mental health center' means a public or private entity which—

"(1) is primarily engaged in providing services for the diagnosis and treatment of emotionally disturbed and mentally ill persons, has a requirement that all mental health care will be under the supervision of one mental health professional, and has appropriate arrangements to insure that all patients requiring medical services are referred to a physician;

"(2) in the case of a center in any State in which State or applicable local law provides for the licensing of community mental health centers, is licensed pursuant to such law;

"(3) has bylaws in effect with respect to its staff;

"(4) meets such staffing requirements as the Secretary finds necessary;

"(5) maintains clinical records on all patients;

"(6) has in effect a utilization review plan pursuant to subsection (ee);

"(7) has in effect an agreement with a hospital pursuant to subsection (ff);

"(8) has appropriate procedures or arrangements in compliance with applicable State and Federal law, for storing, administering, and dispensing drugs and biologicals; and

"(9) meets the definition of—

"(A) a community mental health center in section 201 (a) and (c) of the Community Mental Health Centers Act and the requirements prescribed by regulation thereunder; or

"(B) a community mental health center which meets appropriate Joint Commission on Accreditation of Hospital Standards, and other additional regulations as the Secretary may prescribe.

"UTILIZATION REVIEW PLAN OF A COMMUNITY MENTAL HEALTH CENTER

"(ee) A utilization review plan of a community mental health center shall be considered sufficient if it is applicable to services furnished by the center to individuals entitled to insurance benefits under this title and if it provides—

"(1) for the review, on a sample or other basis, of admissions to the centers, and the professional services (including drugs and biologicals) furnished, (A) with respect to the mental health necessity of the services, and (B) for the purpose of promoting the most efficient use of available health facilities and services; and

"(2) for such review to be made by an external utilization review committee which is established in a manner as may be approved by the Secretary.

"TRANSFER AGREEMENT BETWEEN HOSPITAL AND COMMUNITY MENTAL HEALTH CENTER

"(ff) A hospital and a community mental health center shall be considered to have a transfer agreement in effect if, by reason of a written agreement between them or (in case the two institutions are under common control) by reason of a written undertaking by the person or body which controls them, there is reasonable assurance that—

"(1) transfer of patients will be effected between the hospital and the community mental health center whenever such transfer is medically appropriate as determined by the attending physician; and

"(2) there will be interchange of medical and other information necessary or useful in the care and treatment of individuals transferred between the institutions,

or in determining whether such individuals can be adequately cared for otherwise than in either of such institutions. Any community mental health center which does not have such agreement in effect, but which is found by a State agency (of the State in which such facility is situated) with which an agreement under section 1864 is in effect (or, in the case of a State in which no such agency has an agreement under section 1864, by the Secretary) to have attempted in good faith to enter into such an agreement with a hospital sufficiently close to the facility to make feasible the transfer between them of patients and the information referred to in paragraph (2), shall be considered to have such an agreement in effect if and for so long as such agency (or the Secretary, as the case may be) finds that to do so is in the public interest and essential to assuming extended care services for persons in the community who are eligible for payments with respect to such services under this title."

SEC. 5. (a) Section 1861(u) of the Social Security Act is amended by inserting "community mental health center" after "health agency".

(b) Section 1861(w) of such Act is amended by inserting "community mental health center" after "nursing facility".

SEC. 6. (a) Section 1864(a) of such Act is amended—

(1) by inserting "or whether a facility therein is a community mental health center as defined in section 1861(dd)" before the period at the end of the first sentence;

(2) by inserting "a community mental health center," after "rural health clinic," in the second sentence; and

(3) by inserting "community mental health center" after "laboratory," in the fifth sentence.

(b) Section 226(c)(1) of such Act is amended by inserting "and partial hospitalization services and outpatient services furnished by a community mental health center" before "(as such terms" after "part C of Title XVIII)."

(c) Section 7(d)(1) of the Railroad Retirement Act of 1974 is amended by inserting "partial hospitalization services and outpatient services furnished by a community mental health center," after "inpatient hospital services,".

(d) Section 1861(i) of such Act is amended by inserting "or community mental health center" after "nursing facility" each time it appears therein.

(e) Section 1832(a)(2)(B)(1) of such Act is amended by striking out "or" at the end of subclause (I), and by striking out "and" at the end of subclause (II), and inserting in lieu thereof "or", and by adding the following new subclause after subclause (II):

"(III) a physician to a patient in a community mental health center; and".

ATTACHMENT 2

MEDICARE LEGISLATION—DEFINITIONS

Partial hospitalization services

Partial hospitalization is a psychiatric program with an organized staff whose primary purpose is to provide a planned, individualized program of active treatment and rehabilitation through integrated therapeutic modalities. Services are provided to ambulatory patients who spend no more than a part of each 24-hour day in the program. Services furnished are reasonably expected to improve the patient's condition.

A qualified partial hospitalization program is one which—

Complies with applicable federal, state and local laws regarding facility and staff licensure, certification or registration;

Has written program policies and procedures delineating functional authorities and responsibilities of the partial hospitalization program, and a description of its relationship to an inpatient service and to outpatient services;

Has a requirement that all patients must be under the care of a mental health professional; where such professional is not a physician, such services must be case managed by a physician;

Has a requirement that a psychiatrist is present on a regularly scheduled basis;

Has a psychiatrist or other physician who assumes medical responsibility for all patients;

Requires individualized treatment plans, with patient goals, discharge and after-care plans;

Has appropriate arrangements for storing and administering drugs and biologicals;

Has appropriate record-keeping systems, drug use profiles, and procedures to protect confidentiality; and

Has an appropriate utilization review mechanism, utilizing PSROs where feasible.

Case management

Case management is the process through which a physician, preferably a psychiatrist, and qualified mental health professionals collaborate in order to ensure quality of patient care and treatment. Case management requires that the physician monitor and evaluate all Medicare patients and provide direction and supervision to the qualified mental health professional concerning the medical services to be provided. This process may take place apart from the direct service contact of the qualified mental health professional. This process must be regularly scheduled, depending upon the patient's condition, and documented in the patient's record.

STATEMENT OF THE NATIONAL ASSOCIATION OF TEMPORARY SERVICES, INC.

Mr. Chairman and members of the committee, The National Association of Temporary Services (NATS) wishes to submit its views on national health insurance, and, more particularly in support of the financing mechanism set forth in S. 350 and S. 351, "The Catastrophic Health Insurance Acts," which are now pending before this Committee.

NATS is an organization comprised of 312 temporary help companies with 1850 offices throughout the United States, representing 80 percent of total sales of the industry. Each company is an employer in the temporary services industry. Our members are engaged in the business of supplying temporary help to a wide variety of customers including businesses, institutions, public agencies and other organizations that require assistance in handling excess or special work loads. To perform these services each temporary help company assigns its own employees on a temporary basis to fill the needs of its customers.

Manpower, Inc., Kelly Services, Inc., The Olsten Corporation, Staff Builders, Inc., and Personnel Pool of America, Inc. are perhaps the best known employers in the industry. The industry as a whole provides employment at various times in a year for upwards of 2 million workers. These workers are the employees of the temporary help companies and their employment span is of relatively short duration. The industry services virtually every type of business and public institution in this country.

As part of the growing national debate over federally funded health insurance benefits, many proposals have been made containing varying mechanisms for administration, distribution, and financing of national health insurance. Certain of these proposals include provisions for employer-financed health plans and it is these proposals specifically that concern the temporary services industry.

Under the employer-financed mechanism, employers would be required to contribute a fixed percentage of the total health insurance premiums owed by each employee. These contributions would begin as of the first day of employment and would continue at a minimum until the termination of the employment status. For the temporary help company the question then arises as to whether contributions toward an employee's health insurance would be required for non-working time. That is, would the temporary services industry employer be obligated to pay a monthly premium in advance for an employee who may well not work for the full month and, further, would the employer be required to continue these benefits after employment terminates.

While recognizing the need to ensure uninterrupted insurance coverage, NATS believes that any program requiring employers in the temporary services industry to pay health benefits to employees for any period beyond the duration of their temporary employment would impose an unfair financial burden on the industry that it would not be able to sustain. The temporary services industry as a whole operates on small margins and operational costs must be related to productive hours.[1] Thus the additional imposition of large insurance payments for time not worked by current and former employees would force many, if not all employers in the temporary services industry, out of business.

It is not the concept of national health insurance that threatens the existence of the temporary services industry; rather it is the creation of a funding mechanism that would obligate employer payments beyond the tenure of temporary employment. Unlike most businesses, temporary help companies are designed to operate with extremely high employment turnover; consequently it is both difficult and prohibitively expensive for the industry to maintain contact with its employees on any basis that extends beyond productive time worked. As will be discussed below, S. 350 and S. 351 provide an alternative method of funding that would protect the

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[1] Based upon recent figures, the after-tax margin for Kelly Services, Inc. was 4 percent and for The Olsten Corp., 3.6 percent.

health coverage of the unemployed without destroying an industry which provides a major source of employment opportunities to those who might otherwise remain unemployed.

A brief description of the industry and how it operates should make the special problems of the temporary services industry apparent.

STRUCTURE OF THE INDUSTRY

The temporary services industry offers a vital resource to the community. It also provides an important employment option for people who, for many reasons, are unable to make long term job commitments. A large group of temporary employees, who would like to work, for personal or family reasons cannot meet the continuing commitment of a permanent employee. Another group of temporary employees is unskilled and either cannot obtain or does not desire permanent employment. Still another group of temporary employees consists of persons who are returning to the work force after a prolonged absence. A small group of temporary help employees include persons who are only available for employment for a short period of time, such as college students or teachers on summer vacation. The industry provides job opportunities for these and other persons who either do not want or are unable to accept employment on a full-time basis.

The temporary help companies charge their customers on the basis of hourly rates that vary with the nature of the work assignment. In turn, temporary help companies pay their temporary employees at hourly rates for the time actually worked.

As an employer, the temporary help company reports the wages paid to its employees to the federal government and withholds appropriate taxes and contributions. It also pays the necessary social security taxes and unemployment compensation, and provides workmen's compensation benefits.

Employment statistics of one of the leading temporary help companies in the United States reveal that 98,000 temporary employees or 37 percent of its work force worked less than 40 hours during 1978. Another 39,000 temporary employees worked between 40 and 80 hours. This means that over one-half (52 percent) of the temporary employees of this temporary help company worked less than two weeks in 1978. The statistics of this same temporary help company also indicates that 83 percent of its total work force, or 226,000 employees, worked less than 320 hours in 1978 (the equivalent of 8 working weeks). When these statistics are applied to the total number of temporary employees working for this temporary help company in 1978, they reveal that the turnover of employees for 1978 was between 900 and 1000 percent. This turnover rate provides a startling contrast to the average employee turnover rate in other industries which is far below 100 percent.

Employees of the temporary services industry may work for as many days as they choose assuming there is an available assignment that meets their qualifications. The length of individual assignments varies from a day, a week, sometimes up to several months. Industry statistics, however, demonstrate that the vast majority of temporary employees work for only a short period of time. It is this unique industry characteristic that creates special concern for the temporary services industry when confronted with any broadly-framed obligation to provide health benefits to all employees, regardless of the duration of employment.[2]

FINANCING MECHANISMS—S. 350 AND S. 351

One of the most sharply debated issues arising out of National Health Insurance proposals is the method by which a national program should be financed. There are several models that could be followed in the establishment of a national health care system. For example, both social security and private health insurance benefits offered by employers could provide the basic framework for the creation of a national health insurance program. The first system, social security, is based on contributions directly related to earned wages and is a non-variable expense which can be built into the cost of temporary help services. Thus, a system which does not require contributions by an employer or employee for non-working time, is a financing method which is compatible with the mode of operation of temporary service employers.

It is the latter system, however, requiring employers to buy health insurance benefits for their employees, that could unfairly affect the temporary services

[2] The temporary services industry has been singled out as an industry with special labor problems in other areas of labor administration. For example, the Wage and Hour Division of the Labor Department has recognized the industry's unusual make-up and has issued a special document discussing the travel time of temporary employees. U.S. Department of Labor Publication, "Temporary Help Companies Under the Fair Labor Standards Act" (July 1973).

industry. All known private health insurance plans generally require a monthly premium in advance with no rebate or adjustment if the employee does not work the entire month. As indicated above, over 50 percent of the temporary employees in the temporary services industry work less than 80 hours (two weeks) a year. Thus, it is the short employment tenure for most employees and high turnover rate that create substantial cost and administrative problems, unique to the industry.

Accordingly, NATS supports the approach taken by S. 350 and S. 351 for financing catastrophic health insurance. These bills propose that catastrophic health insurance protection be provided for all United States residents either through a federally administered public plan, or, at the option of the employer, through a private insurance plan funded by the employer. If the employer chooses to adopt a private plan, Sections 2122(a)(1)(C) and (F) of both bills require that the plan cover all employees, other than those who perform services for less than 25 hours per week and temporary employees, who have worked for more than 30 days. Those persons who are not covered by an employer plan would be covered by the federally administered public plan.

This bill affords the temporary services industry the protections it needs, while ensuring that its employees will not be excluded from health insurance coverage. First, S. 350 and S. 351 allow each employer to decide whether or not it is financially feasible to offer a health insurance plan, rather than imposing a mandatory requirement that all employers offer such plans to all their employees. Second, the bill specifically recognizes the difficulty of providing employer-financed health insurance coverage to "temporary employees," and exempts them from coverage.

If an employer-financed mechanism is incorporated into a national health insurance plan, NATS urges this Committee to adopt the S. 350/S. 351 system, or a similar system that recognizes the unique problems of the temporary services industry. Thus, any system adopted should, at the very least: (1) Limit employer coverage to full-time employees or those employees who are either expected to work for a substantial period of time in the future, or who have actually worked for a substantial period in the immediate past for that employer; (2) provide for continuation of benefits for only a minimal period of time after the employment relationship has been terminated so as to protect the temporary services industry and other employers with unusually high employment turnover from having to assume an excessively costly burden that other employers with more permanent work forces would not routinely be called upon to bear; and (3) require employer coverage for only those employees who meet the eligibility requirements for coverage, rather than requiring coverage for the entire work force if *any* single employee is eligible.

CONCLUSION

NATS recognizes the importance of ensuring that all Americans have the opportunity to receive adequate health care benefits. We do not challenge the concept of a national health insurance program. Rather, our concern is with the equities of the funding mechanism that is selected. As this Committee examines this issue, we ask only that the problems of the temporary services industry be considered. We believe that S. 350 and S. 351 fairly take account of the industry's concerns and we urge this Committee to adopt the approach they propose.

We appreciate the opportunity to present our views.

AMERICAN ACADEMY OF PEDIATRICS,
Evanston, Ill. April 6, 1979.

Hon. RUSSELL B. LONG,
Chairman, Committee on Finance,
U.S. Senate, Washington, D.C.

DEAR MR. CHAIRMAN: The following comments are offered for inclusion in the hearing record on your recently proposed catastrophic health insurance legislation (S. 350 and S. 351) on behalf of the American Academy of Pediatrics.

The American Academy of Pediatrics is dedicated to protecting the interests and rights of infants, children and adolescents and insuring that this segment of our population is adequately represented in health care programs. We have a long-standing interest in protecting infants, children, adolescents and their parents against catastrophic medical expenses which can be incurred from the prenatal stage through age 21. The Academy has played a major role in assuring the inclusion of newborn insurance as a requirement in health insurance policies in 48 of our 50 states. Prior to our efforts in this area, many families encountered serious problems in financing health catastrophies in their children's first month of life. We

offer this as one example of how we have dealt with the need for catastrophic coverage and of our continuing interests in this area.

We believe, however, that an important change in the health care financing mechanism in the United States necessitates a re-examination of our priorities to determine exactly what this country's children will be receiving in return for the expenditure of additional billions of dollars on health care. It is the Academy's position that preventive health care as a component of a pluralistic, comprehensive program for children should be our highest priority, for it can result in the greatest and most cost-effective benefit over a span of time. The health problems of our elderly should not turn our attention away from children and young adults whose good health will determine our nation's future.

We believe that catastrophic insurance is a necessary element of any comprehensive program of health care, but we fear the possibility of catastrophic illness generating an inordinately large portion of our national medical bills. The cost of renal dialysis programs, coronary bypass operations and nursing home care must be placed in proper perspective in anticipating a health budget. The newborn period and the first years of life should be the foundation for any comprehensive health care program, and our efforts directed to determining the health status of children in that period so illness can be prevented and congenital defects corrected. Only in this manner can we expect to move toward solutions of the many problems in health care delivery which we now face.

Sincerely yours,

EDWIN L. KENDIG, Jr., M.D.

BEND INDUSTRIES, INC.,
March 8, 1979.

Hon. GAYLORD A. NELSON,
Senate Office Building,
Washington, D.C.

DEAR SENATOR NELSON: We urge you to oppose any program of national health insurance. We want to go on record with you because we understand hearings on a national health insurance program are scheduled in the form of S.350 for March 27 and 28, 1979.

As has been proven in every country that has tried it, a program such as this would be destined for failure. The program would be outrageously expensive to maintain relying on tax revenues, the waiting lists for admission into hospitals would be monstrous and advantage would be taken of the length of stay in the hospitals.

Contrary to the opinion of some national and state officials, a government health insurance program would be totally unworkable. We feel a nation's health is important, but the cost to the taxpayer must be considered. And today's taxpayer is already carrying too many burdens spawned by government.

Sincerely,

FREDERICK H. YAHR, *President.*

AMERICAN COLLEGE OF RADIOLOGY,
Chicago, Ill., March 20, 1979.

Senator HERMAN E. TALMADGE,
Chairman, Health Subcommittee,
Senate Finance Committee, Washington, D. C.

DEAR SENATOR TALMADGE: The following comments on Senate Bill 505 are offered on behalf of the 14,000 members of the American College of Radiology. These physician specialists in the uses of ionizing and other radiation to diagnose and treat patients are affected by several sections of the pending bill. We respectfully request that this letter be included in the record of your recent hearings on the legislation.

We have had the privilege of discussing previous versions of this legislation with you and with your able staff. In this version, as before, we are grateful to you for your understanding of the desires of the nation's radiologists to practice their specialty on the same basis as do most other physicians. We also appreciate your awareness of elements of medical practice which make a significant difference between what we would all regard as good service and what we, at least, would identify as less desirable or inadequate conditions for health care.

Thus, in terms of those portions of the bill which affect the practice of radiology, this organization repeats its endorsement and support.

There are several modifications from previous drafts and some additions which deserve brief comment and a few suggestions for minor changes.

Section 5 deals with physician acceptance of the assignment of benefits by Medicare patients. This organization has consistently encouraged its members to accept assignments, even though the review policies and dilatory reimbursement of some carriers has made this a costly indulgence. We now think it important that you retain the right of physicians to opt in and out of "participating physician" status, even in the face of incentives to take assignment. While we have not sought coverage in the $1 incentive offered to "participating physicians," this is a discriminatory provision. Perhaps it will serve its purpose elsewhere.

Section 6 deals with reimbursement of "hospital-associated" physicians. Therein we are most grateful for the reaffirmation of the right of radiologists in voluntary hospitals to practice on a fee-for-service basis. The American College of Radiology since 1966 has urged its members to discontinue arrangements with hospitals under which physician income represented a fraction of the institutional charge. Our reasons have been stated before. We have not changed our policy. We also find reasonable the assertion that physician fees should relate to services provided to patients by physicians.

Despite the College's admonitions to its members since 1966, some radiologists in voluntary hospitals continue to practice under terms of reimbursement contracts based upon percentage sharing between doctor and hospital. It will be necessary to specify in the legislation or elsewhere a reasonable period during which these arrangements can be changed in an orderly and non-inflationary manner.

In our testimony of June 10, 1977, we called attention to the special needs of a relatively small number of radiologists who serve rural hospitals on a part-time basis. Rather than repeat the discussion in that testimony, we simply reference it here. The situation cited therein remains equally valid.

Some of our members work in other than voluntary hospitals where patients or their representatives are expected to pay for services. There, presumably, the "reasonable salary" would need to be defined by program administrators. We think it unwise for the Congress to define a "reasonable salary." However, we do urge a continuing alertness by the Congress to offset demonstrable bureaucratic zeal for attacking physicians.

Section 7 deals with the proper role of relative value scales as a mechanism to aid third parties and providers in defining services. You are aware that relative value scales were devised by physician groups to assist insurance carriers, including the federal CHAMPUS program. Just the same, the ACR and other groups have been placed under consent orders by the Federal Trade Commission prohibiting further activities regarding relative value scales. This section would redress this prohibition to the extent that we are now free to respond to initiatives from the Health Care Financing Administration. We might have wished for a broader basis for professional initiative along the lines we suggested in 1977. However, the current language will be helpful.

Section 8 defers the implementation of section 227 from Public Law 92-603. Nearly 10 percent of radiologists are full-time faculty members, directly affected by interpretation and implementation of that section. We think the delay provided here will be beneficial.

Section 9 would recognize the advent and benefits of ambulatory surgery centers. We have recognized the value of avoiding costly institutional facilities in all circumstances where these resources are not immediately needed for patient care. Thus, many radiologists have provided their communities with supervoltage radiation therapy units and computerized tomographic scanners in privately operated offices and clinics. In some communities, these are the only such service available.

Where substantial capital expenses are borne by physicians in surgicenters or in the two types of radiation faciliteis cited, we submit that it would be efficacious and even cost-effective to consider extending the same coverage to these radiation facilities.

Section 10 reaffirms the policy of relying upon tested methods of determining allowable levels of reimbursement based upon "reasonable and prevailing" charges and the use of percentiles. Recently, the reimbursement for CT scans has been subjected to a totally arbitrary national ceiling urged upon the carriers by HCFA without consultation, justification or due process. Our protests have thus far been unanswered. Perhaps your restatement of policy will have more effect.

Section 19 relating to reasonable charges and costs, on the face of it, would not relate to the professional services of radiologists. This is as it should be.

Section 20 would broaden coverage of ambulance services to allow reimbursement for needed transportation to appropriate facilities. We applaud your inclusion of free-standing radiation therapy facilities in the transportation coverage provisions. Several of our members have suggested that where the only locally available computed tomographic unit is located in a non-institutional setting that ambulance costs be covered similarly.

Section 23 imposes desirable restraint upon the dissemination of information about physician billings under the Medicare program. With full respect to the right of the people to know the workings of public programs, this information has been used as a form of harassment by federal agencies. Most radiologists are affiliated with groups, often billing in the name of the senior partner for the services of three to 10 physicians. Even where the amounts quoted were correct, an infrequent occurence, the inference was that a single physician was abusing the system. We applaud your corrective measure.

Section 28 would allow physicians participating in the activities of PSRO's to have needed confidentiality in providing their professional expertise to the services of their peers. We supported the creation of the PSRO program in Public Law 92-603. We shared with you and the Finance Committee the expectation that the medical profession could accept the burden and respond to the challenge. The assurance of confidentiality for those physicians undertaking PSRO activities is essential. We favor your proposed action.

Section 31 deals with adoption of uniform claims forms by public and private programs. We have attempted to work with the Medicare Bureau and with the several private carrier groups in developing standard nomenclature and reporting procedures. We offer the caveat that a single form, oriented for the primary care physician, may impose unintended burdens upon consultants. For example, radiologists usually are asked to participate in the diagnostic process at an early stage in the patient's care. A clinician may rely upon his own examination, the patient's history, X-ray, laboratory and even surgical procedures before attaining a certain diagnosis. The diagnostic radiologist can identify densities in the lung or intestines strongly suggestive of disease. He is not made aware routinely or promptly of the pathologist's test findings or the result of a biopsy unless he is asked for additional assistance. In this example, a form requiring a final diagnosis would not be suitable for use by consultants. Obviously, such details are not proper for legislative language. But the intent of section 31 is well taken with the single caveat.

Section 33 would encourage the continuation of private philanthropic support of health institutions. Hospitals in some states are exhausting endowments because of the pressure of rate commissions to use capital to offset operating expense. We hope section 33 would deter such short-sightedness by regulators.

We have limited our comments in the paragraphs above to those sections of the bill which affect the specialty of radiology and concerning which we might claim to have some informed interest. If you wish elaboration on any of the points, we respectfully urge you to request it of us through our legislative consultant, J. T. Rutherford.

Sincerely,

HAROLD N. SCHWINGER, M.D.,
Chairman, Board of Chancellors.

STATEMENT OF CANDLELIGHTERS ON CATASTROPHIC HEALTH INSURANCE

Mr. Chairman and members of the committee, My name is Grace Powers Monaco; I am representing CANDLELIGHTERS, an international coalition of families of children affected by cancer in 45 states, Canada, Australia and Europe. We wish to bring to your attention the unique problems of children affected by cancer and their needs in catastrophic health coverage.

CATASTROPHIC COVERAGE FOR PEDIATRIC CANCER MUST INCLUDE TRANSPORTATION COSTS

The problems families of children with cancer share is a large one: after accidents, the second leading cause of death in American children is cancer.

The emotional burdens of cancer on a family unit that is faced with a child or adolescent with cancer are self evident and need not be stated here. However, the financial burden borne by each family is second only to the distress caused by the disease itself. A study of seventy families with children in treatment for cancer at the University of Kansas Medical Center, demonstrated that in addition to medical expenses (usually covered by third party coverage and installment payments, and in some cases helped also by the Crippled Childrens programs), the out-of-pocket for

non-medical expenses usually averaged more than 15 percent of the family budget. For half of the families, the figure was over 25 percent. These non-medical expenses include loss of pay, transportation to different medical facilities, food and lodging while away from home, child care, special clothing and special food. The burdens also include inability to change jobs because of loss of medical coverage for the affected child.

Although cancer is the second leading cause of death for our children, children account for only 1 percent of the population affected by cancer in this country. What this means is that specialized cancer care facilities to provide skilled treatment for children are not right around the corner as they are for the adult cancer population. What this means is that even if a family can be assured that all its direct medical expenses are paid, transportation costs to a care facility, board, lodging, child care for other children remaining at home, loss of work time must be borne by the family and indeed are as "direct" costs as the medical treatment itself.

Transportation and the related costs are necessary to assure receiving skilled medical treatment.

One illustration is the circumstances presented for pediatric cancer patients in Nevada. This child and the family unit has three treatment options. The closest oncology care centers are in California (San Diego, Los Angeles or San Francisco). They are from 250 to 460 miles away. Air transportation ranges from $150–300 per person round trip and remember that a parent must always accompany the child. Visits to the clinic vary in frequency from once every two weeks to once every eight weeks. When a child is hospitalized, there are food and lodging costs for the parents and often lost wages.

One Nevada family spent over $6000 in out of pocket expenses the first year their child was diagnosed. A few months ago they spent $750 for a five day trip to San Diego for tests. When they have to stay several days, the family makes the trip across the desert in a camper to save on lodging.

Another Nevada family recently had to spend $2350 in just seven weeks for out-of-pocket expenses incurred during the treatment of their child's cancer. These expenses were for gas, lodging and food incidental to their needs when they were at their treatment facility.

Another example involves a Michigan teenager with a cancerous bone in her right leg. Local doctors were ready to amputate but contacted a specialist in New York that led to a special operation at Memorial Sloan Kettering that saved the teenager's leg. Her mother had to quit her job in order to accompany the child to New York for treatment and to care for her. The mother's living expenses in New York, travel bills, and caring for five other children completely depleted the family's savings. Thus, even though the family's insurance covered most of the teenager's medical bills and the State Crippled Childrens Program paid remaing expenses the family was in effect destitute.

A further example involves a divorced mother with four children in Irving, Texas. Her daughter has had osteogenci sarcoma (amputee) since 1972. Every third week she goes to M.D. Anderson with her daughter for treatment for a week stay. She works weekends to make up lost pay and after using her vacation time she has her pay docked. The Texas rehabilitation agency will not help with her daughter's prosthesis or education because they assume she will die.

A further example is the plight of families whose children need bone marrow transplants and must travel to one of the half dozen pediatric facilities in the country that can offer this service with the same indirect expenses covered above.

PROVISION FOR TRANSPORTATION AS PART OF A CONSORTIUM APPROACH TO PEDIATRIC CANCER

It is obvious that catastrophic coverage for pediatric/adolescent cancer patients requires more than reimbursement for direct medical expenses. It is also obvious that it would be impractical and not cost effective to multiply the number of skilled pediatric/adolescent cancer facilities to avoid the transportation and indirect expense burdens. Candlelighters suggests an approach to this problem which will provide optimum care to the child and true protection to the parent from catastrophic expenses.

In view of the shrinking dollars allocated to health, it is important to develop an approach to cancer research in children and its application that produces excellence in research and provides an optimum in application of research for all children/adolescents with cancer at the lowest cost to families and to society. One suggestion growing out of observations by patients is the consortium approach to health care for children with cancer.

Childhood cancer research has proven to be the single most effective model for understanding and treating many forms of cancer. Pediatric cancers pioneered combined modality therapy utilizing surgery, radiotherapy and chemotherapy, various rescue factor approaches and adjuvant chemotherapy which have effectively arrested or retarded the development of many adult cancers. Dr. Emil J. Freireich of the University of Texas Systems Cancer Center in Houston has said that drug combinations pioneered in pediatric cancer are not producing remissions in a majority of adults with acute myelogenous leukemia and a "proportion of these patients are being cured. Five years ago if you asked me if we were producing cures, I could only say, 'rarely'." Additional specific examples include the development of and use of antifols in childhood leukemia which lead to curative measures in adult cancer, specifically the use of antifols in women with choriocarcinoma; adjuvant chemotherapy in breast cancer to prevent metastases; and, the combination chemotherapy in acute lymphocytic leukemia which is now being used successfully in adult Hodgkin's disease, finally, the total therapy concept used for childhood ALL is now being used successfully in cooperative study clinical trials involving adult lung cancers.

These applications of the results of research in pediatric and adolescent cancers underscores the importance of preserving, expanding and building upon the research efforts committed to childhood and adolescent cancer. The proposal Candlelighters suggest would work toward a guarantee that all children with cancer will have ready access to the most expeditious, safe and effective care available as measured by national standards, but all will have responsible primary physician-advocates, that no family will be economically constrained or burdned by the costs of care, that childrens cancer research will proceed viogorously.

There is already an example of the consortium approach that we suggest within the National Cancer Institute's intramural research program into childhood cancer which has its clinical application on site at the National Institutes of Health Clinical Center. The ways of managing the burdens of transportation costs, costs of lodging and board away from home, coordination of care with local physicians and the childrens hospital are all contained in the blueprint that already exists within the intramural federal program. The consortium approach as suggested by Candlelighters recognizes three conventionally defined levels of health care:

Primary (Level I)—located in the child's community, and providing home and outpatient/office health supervision with particular regard to normal growth and development, prevention of infectious disease, treatment of minor infections, liaison with school and community, and family counseling by professional and by peer group. This would be provided by a pediatrician, family practitioner, internist or pediatric oncologist.

Secondary (Level II)—The pediatric cancer care facility, usually connected with a children's hospital located close to the child's community and providing outpatient and inpatient care for the particular disease and its complications. This would include: administering anticancer drugs accoring to protocol; maintaining treatment records, and managing moderately severe infections, bleeding episodes, anemia, nutritional and metabolic disorders. This would be provided by a pediatric hematologist/oncologist or a pediatrician with additional training or experience in pediatric oncology. Also, this facility should provide access to childlife specialists, psychosocial support by professional or peer group as well as undertaking an education program directed to medical and nursing students, graduate trainees, and practitioners.

Tertiary (Level III)—A regional childrens cancer center. This would be accessible to provide confirmation or correction of initial diagnosis, subcategorization and staging, complete evaluation of the child's needs through discussion among team members and with child and family, assignment to protocol study with consent of child and parents, initiation of therapy, conduct of any Phase I experimental treatment, basic and clinical research relevant to children's cancer, and training of oncologists in research and practice. The child and/or his specimens and findings would be periodically sent to the center for reassessment, change in therapy, investigative studies not available at the secondary level and documentation of disease course.

Secondary care persons might provide primary care as well, and tertiary regional centers could provide primary and secondary care also. This would be decided in accordance with the residence of the child, the particular cancer and its treatment, and the wishes of the child and family.

The tertiary center is the outreach program at the hub of the wheel and the secondary (usually a children's hospital) and primary (usually a pediatric oncologist) are the radials. In this consortium approach the primary and secondary levels of caregivers provide most of the care in concert and in collaboration with the tertiary center. Under such a cooperative approach, given the primary sentiment of families

to achieve as much care as possible close to home if their child would not be endangered by that decision, the transportation and lodging requirement of the catastrophic coverage plan would not be abused.

WHAT SERVICES SHOULD BE COVERED IN A CATASTROPHIC INSURANCE PROGRAM

1. The cost of transportation and lodging as needed for evaluation, re-evaluation and specialized care at the tertiary research facility.
2. In-patient hospital costs.
3. Out-patient visits
4. All drugs, radiotherapy, blood components, prosthesis
5. Nursing home care for the child who no longer needs hospitalization but cannot be cared for at home.
6. Home care during terminal stages. A study at the University of Minnesota shows that home care for the terminal child with full team support costs less than a third of death in a hospital.
7. Counseling costs for the family during illness and after termination of care.

NEED FOR A NATIONAL STANDARD FOR CRIPPLED CHILDRENS PROGRAMS

The need for uniform catastrophic coverage is particularly apparent from the checkerboard coverage pattern of the Crippled Childrens Programs. Candlelighters of Connecticut has been acting as a task force in reviewing the pattern of coverage in the States. Most of the states provide full or partial coverage for treatment of childhood cancer or leukemia. Some States cover all childhood cancers while others limit coverage to but a few types. Some states cover diagnostic tests but not treatment and visa versa. Some states have no coverage under the Crippled Children's Programs but provide support from private or other sources. In most cases the coverage is very minimal, especially in today's inflationary economy. Further, it varies widely from state to state. A few are semi-generous. One or two will cover incomes of $20,000 or more, if there is hardship. The eligibility requirements in almost all cases are very strict, so much so that many needy cases are not covered. The requirements are generally so complicated or couched in such language that even the educated layman will find it difficult to understand.

What bothers us most is those states with provisions that require the child to have a good prognosis for cure before they are accepted in the program. Others have the inhumane provisions of dropping children when their outlook turns from good to poor. Since the Crippled Children's Program is an outgrowth of the Social Security Law, we think that minimum national standard ought to be the goal—standards that include coverage for all children with leukemia or cancer. See study appended for survey of states.

The difficulties caused by this checkerboard coverage can be resolved with uniform catastrophic coverage standards.

Mr. Chairman, Members of the Committee, on behalf of parents across the country who have children affected by cancer, I should like again to commend you for your efforts and your understanding.

State	Covers the medical treatment of all childhood cancer and leukemia	Covers the medical treatment of specific diagnoses of childhood cancer and leukemia	Alternative programs within the State	Eligibility requirements
Alabama		They do not routinely accept cases of leukemia or childhood cancer but will accept a very few cases of leukemia on a special per case basis.		Age, diagnosis, and financial means test.
Arizona		Pays for some childhood cancer and leukemia but requires that the child have a prognosis for cure or significant improvement toward rehabilitation.		Do.
Arkansas		Covers certain operable cancers of the bone or skull.		Residency requirement, age, diagnosis, and financial means test.
California	Pays for the treatment of all childhood cancer and leukemia—includes in- and outpatient care, meds, blood products, lab work, psychosocial counseling and terminal home care.			Age, diagnosis, and financial means test.
Colorado	No coverage			None.
Delaware	No		Alfred J. DuPont Institute (private) will handle crippling bone cancer.	
Florida	Medical care is covered only in certain designated clinics and hospitals in Florida.			Age, diagnosis, and financial means test.
Georgia	No		Cancer control program—managed through the adult health unit, division of physical health.	
Hawaii	No coverage			
Idaho		Offers very limited coverage—leukemia is not covered, only malignancies that require rehabilitation are served.		Age, diagnosis, and financial means test.
Illinois		Covers medical care for cancer related to neurologic or orthopedic conditions.		Do.
Indiana	Full coverage for treatment			Do.
Iowa	No coverage			
Kansas		Pays for the medical diagnosis and treatment of solid tumors but not leukemia.		Age, diagnosis, and financial means test.
Kentucky		Covers the treatment of brain tumors and orthopedic (bone) cancer.		Do.
Maine	All diagnoses		Catastrophic health insurance	Do.
Maryland		Diagnostic work-up both as in- or outpatient; medication provided by approved hospitals or M.D.		Financial means test.
Michigan	All diagnoses—only restriction is that the treatment must be rendered by a provider approved by the program.			Age, diagnosis, and financial means test.
Minnesota	All diagnoses		Catastrophic health insurance	Do.
Mississippi	No			
Montana		Assist with diagnostic evaluations but not treatment.		Age, and financial means test.

State	Covers the medical treatment of all childhood cancer and leukemia	Covers the medical treatment of specific diagnoses of childhood cancer and leukemia	Alternative programs within the State	Eligibility requirements
Nebraska	Yes—all treatment			Age, diagnosis, and financial means test.
Nevada	Yes—pays of all or part of the costs of diagnosis and treatment of all childhood neoplastic diseases, malignant or benign.			Do.
New Hampshire	No		Treatment is covered by the New Hampshire Cancer Commission.	
New Jersey	Yes—all diagnoses			Age, diagnosis, and financial means test.
New Mexico	No			
New York	Yes—all diagnoses: except two counties in New York have elected to exclude malignanacies.			Age, and financial means test.
North Carolina	Yes—all diagnoses			Do.
North Dakota	Yes—includes cancer and leukemia; however, it does not cover supportive care, transportation, or out of hospital drugs; they will not go above $5,000 hospitalization limit in 12 month period.			Do.
Oklahoma	Yes—includes all diagnoses			Do.
Oregon	No			
Pennsylvania	No			
Rhode Island	No		Catastrophic health insurance to cover cost of treatment.	
South Carolina		Covers treatment of children who require orthopedic followup and/or appliances as a result of amputation, etc. because of bone tumors or other types of cancer.	Also the Division of DHEC cancer program provides diagnostic services, curative therapy and and follow-up for all kinds of childhood cancer and leukemia	Age, and diagnosis
Tennessee		Children get initial diagnostic evaluation free of charge; cancer and leukemia are considered on an individual basis including: Wilm's neuroblastoma, retinoblastoma, osteogenic sarcoma, Hodgkin's, multiple myeloma.		Age, diagnosis, and financial means test.
Texas	No			
Vermont	No			
Virginia		Has speciality programs for primary bone cancer, Wilm's tumor, brain tumors.		Age, diagnosis, and financial means test.
Washington		Covers treatment of Wilm's tumor, rhabdomyosarcoma, Hodgkin's lymphoblastic leukemia (may include osteogenic sarcoma and Ewing's sarcoma soon).		Do.
West Virginia		Covers only malignancies of the bone		Do.
Wisconsin		Covers neoplasms and chronic infections of the bone.		Do.

Testimony of Reverend Richard Bowyer, Chairman of the West Virginia Committee for the Health Security Act

SUMMARY

Mr. Chairman and committee members, it is an honor and privilege to be granted this opportunity to share with you a mutual concern for the health and well being of the people of the United States of America.

Senators, I am currently on the board of a general hospital, of an outpatient clinic and of a community comprehensive mental health center. In the recent past I have served on the board of a regional health planning association and on the board of the West Virginia Health Systems Agency. The issues before you which S. 350 and S. 351 seek to address are not new to me.

As I talk with people in general and especially with those who come into direct contact with the health care system, it is increasingly clear that we must find a solution to the spiral of uncontrolled inflation and costs. While we in America enjoy the benefits of much of the world's finest health care practitioners, facilities and technologies, the cost of such services are becoming more and more prohibitive. It seems to me that we are at a stage in our history at which a token approach or a moderate effort will not do the job. We must do that which needs to be done. I believe a conservative financing approach is essential.

I am further convinced that we must put into place a system which will not only bring temporary relief, but will enable us to deal with these problems over the years that lie ahead.

While I am certain none of us want to see anything but the finest quality of health care for all Americans, the fact is that many do not have the kind of service which some of us enjoy. Many live where quality care is not available. In many instances economic and other factors complicate or prevent the delivery of quality care.

These are the issues which I wish to address: the quality of care, the scope of care as it relates to the delivery system, and the financing of such a system. Let me comment briefly on each of these concerns on which I will comment in some more detail in my attached remarks.

1. The financing of health care is critical to the solution of our problems. Several years ago it was stated often with considerable accuracy that the major problem was with the poor and elderly. The Congress designed programs to attempt to meet those needs. Increasingly, the working people and middle class began to sense that they were financing services for others, but were not benefiting themselves. But before that has been dealt with, even those systems for the poor and elderly have broken down either in terms of services which cost too much to deliver or services which those for whom they were designed cannot afford.

Our third party payment systems have further contributed to the problems. We have turned to an insurance model which is based on care for the sick rather than on incentives for health. We reward illness and reward those components of the system which both cost the most and which generate other costs.

I propose a conservative approach, one which I learned in school as a child, one which encourages planning and discourages waste and excess. Simply stated it is a budget approach. If we would set into place a system of prospective budgeting, establish an annual budget beyond which we will not go, we will control cost. Once I know that I will only have so much money to spend, I plan my expenditures with care.

The opponents to such an idea are obviously those who benefit most from uncontrolled cost, and those who may be careless and irresponsible with the use of our money.

We in this country used to think that frugality, thrift and budgeting were virtues. But there is a further moral issue raised when we by design reward sickness and encourage physicians, hospitals and clinics to generate a larger "utilization rate," or "patient population."

Unfortunately, both S. 350 and S. 351 provide the same kind of negative incentives and would encourage excessive utilization at the higher cost areas of the health care system.

2. Further, if we are to apply conservative principles to our problem, we must put into effect a system which will have long range impact rather than short term measures. It is not the exceptional or unusual situation which is running up our health care cost, but the day in and day out health services which is coupled with the catastrophic. Catastrophic illnesses are often not the result of traumatic events, but are the outcome of problems not dealt with soon enough. The reason so many in poor, minority and elderly populations have such high medical bills is that they

have had to postpone treatment which by comparison would not have cost nearly so much.

If we were to implement a phased in approach to national health insurance, the real cost saving phase one would be aimed at early treatment and prevention. Unfortunately, S. 350 and S. 351 address only the late stages of costly illness and accidents. Thus they fail both to control present cost and to curtail the future costs of latent health problems.

3. The third concern is quality care. On the surface it would appear that if the higher cost components of care were to be affordable to more people then quality care would also thereby be extended. But quality health care is more involved than that. Quality care is dependent upon early detection and prevention. Quality care is oriented to health and not to sickness. That is not to say, of course, that we would not or do not make the finest resources possible available to those who are sick. But it does mean that we take those fine resources to those places and persons or situations where they can be most effectively used in the development and maintenance of health.

Again, unfortunately, S. 350 and S. 351 are aimed at the late stage of care and not to the kind of quality care we need which provides the stimulus for health maintenance and early detection and treatment of illness.

Senators, thank you for your attention to these remarks. I recognize that many on this committee are co-sponsors of these two bills and thus will find my statements contrary to the views which led to the drafting and introduction of S. 350 and S. 351. But I believe we all share a common commitment to providing quality care and reasonable cost to all Americans. I believe that if you will read my further statments and reflect on the conservative approach which I recommend, that you may agree that good intentions will not necessarily lead to good results and you may be inclined to agree with us that a comprehensive and universal system based on prospective budgeting is the route we need to take.

Summary of Testimony of Margot L. Willis

It is a privilege to be here today and have the opportunity to discuss with you the effects "Catastrophic Health Insurance" would have on the health of my fellow West Virginians. As a health science researcher and an emergency medical technician I am greatly concerned about the current problems in our health care system.

The members of Congress are to be commended for their continuing concern and efforts to find solutions to the problems which we face in health care today. I hope, as I am sure you do, that we will soon take positive action to curb the cost of care and ensure that care is available to those who need it.

Gentlemen, the population of West Virginia is a little less than 2 million and most of it is rural. The mean income for a family of four in West Virginia is $9000, but only about 20 percent of the people fall under the federal definition of poor. After federal and state income taxes and FICA are deducted from the average family's wages, they have $670 a month for living expenses. Federal figures for a family of four on a low budget show necessary expenses (excepting medical care, health and life insurance) to be $651.32 a month. That leaves this family with less than $20 for medicare care, insurance, emergencies, incidentals and recreation each month.

In considering the legislation before us today these figures are of immense value. What would "Catastrophic" mean to this family? Will it keep them from being bankrupted by illness or injury? Will it give them adequate basic insurance? The data shows these people have too much income and probably too little disability to qualify for Medicaid or the "Medical Assistance Reform Legislation." So let's concentrate on the middle-income, average family.

Given the national trend of only 50 percent of doctors accepting Medicare assignments and the history of Medicare reimbursement in West Virginia being less than 50 percent, probably half of these families in West Virginia can expect to accrue bills in excess of $2000 before they meet that figure in "allowable charges" and become eligible for assistance under the supplemental insurance plan. The average individual cost of health in West Virginia per year is $600. Thus, this average family can plan on spending about $2,400 and still not be eligible for help; and quite clearly with an average per diem of $150 for hospitalization they won't have met the 60 days of confinement requirement for aid under the other part of this bill.

They will be in debt several thousands of dollars. They don't have enough money to pay that out-of-pocket. They won't qualify for help under "Catastrophic". More than likely, they won't have other insurance; or if they do have insurance, it won't be adequate. Only 611,000 people under 65 year of age living in my state are covered

by any kind of major medical insurance. Recent studies show that nearly half of all employees in industries employing more than 50 people have either no insurance or insurance that has a life-time limit of $20,000 or less. At today's prices one bad illness or injury would wipe those policies out in four months or less.

When I was gathering this data, I became concerned that the statistics might not paint a true picture of the average person's actual situation. Therefore, I reviewed the testimony of eleven witnesses from the state who testified before hearings last year in the presence of Senator Randolph and Congressman Staggers. Senators, I was surprised to find that 10 of those 11 witnesses did, in fact, fit the picture which I had painted with the data. This profile of problems developed: (1) They had too much income or too little disability to be helped under "Catastrophic"; (2) Their other insurance was inadequate or non-existent; (3) Their family income was below $10,000 a year; (4) They were bankrupted or severely in debt; (5) They were avoiding some care or therapy because they could not afford it. One family had had a prior income of $20,000 to $30,000 a year. They had been forced to sell all of their belongings. Indeed, they were so far in debt that if their income were restored to its earlier level, it would take them years to recover what they had lost. Two families found that they could not get the care for their children that they needed unless they were under-employed. If they worked at a job of their full potential, they would loose the assistance they were getting for their children and they would not be earning enough to provide that care themselves. Of these people 91 percent would not be helped by "Catastrophic".

I seriously suspect that that figure is close to accurate for the other middle-income people of West Virginia, Appalachia, and surely for millions of other Americans. My concern is that "Catastrophic" will do little or nothing for too many people. Both the data and the actual case studies show that the average person, the average family, will be caught in the "Catch 22" of exclusions and prerequisites. They will once again be left with large bills, little money and no insurance.

We do need insurance against catastrophic illness and injury in America today. But "Catastrophic" is not the answer by itself. With my full statement I have submitted two tables of data: (1) On the impact of "Catastrophic" on the average family of four at income levels from just above the bill's low-income level to $50,000; (2) The counties of West Virginia with data showing that "Catastrophic" will not apply to most middle-income families in the state. In fact, it appears that only the poor and those who are well-insured or earning $40,000 a year or more will derive much benefit without severe financial hardship.

We need a comprehensive national health plan that will include catastrophic protection—one that will insure that no one is bankrupted by the expenses of poor health, that noone must do without care, and that has cost and quality controls built into the system. The statistics and the case studies both show clearly that the present "Catastrophic" bill as it is presented in S. 350 and S. 351 does not meet these criteria.

TESTIMONY OF MARGOT L. WILLIS, HEALTH RESEARCHER, MORGANTOWN, W. VA.

It is a privilege to have been invited here to speak with you you about the ways in which "Catastrophic Health Insurance" will affect the health and health care of the people of West Virginia. As a health science researcher and an emergency medical technician, I am familiar with and concerned about the cost and quality of health care services.

In light of the runaway cost of health services in recent years, you are to be commended for your concern and efforts to control those costs. When Senator Long introduced S. 350 and S. 351 he said they were designed to assure "all Americans that they will not be bankrupted by the devastating effects of serious illness or injury * * * to provide equal benefits to all Americans at the lower end of the income scale * * * to assure * * * adequate basic private insurance to many millions of * * * middle income Americans." It is those three assumptions which I shall address today.

More than 84,000 West Virginian's have no doctor*(1)* and another 1.2 million West Virginians have only inadequate medical services are available to them.*(2)* The probability is that if quality services were available and accessible to that one million plus Mountaineers they would not be able to pay for it. West Virginia University Hospital in May, 1978, reported "During the last four years, uncollected bills at the hospital total $5,885,000 . . . these are for poor people 'who can't afford to pay'."*(3)* In all since the hospital opened in 1961 WVU has accrued $26 million in unpaid bills,*(4)* of this amount only $9.2 million represent current outstanding debts that are probably collectable.*(5)*

Gentlemen, the population of my state is about 1,800,000.*(6)* Sixty-one percent of the population is rural*(7)* and for the entire state the total personal income per capita is 20 percent below the national average.*(8)* Figures from the 1970 Census place nearly 20 percent of all West Virginia families below the poverty level, or approximately 82,000 individuals fall into the category of poor.*(9)* Thus, a little better than 80 percent of the people in West Virginia are not poor by federal standards of poverty. Like the national average, the average West Virginia family has four members. Senators, the mean income of that West Virginia household is $9,000 a year.*(10)* After Federal and state income tax plus F.I.C.A. are deducted from this family's wages, they have $670 a*(11)* month on which to live. Not poor by federal standards, their monthly expenditures for housing, food, clothing, transportation and other necessary expenses (excluding medical care, health and life insurance), their expenditures total $651.32 a month.*(12)* In other words, each month they have $18.68 to cover medical care, insurances, emergencies, incidentals and recreation.

There are important questions that we must address in considering the legislation before us today. What would "catastrophic" mean to these "average" people? Will it keep them from being bankrupted by illness or injury? Will it ensure them adequate basic insurance? Let's see what the data on West Virginia shows.

First, we know that they have too much income and probably not enough disability to be covered by Medicaid or the "Medical Assistance Reform Legislation" which is proposed in S. 350. So we aren't even going to discuss that element. Let's just concentrate on the middle-income, average family in West Virginia, or elsewhere for that matter. What will "catastrophic" mean to them if they are struck with an illness or injury.

Second, we must consider the $2,000 deductible which is the counterpart of part B, medicare. The latest HEW figures show that nationally only 50 percent of the doctors accept Medicare assignments. If this trends holds true in West Virginia, then nearly half of the state's families can expect to have bills exceeding the $2,000 deductible in this provision. Furthermore, Social Security Administration data shows that in 1976 the supplemental medical insurance plan averaged a 74 percent reimbursement rate on "approved" physician charges.(13) With this as an indicator, the family can expect to expend at least $2,700 for services before they have $2,000 worth of "reasonable charges" under this section.*(14)* Yet this family has only about $20 per month to spend on these items.

Many health care related items such as medication, O.T.C. or outpatient prescriptions; eye care; injections that can be self-administered, i.e. insulin; dental care, in some cases; and other health needs.*(15)* Moreover, the average individual cost for health care in West Virginia in 1976 was $600.(16) That means if this family of four is average in its health expenditures, it will probably spend $2,400. With that amount they will probably not be eligible for assistance under the medical coverage plan nor will they be eligible under the hospital plan. But they will be in debt $2,400.

Third, lets consider the 60-day per individual hospitalization section, or part A, medicare, as it applies to this family under "Catastrophic". West Virginia has the second highest hospital bed utilization rate in the country,*(17)* with an average length of stay in a community hospital at 7.4 days.*(18)* Given the national average cost of $150 per day for hospital care this middle-income family will owe $1,110 and not even approach the benefits requirements for aid under this provision. They don't have the money to pay this bill outright. They don't have private insurance because they can't afford it. But one average hospital confinement of eight days (that's what they will be billed for) will put them in debt several thousands of dollars.

Fourth, let's consider then some other relevant data about the people of West Virginia. Only 611,000 West Virginians under the age of 65 are covered by any kind of major medical insurance.*(19)* The amount and quality of those existing policies is an unknown. What we do know is that most of those policies have life-time benefit ceilings. It is my understanding that a recent Congressional Budget Office study shows that nearly 50 percent of all workers who are employed in businesses with 50 or more employees have either no insurance or the insurance they have has a life-time maximum of $20,000 or less. At current rates they are covered for less than 4½ months of hospital confinement in a life-time—one major accident or illness would render this typical policy worthless.

When we're told in West Virginia that the Medicare umbrella is going to be extended, frankly, we expect to be the ones who get wet. West Virginia has been 51st in the receipt of all Medicare payments since the inception of the program.*(20)* "The average Part B per capita amounts reimbursed * * * ranged from 49 to 62

percent of the national average * * * considerably below the national monthly premium."(21) So West Virginians typically get at 12 to 25 percent lesser return on their Medicare dollars than do their counterparts in New York or California.

Now with the demise of the United Mine Workers traditionally progressive health plan, the lengthy coal strike, and continued reduction in mine production, the economy and the health care of West Virginia are undergoing drastic revision. People aren't seeking care they can afford. Providers are leaving, services are being curtailed, and clinics are closing.(22) Preventive care has been eliminated for many of these people who need it most.(23) As I look around West Virginia, I see a health care system that is so fragmented that it reminds me of the opening scenes of the Arthur Miller movie, "The Misfits," in which pieces of a jigsaw puzzle move back and forth across the screen looking like they are going to mesh. They never do. They just keep on moving, passing one another, never making a connection.

In short, I come from a state with rich resources, a few poor people and many lower middle-income people. A recent WVU Medical Medical Center study showed that 9 out of 10 people in the state are within thirty minutes travel time to a hospital.(24) Still the services of those hospitals is inaccessible to a great amny of them. Some of the nation's top physicians are on faculty at the WVU School of Medicine,(25) and the school's record in qualifying specialists in internal medicine is "far above the national average".(26) The state has the second highest hospital bed utilization rate in the U.S.,(27) one of the highest accidental death rates in the country,(28) and an infant mortality rate that is higher than the national average.(29) Forty of the fifty-five counties are deficient in health services by criteria of the National Health Services Corps.(30) Every doctor in the state has a patient load 28.1 percent higher than his national counterpart, and the median age of practicing physicians is 50 years.(31) It has been estimated that the state of West Virginia spends from 16 to 24 percent of its budget for health care.(32)

I would like to add one more consideration to this list regarding the affect of "catastrophic" on the people of West Virginia. Having researched the data, I was concerned that the picture drawn from it might not fit actual cases. Therefore, I reviewed the testimony of eleven witnesses from the state who testified in hearings last year conducted in the presence of Senator Jennings Randolph and Congressman Harley Staggers of West Virginia. In fact, gentlemen, I was surprised to find that 10 of those 11 witnesses did fit the picture of the data.(33) More importantly to us today, this profile developed: (1) They had too much income or too little disability to qualify for Medicaid; (2) Their other insurance was inadequate or nonexistent; (3) Their family income was below $10,000 a year; (4) They were bankrupted or severely in debt; (5) They were avoiding some care or therapy because they could not afford it. Indeed one family whose prior income had been $20,000 to $30,000 had sold their saleable assets and were still so indebted that they would need years to recover even at their prior income level.(34) Indeed, two of those families found it necessary to limit their income to a level where they could receive services for their children because they could not otherwise make enough money to get them the care they required.(35) For 91 percent of these people "Catastrophic" would be of no help.

My concern is that "catastrophic" will do little or nothing to help the middle-income people of West Virginia, Appalachia, and probably millions of other Americans. Both the data and the actual cases I have examined show that too many average Americans will be caught in the "Catch 22" of exclusions and prerequisites. They will have large health care bills that neither they nor their insurances can pay. And "Catastrophic" will not meet their needs.

If history is any criteria for judgment, and I believe it is, then these same individuals may, in fact, be further indebted because of "Catastrophic", if it is enacted. The rate of inflation in health care since the beginning of Medicare and Medicaid has been widely documented as greater than that of the overall inflation. Yet this bill as it exists today offers no provisions for cost or quality controls.

Over the past several years the research which I have done has consistently shown that what the people in West Virginia and the rest of this country need is a delivery system that promotes health care not one that delivers sickness care. We need a system which is wholistic in scope and positive in regard to the role of the individual in determining much of his own health. Mrs. Jacqueline Stemple's master's thesis at WVU School of Nursing stated: "The goal is to help the individual change the course and cycle of events of events in his own life-style; and to develop his own self-care agency so, he can more effectively use the present system and develop skills to influence the health care system of the future."(36)

The importance of this idea is underscored by H. E. Hillboe when he writes: "Health no longer is an end in itself . . . but as a means for attaining optimum social well being within the constraints of the physical, social and biological envi-

ronment in which man finds himself. Health can no longer viewed out of context of the social and economic aspects of daily living."*(37)*

If people are going to have more individual responsibility for for their own health, then they need to know more about and and have a greater voice in the organization and operation of the systems that deliver health care services. In West Virginia the people have had a minimal role in the delivery system. This must change so that consumers needs can be met in such a way as to improve the overall level of health in the people. John Dewey wrote in the "Problems of Men:" "The idea of democracy as opposed to any conception of aristocracy is that every individual must be consulted in such a way actively, or passively, that he himself becomes a part of the process of authority, of the process of social control; that his needs and wants have a chance to be registered where they count in determining social policy."

We need insurance against catastrophic illness and injury in America today. With that insurance we need cost and quality controls. With that insurance we need provisions will be sufficiently broad to include that bulk of Americans in the middle income brackets who largely bear the tax burden of this nation.

We need a comprehensive national health plan that *will* ensure that noone is bankrupted by the expenses of poor health, that noone must do without care because it is too costly, and that has cost and quality controls built into system. I ask you, Senators, will the "Catastrophic" bill which is before us today do these things? The statistics and the case stuuies show that it will not.

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The following table is a profile of a West Virginia family of 4 at different income levels showing their finances after taxes and the minimum expenditures to qualify for aid under "Catastrophic health insurance". Data derived from 1978 United States and West Virginia income tax manuals for forms 1040 and 1040A using standard deductions.

Income	Federal tax	FICA	State tax	Catastrophic	Total	Net income
$50,000	$12,524	$1,070	$1,923	$11,000	$26,517	[1]$23,483
$40,000	9,226	1,070	1,340	11,000	22,636	17,364
$35,000	7,222	1,070	1,076	11,000	20,368	14,632
$30,000	5,408	1,070	836	11,000	18,314	11,686
$25,000	3,857	1,070	620	11,000	16,547	8,453
$20,000	2,524	1,070	436	11,000	15,030	4,970
$15,000	1,375	907	276	11,000	13,558	1,442
$12,000	817	726	191	11,000	12,734	−734
$10,000	442	605	143	11,000	12,190	−2,190
$9,000	274	545	122	11,000	11,941	−2,941
$8,000	116	484	101	11,000	11,701	−3,701
$7,000	0	423	81	11,000	11,504	−4,504
$6,500	0	393	72	11,000	11,465	−4,965
$6,400	0	387	70	11,000	11,457	−5,057
$6,300	0	381	68	11,000	11,449	−5,149
$6,200	0	375	66	11,000	11,441	−5,241
$6,100	0	369	64	11,000	11,433	−5,333

[1] The figures for $50,000 are approximate.

Note—For this chart it is assumed the family has no private insurance. The figure for "Catastrophic" includes the $2,000 medical deductible of allowable expenses and 60 days of hospitalization at the national average per diem of $150.

DATA ON WEST VIRGINIA COUNTIES PERTINENT TO THE VALUE OF "CATASTROPHIC HEALTH INSURANCE TO WEST VIRGINIA RESIDENTS COMPILED FROM ARC STUDY 1

County	Population	Household mean income [1]	Family of 4, net income	A.D.C population	Outpatient visits per 100,000	Inpatient visits per 1,000,000	Percent of population 65 and over
Barbour	13,900	$6,980	$6,363	938	269,813	192,978	14.5
Berkeley	36,300	9,718	8,652	830	41,050	191,325	11.0
Boone	25,100	7,376	6,815	1,584	73,072	103,275	10.0
Braxton	12,700	7,423	6,849	797	23,386	55,457	15.2
Brooke	29,000	10,861	9,433	647	[2]0	[2]0	9.2
Cabell	107,000	10,551	9,206	4,504	130,173	338,058	12.1
Calhoun	7,100	6,182	5,742	666	54,887	117,972	14.1
Clay	9,300	5,266	4,898	1,212	[2]0	[2]0	11.0
Doddridge	6,400	6,390	5,933	182	[2]0	[2]0	15.4
Fayette	49,300	7,440	6,865	3,053	77,069	135,345	12.6
Gilmer	7,700	6,124	5,685	373	[2]0	[2]0	12.8
Grant	8,600	7,249	6,719	263	[2]0	[2]0	12.2
Greenbriar	32,100	7,707	7,065	858	42,907	69,240	12.9
Hampshire	11,700	7,390	6,828	460	29,983	66,786	12.1
Hancock	39,800	11,757	10,081	792	50,327	188,030	8.5
Hardy	8,800	6,944	6,443	329	[2]0	[2]0	12.6
Harrison	73,000	9,391	8,353	1,741	103,140	217,305	13.0
Jackson	20,900	8,476	7,657	615	57,239	86,890	9.2
Jefferson	21,300	9,600	8,500	406	7,455	52,263	8.9
Kanawha	229,400	10,589	9,241	8,278	110,656	190,967	9.4
Lewis	17,800	7,539	6,934	597	67,281	92,517	16.4
Lincoln	18,900	6,377	5,921	2,422	[2]0	[2]0	11.2
Logan	46,000	8,042	7,328	2,997	90,206	140,732	9.1
McDowell	50,600	7,217	6,689	5,643	149,721	138,787	8.9
Marion	61,400	9,108	8,133	1,870	71,691	130,182	13.0
Marshall	37,500	9,683	8,569	1,271	75,960	187,501	11.0
Mason	24,200	7,682	7,051	885	24,384	101,455	10.0
Mercer	63,200	8,868	7,953	3,232	206,329	182,030	11.7
Mineral	23,100	8,520	7,689	730	42,645	112,861	10.0
Mingo	32,800	6,692	6,212	4,199	79,070	64,549	9.8
Monongalia	63,700	10,385	9,092	1,053	320,259	290,501	9.3
Monroe	11,200	6,766	6,280	325	[2]0	[2]0	14.7
Morgan	8,500	7,939	7,249	173	47,682	166,376	11.6
Nicholas	22,500	7,478	6,894	915	17,960	83,200	10.2
Ohio	64,100	11,676	10,036	2,117	154,889	410,480	13.4
Pendleton	7,000	6,926	6,426	262	[2]0	[2]0	14.7
Pleasants	7,300	9,205	8,206	294	[2]0	[2]0	10.0
Pocahontas	8,800	6,612	6,137	364	44,159	118,091	15.1
Preston	25,500	7,224	6,698	1,288	11,925	43,443	12.6
Putnam	27,600	8,730	7,850	846	[2]0	[2]0	8.7
Raleigh	70,100	8,184	7,437	3,239	209,572	234,705	11.5
Randolph	24,600	7,545	6,947	1,035	513,411	352,374	12.4
Ritchie	10,200	6,920	6,420	360	[2]0	[2]0	17.6
Roane	14,100	6,880	6,385	718	21,426	63,220	15.1
Summers	13,200	6,663	6,185	1,267	176,205	205,508	15.6
Taylor	13,900	7,960	7,261	637	75,554	93,856	15.3
Tucker	7,400	6,504	6,038	192	[2]0	[2]0	15.1
Tyler	9,900	8,421	7,614	354	27,061	48,788	13.9
Upshur	19,000	7,896	7,218	561	45,432	119,089	13.2
Wayne	37,600	8,068	7,346	2,786	[2]0	[2]0	9.7
Webster	9,800	5,893	5,476	978	67,490	178,163	12.1
Wetzel	20,300	9,650	8,538	622	43,153	114,089	11.7
Wirt	4,100	7,477	6,893	81	[2]0	[2]0	15.0
Wood	86,700	10,369	9,077	1,676	84,003	195,864	10.0
Wyoming	30,100	7,560	6,954	1,890	141,671	63,173	6.4
State	1,742,900	9,003	8,052	76,407	102,134	164,744	11.1

[1] The average American family.
[2] No hospitals in county.

Statement and Recommendations by L. Napoleon Cooper, Chief Spokesman of A. P. Action and Co., Inc.

Mr. Chairman and distinguished members of the subcommittee, I am chief spokesman for A. P. Action and Co., Inc. (a political action committee representing a membership made up of public charity, non-profit, social welfare and general public service organization chief executives).

We are pleased to contribute to the discussion being conducted throughout the nation on the future of medical assistance in general and catastrophic health care in particular, relative to financing and cost for America. We see coming from these decisions, sooner or later, a categorical reversal in the long-standing trend to place more and more of the responsibility for the provision of these vital services upon private for-profit sector businesses. We expect this change of emphasis to result from quickly spreading citizen realizations that they merely add to labor costs, inflation, taxes, and reduced standards of life throughout the economy—all at the expense of consumers. We see tax incentives playing a much larger role in the future in the financing of these types of programs.

We go as far as to suggest that the health of the overall economy is dependent upon making the provision of health care competitive and drastically reducing abuse potential (for all public medicare, medicaid programs). In that we see tax incentives in the future of medical care, we add that these tax incentives, if implemented as recommended, could significantly reduce abuse potential in the administration and financing of these services.

We recommend a complete restructuring of everything but the intent of medicaid, medicare and all pending catastrophic health care proposals. We recommend combining or developing incentives that encourage those burdened with the financing of medicaid, medicare and catastrophic treatment to also administer the treatment itself. We hold placing the two responsibilities in the same hands could in a proper environment inspire the incentive to heal instead of the treatment of symptoms that in itself mandates further visits, tests, etc., and heal efficiently the hopelessly ill and curable within reach of government programs.

We support the idea that there should be available to citizens private coverage in the catastrophic health care treatment area, but oppose exempting from the Clayton Act private insurers for purposes of further conglomerating and oligopolizing concentrations within this already enormous sector, except in the case of non-profit groups from the third sector.

It is our contention that implementation through a Congressionally controlled tax incentive program available to corporations funding non-profit coverage and treatment could be the most effective hospital cost containment measure to be discussed or implemented within the foreseeable future. It is most likely the only one taxpayers and the federal budget can afford.

As far as the many proposals offered, their intent is honorable and the nation is well served that distinguished members of Congress are willing to raise them to discussion level. However, without amendments, the nation could be ultimately subject, as a result of them, to the ongoing health care rip-off.

In summary, we think that all plans offered thus far, excluding our own (see attached, "The Case for a Revitalized Third Sector") should be sent back to the drawing board. We think that as they now stand, they represent the least effective method of providing services, to be financed in the most expensive way.

We further support the intent of all of the bills offered to encourage the private financing of catastrophic health treatment, but not with incentive from a by-gone period.

On the other hand, through our recommendation, the government could add as much as 100% to the amount of aid reaching the needy in this area, as well as across the general health care spectrum, without increasing its appropriations to do so by one dollar and/or without costing the taxpayers directly or indirectly one additional cent more than under current appropriations.

While the following was not exclusively designed to implement health care benefits in the public interest, the major portion of its purpose in development was to streamline the funding and administration wherever possible of health related social services and to entice the Congress to gradually shift the responsibility in this vital area to a reorganized for this purpose, third, non-profit sector. Please note that a brief discussion of the history and circumstance in which the recommendations were developed precedes the organization's specific recommendations.

Thank you.

PROJECT 76—AN AMERICAN AFFAIR, INC.

AN INTERNAL ANALYSIS OF ITS PHILOSOPHICAL ORIGIN, AND PURPOSE OF LEGISLATIVE PROPOSAL

(The Case for a Revitalized Third Sector, L. Napoleon Cooper, Chief Executive Officer)

Could a third, nonprofit sector, revitalized in accordance with the provisions of the pilot program recommended (implemented on a limited basis over a specific period of time) assume the administrative and funding responsibilities for some of the social welfare and public works programs of the Congress of the United States allowing it to retain oversight capabilities at current or greater levels?

Could such a nonbudgetary approach serve an anti-inflation function in the overall American economy, reduce Federal budget outlays in these areas, eliminate the budget deficit, increase antirecession assistance to State, county, and municipal governments, and subject to balancing the Federal budget, reduce individual income taxes (without increases in business taxation), as well as allow for an increase in the total amount of aid reaching the deserving and needy within American society.

INTRODUCTION

One of the main reasons for the vitality of America is "that we have developed over the two centuries of our existence a remarkable system of three interlocking sectors of activity. As long as each sector is healthy, we will preserve our uniqueness, our diversity, the source of much of our creativity—and our best hope for a promising future.

Two of the sectors are recognizable to everyone: business and government. But the third, the private non-profit sector, is so little understood that I am tempted to call it 'the invisible sector.' It is crucial to our way of life. But it is eroding before our eyes. The third sector is omnipresent throughout our society, yet so taken for granted that it is barely recognized as an important social force. Millions of Americans participate in third sector activities, contributing time or financial support, or both * * *.

If support for the private non-profit sector "continues to lag, we will be well on our way toward a two sector system. Opportunities and incentives for individual initiative will disappear, and the vaunted pluralism of American society will gradually give way to a monolithic one."[1]

Project 76—An American Affair, Inc. is a federally recognized 501(c)(3) public charity. It was organized in pursuit of a revitalized institutionalization (conglomeration) of the third (private non-profit) sector and any future role for this vital sector in the administration and financing of public works and social services in cooperation with the private (business) and public (government) sectors.

The purpose of this report is to demonstrate that through wide-scale and effective utilization of the provisions called for under the legislative proposal (establishing a Congressional Charter with a new, limited life tax status for Project 76—An American Affair, Inc.) conceivably could result in increased per-man-hour productivity, better utilization of our vital business capacity, as well as facilitate the research and development of selective energy sensitive capital improvements, all of which are undeniably necessary to enhance the international competitiveness (export) and growth potential (full employment) of America's economy.

And to show that all of this could be achieved through a voluntary, pragmatic, incentive-based, revitalized, non-governmental institutionalization of the third (private non-profit) sector, it is our intention to emphasize that these are important propositions based on private sector demonstrations that given creative leadership and sound incentive-based management, they would be willing to finance many inventory needs of social welfare, public works, as well as other service programs designed in the public interest, without government appropriations or guarantees.[2]

Further, the intent is to illustrate, through graphs, statistics and logical conclusions, that social, economic and political problems, including plummeting productivity, runaway inflation, illegal immigration, structural unemployment, decreased standards of life and increasing taxation could in many ways be systematically reduced.

Reactions (business and government) to the Congressional application for a charter and the creation of a limited life tax exempt status in that connection have resulted in offers involving large monetary contributions (investment in America's

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[1] John D. Rockefeller, III, "America's Threatened Third Sector," See Appendix.

[2] E. W. Industries, Inc., Letter of September 11, 1978.

future) and descriptions ranging from "innovative"[3] to "far-reaching"[4] and "impressive"[5] to "unique"[6]. An effort is herewith made in describing this phenomenon, to elaborate on the environment in which it was born and to clarify the nature, scope, objectives and the projected consequences of the proposed third sector conglomeration, particularly the role the pilot implementation, Project 76—An American Affair, Inc., was designed to serve.

HISTORY AND BACKGROUND

The 76 Project was incorporated in February 1974. At that time our government was paralyzed by many preoccupations, national as well as international. There were energy and mineral shortages. Inflation, recession, lack of faith in the executive and legislative branches, plus the declared intention of the Common Market countries to subsidize important private production in their respective nations, had combined to confuse and strain ideological ties and economic relations even between Americans.

In other respects, around the world governments were threatening, out of political necessity and economic frustration, the nationalization of the larger energy, transportation and mineral-based corporations. At home, Ralph Nader was preparing a push to mandate a federal chartering system for corporations and to impose it upon America's largest. Inflation had, as it is doing today, begun destroying the wage benefits of the employed, while substandard productivity (reduced international competitiveness) took its toll on the number of those in America lucky enough to be employed. Also, high taxes that were necessary to meet the ongoing expenses of the Great Society "War on Poverty" and "emergency economic programs" had begun to show signs of eroding the long-standing idea that hard work, dedication and *extra* individual effort held out the possiblity of raising one's standard of life—generation after generation.

In our opinion, the most significant observation we were able to make at that time was the wide-spread conclusion among our peers that America's political system, which had encouraged American greatness over the last two centuries, had at that point begun to highlight a void of technological and ideological innovations. During this period, it appeared that America was reduced from a highly competitive nation of producers to an insecure, over-governed, uninspired, and if foreign accounts were even remotely correct, a will-less nation.

It appeared as a direct result that the old answers, at best, were over-used, temporary economic and social stopgaps that had failed. From among the more optimistic of us, came the request to government for a more broad-based economic innovation which would maintain political freedoms while effectively confronting poverty, selective justice, inflation, unemployment, deficit spending. In addition, as a direct by-product, we were requesting some means of overcoming declining growth in productivity, standards of life and international product competitiveness.

The Congress, in trying to meet the nation's problems head on, relied on the familiar but, some had alleged, proven unworkable remedies. Because of the emergency nature of the times, there was very little support in the Congress for a broad-scaled, gradual reconsideration of America's socio-economic systems. Instead, its membership, out of dire frustration, resolved correctly that too many social welfare, charitable, civic and emotional needs of the people had fallen at the feet of government. Many concluded that these misplaced responsibilities were at root, the cause of higher taxes, lost freedoms, deteriorating race relations, and unless soon reversed, potentially catastrophic economic facts of life.

Today, however, it is very doubtful, even within the Department of Treasury, that anyone would seriously argue that the problems have not remained and/or been exacerbated in the years that followed, up to and including the present. Only the naive would wager his livelihood that the nation can expect anything but a round of

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[3] Ibid.

[4] Representative Frank Thompson, Jr.; Letter of July 5, 1978.

Larry Boyd Barrett, Assistant to the President, Potomac Electric Power Company; Letter of June 19, 1978.

Ovid R. Davis, Senior Vice President, The Coca-Cola Company; Letter of July 20, 1978.

Charles A Meyer, Senior Vice President (Public Affairs), Sears, Roebuck and Company; Letter of July 15, 1978.

Stephen A. Stitle, Director, Governmental Relations, Eli Lilly and Company; Letter of September 15, 1978.

Note: All letters in response to Project 76—An American Affair, Inc. letter.

[5] Senator Bob Packwood; Letter of July 12, 1978, in response to Project 76—An American Affair, Inc. letter.

[6] Donald C. Lubick, Assistant Secretary (Tax Policy), Department of Treasury; Report to Senator Russell B. Long, December 7, 1978, in response to Project 76—An American Affair, Inc. letters.

new highs in interest rates (13-15 percent), inflation (leveling off at 9-12 percent), unemployment (settling down at 6.5-7 percent) and high, high taxes over the next three to five years.

It was within this environment, and through a pragmatic reconsideration of major economic and political philosophies that a group of citizens agreed that five corporations should be formed and that every effort should be made to confront the economic inconsistencies, ideological insecurities and philosophical skepticism of young America; and to stress the psychological importance of pursuing the elimination of these pitfalls that many a civilization had yet failed to overcome. A. P. Action and Company, Inc. (APAC), a political action committee, was formed to further these aims through American constitutional precepts.

APAC's membership was composed of non-profit organizations, the leadership of which adhered to and pledged as a condition of membership to support the Constitution of the U.S.A. and the political objectives (as stated above) of A. P. Action and Company. All membership was made aware that this meant voluntarily engaging in activities on a federal, state and local level to ensure America's ideological advantage in the international competition for the hearts and minds of man, and to ensure her economic independence through whatever means compatible with her Constitution. Toward that end, several charitable and other concepts were born.

For the purpose of carrying out the charitable objectives of A. P. Action and Company, Inc., Project 76—An American Affair was incorporated (February 1974). It was meant to be a purely charitable demonstration of the conceptual alternative embodied in APAC's social welfare, public works and service proposed distribution processes. In addition, it was meant to serve as a vehicle to test its recommended balancing of the federal budget and conglomeration and expansion of the third non-profit private sector, in addition to demonstrating its proposed processes for the solicitation, coordination and distribution of labor, inventory and consultant services currently in use by federal, state and local governments in their economic impact, social welfare, public works and service activities.

In order to qualify as a public charity, Project 76—An American Affair, Inc. amended its Charter by mandate of the Department of Treasury to restrict the administration of any and all of its aid, should Congress approve, "to or through state, county and municipal agencies or to or through duly recognized non-government social welfare and/or public works and service agency subdivisions thereof".[7] This it did by amendment to its charter, and as a consequence, was granted a 501(c)(3) status by the Department of Treasury and entered the non-budgeted development stage of its proposed operations on January 26, 1977.

SPECIFIC LEGISLATIVE OBJECTIVES

A. P. Action and Company is submitting to the Congress a legislative proposal in draft form on behalf of Project 76—An American Affair, Inc. The proposed legislation is entitled "The Third Sector Social Service, Public Works, Energy and Productivity Development Reorganization and Private Funding Act of 1979". It calls, as a practical matter, for the establishment of a Congressional Charter and the creation of a new, limited life tax exempt status for The 76 Project. The proposal as submitted is offered and recommended to be implemented exclusively on a pilot program basis.

It takes into consideration that the nation's needs include balancing the budget, but that they also extend at this point to combating concentrations of economic power, to making sure that all economic activity (competition, supply and demand) is determined by a fair and free market and proceeds on to the conclusion that the consuming public deserves an alternative semi-public source of supply for energy and other vital products, on a competitive basis and on reasonably short notice. And that while the nation's supply circumstance is overheated within the American economy, this is so primarily because of low levels of productivity (which is part labor's and part business' fault).

It was further taken into consideration during the development of this Act that abuse of the taxpayer through waste and theft of government property is inherently built into the current system of procurement and that this abuse and many of the demands made upon political leaders in and out of government at the federal level could be significantly reduced through a more active citizen participation directly in the administration and funding of non-military and non-intelligence priorities set by the Congress of the U.S.A.

Note that in reading the following, one should keep in mind that any reduction in the deficit or in taxation of individuals at the federal level intended by the Act could be realized only where the private non-profit sector has assumed a larger

[7] Certificate of Amendment; October 22, 1976.

portion of the funding and administrative cost of social welfare, public works and non-military, non-intelligence foreign assistance programs of the federal government.

Further, one should bear in mind that the impact on the overall economy proposed by the third sector conglomeration is calculated to withdraw indirectly from the money supply, significant amounts of excess cash and/or to add necessary per-man-hour increases in productivity levels without causing the traditional stress and strain of recessions and/or inflation, caused by direct money supply manipulations by the Federal Reserve system.

PILOT PROGRAM SUMMARY

The primary feature of the legislative proposal is that it institutes (during its experimental life and Congressional oversight period) tax credits for 50–52 percent of the fair market value of any contributed (bargain sale) inventory or service, excluding cost, made to The 76 Project, and permits, during the pilot program, The 76 Project to pay to said contributing taxpayer its cost. The 76 Project (also under the Congressional Charter created temporarily by the proposed legislation) would be required to forfeit its current status under which contributions to it are charitable deductions, and it would eventually be obliged to pay local property taxes in all locations of its operations if the Congress (subject to post-pilot review) extended its life and makes the charter available across the board to any charitable organization voluntarily accepting its requirements.

The legislation also provides that per one dollar tax credit diverted from the Treasury as a result of a bargain sale or cash contribution to The 76 Project under the pilot program, two dollars (matching fund) must be raised in the private sector and spent by the charity financing congressionally targeted social welfare or other public services having a value of two dollars.

Also embodied within the provisions of the legislative proposal is significant incentive and opportunity for entrepreneurial, energy-sensitive, capital investment, economic growth, and non-deficit financing of basic social welfare and other public services.

WHY A LIMITED BEGINNING?

Some concern has been voiced that the legislation applies solely to The 76 Project.[a] The proposed legislation implements a new concept which calls for a review period and consequently should constitute only a pilot project of limited life (to be determined by the Congress) after which, subject to Congressional approval, the Congressional Charter and new, tax exempt status created thereby could, and as recommended by the developers, should be made available to any other qualified, non-profit, publicly charitable organization willing to accept Congressional oversight and other Charter mandates.

Congress, in the normal course of its legislative process, authorizes social welfare (housing, education, medicaid, social security, nationwide health care system, etc.) and public (mass transportation, civil defense, highway, bridge, airport and water project construction, etc.) services and makes appropriations for them. The 76 Project would, under the legislative proposal, have only the option of choosing from among these authorizations, which to finance and administer. In this way, private non-profit sector resources are directed toward the services which Congress has deemed necessary and valuable without undertaking a wide-scale restructuring of Congressional oversight and Department of Treasury functions before the nation is well familiar with the potential consequences of its action in this area.

In order to enhance oversight possibilities, the burden of proof lies with The 76 Project to demonstrate to the Internal Revenue Service, before any tax credit is recognized, that the matching fund requirements have been met. And, in addition to ongoing Committee oversight, in its annual accounting to the Department of Treasury, The 76 Project would have to demonstrate that its expenditures are being made in accordance with the pilot legislation's mandates.

While we recognize that all things are possible, we do not, however, expect to revitalize the entire third sector through Project 76—An American Affair, Inc. Our objective is merely and clearly to demonstrate that with combined cooperation, entrepreneurial ability and reasonably exercised civic duty at the federal level, and that after the demonstration, if the charter is made available by Congress to other qualified charitable organizations, that through the revitalization a potentially beneficial impact on the public interest by the third sector could be realized.

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[a] Donald C. Lubick, Assistant Secretary (Tax Policy), Department of Treasury; Report to Senator Russell B. Long, December 7, 1978.
Office of Senator J. Bennett Johnston; Letter of July 6, 1978.

DETAILED ANALYSIS OF SPECIFIC ACTIVITIES AND CONSEQUENCES OF THE LEGISLATIVE PILOT PROGRAM

The following is a discussion (in question and answer form) of the pilot program in combination with a description of planned facilities and observations made by the Department of Treasury's review (See Appendix, Page 25) of The 76 Project's proposed legislation.

Question: The Department of Treasury, in its official analysis of the legislative proposal (dated December 7, 1978), questioned why "50–52 percent would be an appropriate tax credit rate" for manufacturing taxpayers rather than some other.

Answer: It is the stated intention of The 76 Project (as a test of viability) to fund Congressional programs and to construct, over the life of the pilot, an American Educational, Agricultural, Scientific Research, Small Business and Industry Development, Public Works, Service and Inventory Distribution Complex. But, notwithstanding the $4.5 billion value of the finished complex, having raised the necessary money utilizing the tax credit provisions of the legislation, i.e. $1.5 billion in tax credits; the facility, in itself, would not fulfill the matching fund requirement imposed by the legislation that The 76 Project finance and administer in coordination with the Congressional Committees, $3 billion worth of Congressionally targeted by statute, social welfare or other public works activites. Thus, the purpose of this particular construction is twofold:

(1) To demonstrate that private financing for worthwhile ventures could be obtained at no cost to taxpayers; and

(2) If this is demonstrated, and the Congress all along the way approved of the procedure, the pilot facility could at that point serve as a center to begin the immediate coordination and distribution of inventory and other services (to and/or through state, county and municipal agencies).

The statement above is made at this point in the analysis to emphasize that the actual construction of the complex, for example, and the third sector financing of Congressionally targeted efforts, is very much dependent upon the voluntary cooperation of the private sector. With a 52 percent tax credit provision, while the level of return to the taxpayer (manufacturer) is not the maximum return on investment as would sale on the open market, it would be an assured sale and does result in an increased sales volume for the manufacturer. Otherwise, it would not be reasonable to expect business to participate.

Further, in a circumstance of economic depression, a 76 Project bargain purchase of inventory constitutes a logical method of avoiding unemployment (layoffs) within a depressed economy. Otherwise, in such a circumstance, lost demand and layoffs could require concommitant unemployment payments by local governments. The requested level of tax credits would, in fact, encourage business to stay in production avoiding layoffs, without making bargain sales more attractive than a sale by the manufacturer on the open market.

Question: The Department of Treasury raised some objection to the use of tax credits on the premise that previous statutes, up to 1969, allowed "bargain sale of inventory where the contributing taxpayer (the manufacturer) realized the pure tax benefit, through deduction, of transferring unrealized income" to a charity; and that these statutes were "subject to abuse" and thus were prohibited. The Department of Treasury on this basis stated it would be opposed to the Congress counteracting this provision.

It was also shown that under the legislation prior to 1969, such donations, where a deduction was allowed to the taxpayer for 100% of the fair market value of contributed inventory, while unlike what is proposed by the pilot legislation, "proved more profitable than sale on the open market" to manufacturers. The Congress, in the Tax Reform Act of 1969, as a result, disallowed any deduction for unrealized income above cost in contributions of inventory.

Answer: The Congress itself, in the Tax Reform Act of 1976 (see Appendix, Pages 29-32), recognized that it had gone much too far in disallowing deductions for any part of unrealized income and, through the 1976 Act, re-established deductions for up to one-half of the unrealized appreciated fair market value, plus cost, of any contributed inventory. Consequently, the pilot project's tax credits, as proposed, do not violate the present spirit or intent of the law nor that of the 1969 revisions (coincidentally, the last year of the balanced federal budget).

Further, to address the issue of abuse, under the proposed legislation, the Department of Treasury would by legislative mandate of the pilot program, perform a vital but specific oversight role. In order for a taxpayer to be eligible for a tax credit for a contribution of inventory or cash to the charity, the charity must first show to the Treasury that it has met the matching fund requirements called for under the legislation. In order to make such a demonstration, the Department of Treasury

would have to be brought into the procedure well in advance of any eligibility acknowledgement, thus providing it an effective opportunity to monitor all such transactions on an ongoing basis and in so doing deny the opportunity for abuse.

Statement: The Department of Treasury stated "an evaluation of the purposes of The 76 Project may be beyond the purview of our area of expertise".

Rebuttal: In my opinion, it is clear that the purpose of The 76 Project's legislative proposal is to demonstrate that an alternative program for financing most social welfare and some public works projects, by means other than the individual income tax collected at the federal level, is available.

Statement: The Department of Treasury says further that "to the extent The 76 Project objectives are understandable, we find it difficult to believe that they could be realized."

Rebuttal: It was not easy for man to fly, much less land on the moon; to invent the light bulb, much less distribute electricity; to overcome polio, etc. It may be difficult for some to understand and remember many of our great advances as a nation for mankind took place when we had no individual income taxes. The U.S.A. then managed to meet its needs and it could conceivably in a totally cooperative environment, do so again.

Question: The Department of Treasury stated "we question the propriety of exempting any organization * * * from tax on a basis more generous than is accorded under Section 501(c)(3) of the Code * * * We also question whether Congress has the power to exempt any entity other than" itself from "state or local tax * * * so the proposed legislation may not be constitutional."

Answer: As I have stated earlier, the benefits in the public interest are greater under The 76 Project (matching fund requirements) than they are under current, less scrutinized public charities receiving deductible contributions and/or those provided for profit businesses utilizing investment or other tax credits. Under the requirements, even during the pilot program, benefits in the public interest far exceed any possible benefit to the manufacturer (see chart, next page). Further, we do not advocate a headlong surge in this direction by all 501(c)(3) public charities and doubt seriously if most other public charities would be willing to forfeit their current 501(c)(3) status under which contributions to them are tax deductible. The intent of the legislation (as is the case under current law) is to allow the exemption (where specifically recognized and authorized to operate within the jurisdiction of any state) of The 76 Project from state and local taxation. Except, unlike current laws, it may allow states, where The 76 Project is authorized to operate, to tax its real properties as do they those of other businesses. The results are that states may recapture significant amounts of land-based tax revenue currently uncollectable once the charitable status of an organization is voluntarily recognized. Thus, there is clearly no constitutional issue raised by the above procedure.

Statement: "Finally, there may be considerations that suggest the desirability of allowing a tax credit for * * * charitable contributions rather than the current deduction * * * but we oppose credits made available for * * * The 76 Project * * * while for others they remain a deduction."

Rebuttal: While even the Department of Treasury cannot avoid acknowledging the obvious advantages to tax credits in general over deductions, they refuse to recognize that tax credits under The 76 Project's proposed legislation, following a successfully implemented pilot period, would be made available across the board to all qualifying public charities. During its pilot life, however, the benefits in the public interest realized through tax credits for The 76 Project would far exceed those deductions made, dollar for dollar, through other public charities.

SUMMARY

The actual physical structure to be financed through the pilot program, as a demonstration of capability, would (subject to Congressional approval) serve as a physical base for the undertaking, coordination, financing and broad-based administration of social welfare and other public services.

Economic growth could be triggered by the (energy, automobile development, etc.) capital and research activities of an expanded third sector. Further, under the program, one of the two dollars of Congressionally targeted social or public services financed could account for services at current levels and the second dollar could raise that level or add new ones. In effect, the impact of the legislation and third sector activity, combined, if implemented successfully over a period of years could lower individual income taxes and at the same time raise or expand levels of spending in the public interest.

Otherwise, there are many programs in the public interest that are deserving of financing but the cost to the taxpayers has been unbearably excessive. Either we

must abandon these programs, fall short of research-related national security and energy needs, or find a new way of financing them.

Until the United States once again demonstrates the spark, drive, productivity and creativity which made us great, we will continue to see the erosion of our dollar, the competitiveness of our industrial products and the standing of our superior ideology in the world decline. We could put to death the curse of inflation without further expanding government or adding deficits to its budget.

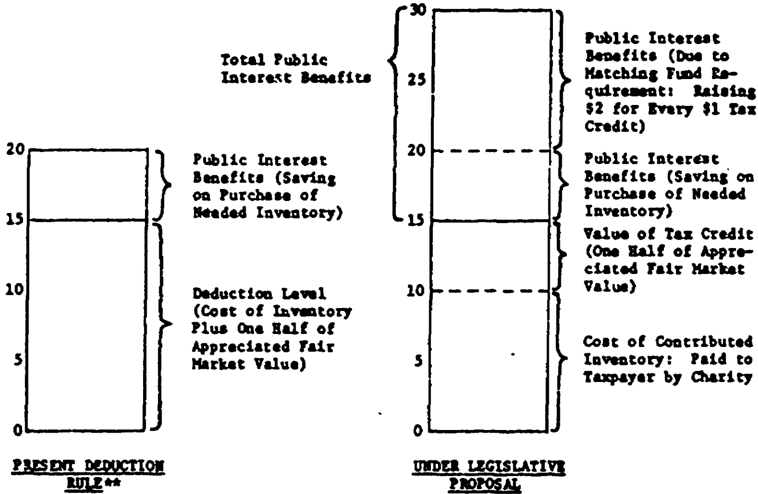
"With such a change in attitudes * * * we could surprise ourselves and the world, because American democracy, which all too many observers believe is on a downward slide would come alive with unimagined creativity and energy. Nothing less than this is at stake".[9]

[9] John D. Rockefeller, III, "America's Threatened Third Sector."

PUBLIC INTEREST BENEFITS COMPARISON:

PRESENT LAW AND LEGISLATIVE PROPOSAL*

(CONTRIBUTIONS OF INVENTORY)

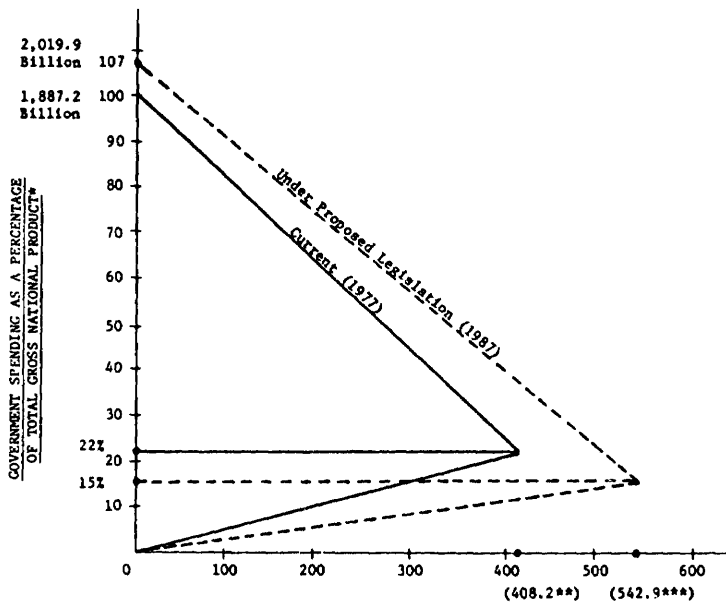


* In Both Cases: (1) Total Fair Market Value Equals $20
(2) Cost to Produce Inventory Equals $10
(3) Fair Market Value of Appreciation Equals $10

** Tax Reform Act of 1976. Sec. 2604. (a) In General, Sec. 170(e). Special Rule For Certain Charitable Contributions of Inventory and Other Property.

LEVEL OF BENEFITS IN THE PUBLIC INTEREST

(The Proposed Legislation Graph Takes Into Account Only Third Sector Effects on the Variables)



TOTAL SPENDING IN BILLIONS OF DOLLARS

** Federal Budget
*** Federal Budget (1/2 the Total) and Third Sector Spending (1/2 the Total)

* Includes tax rate (individual and business) and deficit spending.

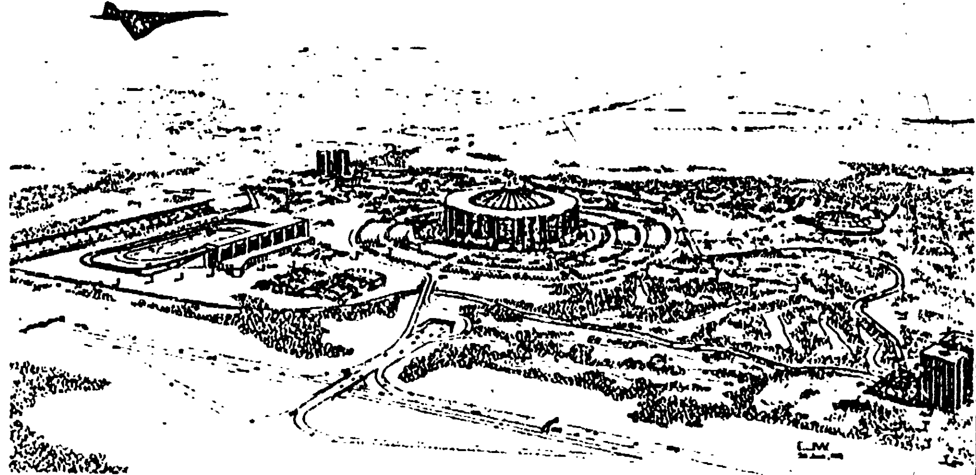
[1] Figures from OMB and Treasury Department Statistics for 1977.

A. P. Action and Company, Inc.

A PROPOSED THIRD (NON-PROFIT) SECTOR PRIVATELY FINANCED DEMONSTRATION PROJECT

AN AMERICAN EDUCATIONAL, AGRICULTURAL, SCIENTIFIC RESEARCH,

SMALL BUSINESS AND INDUSTRY DEVELOPMENT, PUBLIC WORKS, SERVICE AND INVENTORY DISTRIBUTION COMPLEX



PROJECT 76 - AN AMERICAN AFFAIR, INC.

4 JULY 1976

STATEMENT OF EDMUND S. MCLAUGHLIN ON BEHALF OF THE ASSOCIATION OF REHABILITATION FACILITIES

Mr. Chairman, my name is Edmund S. McLaughlin, Executive Director of the Easter Seal Rehabilitation Center of Eastern Fairfield County in Bridgeport, Connecticut. I am appearing on behalf of the Association of Rehabilitation Facilities (ARF).

ARF is the principal national organization of institutions providing rehabilitative services. Among our members are rehabilitation units of acute care hospitals, free-standing rehabilitation hospitals and outpatient rehabilitation centers. The rehabilitation process employs a variety of professional services applied in a coordinated manner to restore to the disabled individual a higher level of functional capacity or to maintain a level of function that results in greater independence for the handicapped disabled individual. At the heart of the rehabilitation process is the team approach to the provision of services in an integrated, coordinated fashion. The whole is greater than the sum of the parts.

I appreciate having an opportunity to testify on S. 350 and S. 351. My comments will be directed to S. 350, which is inclusive of all provisions contained in both bills.

Mr. Chairman, I will be brief. This legislation which would provide a comprehensive program of catastrophic illness insurance does not however, cover certain types of rehabilitation services when provided on an outpatient basis. This deficiency should be corrected in the final version of any such legislation reported by this Committee. Rehabilitative services are particularly relevant to the needs of persons suffering catastrophic illnesses such as stroke, spinal cord lesions, and severe traumatic injuries. Out patient rehabilitation services are often, in the case of catastrophic illness or accident, the link between acute care hospitalization and a discharge to home and a productive independent life. The elimination of this link may result in continued institutionalization, a life of greater dependence, reduced earnings and excessive costs in the delivery of services. It is precisely these types of severe debilitating conditions to which this legislation is addressed and yet some of the rehabilitative services essential to provide full or partial restoration of the people affected are excluded from the scope of benefits prescribed in the three programs which would be established by this bill. This anomoly arises because the bill adopts the definition of coverage and benefits currently contained in Title XVIII of the Social Security Act, the Medicare Program. Medicare does not currently cover comprehensive rehabilitation services when provided by outpatient rehabilitation centers even though the identical services are covered when rendered by hospitals to outpatients.

This situation discriminates among beneficiaries as to availability of services and among facilities which are equally qualified to render care. Different committees of the Congress including this one, have taken cognizance of this problem in the past. In 1972 this Committee reported legislation (H.R. 1) which would have added comprehensive outpatient services to the Medicare Act. The pertinent provision was dropped in Conference. In the last session of the Congress the House Ways and Means Committee reported and the House of Representatives passed legislation to add comprehensive rehabilitation services to the scope of benefits under Title XVIII and to make comprehensive outpatient rehabilitation facilities providers under Medicare. The pertinent provision was Section VIII of H.R. 13097. The bill was not acted upon in the Senate. We support and commend to you as a model, the language to which I have referred in H.R. 13097.

With respect to S.350, we wish to call to the Committee's attention the following points:

(1) The scope of benefits established by Section 2103(c)(1) does not include comprehensive outpatient rehabilitation services because of the inadequate coverage under Title XVIII and the interplay of the definition with the Medicare Act.

(2) Out-of-pocket expenditures by beneficiaries for such services would not be recognized toward meeting the deductibles under Section 2104(b).

(3) The scope of benefits mandated in employment plans and self-employed plans in Part B of the bill ties back to the benefits under the Federal Catastrophic Health Insurance plan. This provision appears in Section 2122(a)(1)(B).

(4) The amendments to Title XIX which would establish a medical assistance plan for low income people (Title II of S.350) reflects the same problem with respect to rehabilitation services provided by outpatient facilities with a slight twist. Such services are excluded from the scope of benefits provided in Section 1912 but are included in the spenddown requirements set forth in Section 1932 in which the phrase "other rehabilitation services" appears.

The basic solution to this problem is inclusion in the Medicare program of comprehensive outpatient rehabilitation services. Senator Ribicoff sponsored legisla-

tion to this end in the last Congress and will, I believe, be introducing another bill shortly.

In the context of a catastrophic illness insurance program, it makes no sense to exclude a major category of service which has particular relevance to the needs of people experiencing major problems from stroke, spinal cord injuries, traumatic injuries and the like. Mr. Chairman, we urge the Committee to deal with this issue in its consideration of a catastrophic illness bill.

We also wish to provide for the record a memorandum on rehabilitation coverage under Title XVIII which may be helpful as the Committee and its staff address this issue.

Statement of Tony T. Dechant, President, National Farmers Union

National Farmers Union opposes the passage of catastrophic health insurance measures because we feel a federal policy that provides reimbursement only for the costs of catastrophic illness will be the cause of further deterioration of health services in rural areas.

Health care in this country has been moving toward concentration in major cities and away from rural areas for several decades. It has been moved in that direction by the increasing emphasis on specialization and the development and use of sophisticated equipment. This change has, of course, been of immense benefit to all Americans.

The modernization of medicine might have developed as it did in any case, but it has been hastened by the growth of the health insurance industry and the development of federal health care financing programs. The fact that a high proportion of consumers could afford to pay whatever it cost to secure this specialized, sophisticated care has fueled the modernization and urbanization of medicine.

The natural consequence of this major change has been the depletion of health care services in rural areas and has left much of rural America without even primary care. The general practitioner, as we all know, became an endangered species, but is nowhere as scarce as in the rural small towns of this country. Doctors could practice modern medicine in only the best equipped facilities and the small rural hospitals, although they still exist, could not offer the marvels of medicine available in the cities.

It has been repeated so often that it has almost lost its ability to stir a response. Rural people today do not have services available to them except at great distance. No other health care provider has replaced the vanished general practitioner in rural small towns.

There is another consequence of the way in which we have financed health care for the last few decades and that is an excess of facilities and services in the urban and suburban centers. Where health care providers have settled, there has developed a great oversupply of these expensive, modern facilities and services in marked contrast to the small towns and inner cities. The U.S. Congress was finally forced to intervene by establishing a health planning system to reduce haphazard duplication and control escalating costs.

If there were any way to control the health delivery system's predilection to move toward the kinds of care that offer the most and easiest compensation, it might be possible and logical to cover catastrophic illness as a next step. Experience has proved otherwise and we know that if there is an incentive to give more and more specialized care the total resources that goes into that kind of care will become greater and greater.

Medical professionals go where there is opportunity, and service in the already underserved areas of the country will become even more unattractive. Young mothers and fathers in rural areas will have to go even farther to find the health care professionals who can advise them when their children become sick. Instead of providing incentives to medical people to go to the rural small towns or the inner cities, catastrophic insurance will continue the present imbalance or make it worse.

National Farmers Union firmly supports the Administration's efforts to secure mandatory controls on rising health care costs and it has supported health planning legislation. Our members have become involved in the health planning system. But neither cost controls nor better planning can improve services in rural areas as long as we create disincentives for the health care industry to develop those services.

National Farmers Union has supported a national health insurance system for many years and its members have expressed their support at their state and national conventions over and over again. They have supported national health insurance because they believe health care ought to be the right of every American—that no one should be sick and not be able to afford care.

Accessibility of medical care both in an economic and a physical sense will not be achieved by a piecemeal approach that promotes further specialization at the expense of primary care.

We believe that families should be protected against the destructive weight of catastrophic illness, but we do not want to see our health care system further distorted by a well-meaning but half-hearted effort that is no real solution to a very major problem.

We urge this committee and the Congress to give the American people a program that will guarantee health care as a right, that will encourage the development of services in the areas which are presently underserved and that will emphasize preventive care and early diagnosis. It is within our power to create such a program and we must do so if we are going to further intervene in the health delivery system.

The American people need to be protected against catastrophic illness but that protection must be part of a comprehensive plan.

Statement of Dr. Seymour Z. Mann, Chairman and Dr. Martin Hochbaum, Director of the American Jewish Congress

INTRODUCTION

The American Jewish Congress, a national organization of American Jews, welcomes this opportunity to testify on a bill to provide catastrophic health insurance. The question of providing health care to all Americans has for the last few years been one of our priority concerns. This stems from our long tradition of concern for the health and welfare of all people.

Title I of the proposed legislation, S. 351, would establish a catastrophic health insurance program "to provide protection to all individuals who are citizens or permanent residents of the United States against the costs of . . . catastrophic illness." Payments for hospital and related services would be made from a Federal Catastrophic Health Insurance Trust Fund. In order to be eligible for such payments, the individual must have spent 60 days in a hospital or incurred medical expenses of over $2,000 (the Congressional Record of February 6, 1979, p. S1130, contains a statement by Senator Long to the effect that it is possible, depending upon additional information, "that the threshhold for coverage should be increased to $3,000").

Title II would encourage and facilitate the availability to the public of private health insurance coverage at reasonable rates. It would do so by establishing a procedure to certify health policies offered by private carriers as meeting minimum standards in such areas as adequacy of coverage and reasonableness of charges and encouraging states to facilitate the offering of basic health insurance coverage by private carriers. The proposed legislation would also standardize Medicaid benefits.

NATIONAL HEALTH INSURANCE

Interest in national health insurance has developed during a period of widespread public discontent with the nation's health care system. Major sources of this dissatisfaction are:

(1) Costs which are escalating far above the inflation rate;

(2) The lack of major incentives to improve the efficiency and effectiveness of health delivery systems;

(3) Gaps in protection for those covered by private health insurance;

(4) The uneven distribution of health services;

(5) Poor protection against the cost of catastrophic illness or disease.

1. Escalating costs

In fiscal year 1978, annual expenditures for health in the United States totaled $163 billion (8.8 percent of the Gross National Product), a per capita expenditure of $737. It is likely that these costs will continue to rise. Indeed, the primary force behind the more than doubling of health expenditures since 1971 has been the increased cost of services.

Hospital care, totaling over 40 percent of all health care costs, was the largest of these expenditures (the outlook for the adoption of the President's cost containment bill is uncertain). These were followed by the 20 percent devoted to physicians' services and 8 percent each to nursing homes and drugs.

2. Lack of major incentives to improve efficiency

The health care industry is increasingly criticized as being inefficient. Among the major reasons for this view is the contribution of excess beds towards unnecessary

hospitalizations, the maldistribution of physicians and unnecessary surgery. There has also been criticism that third party payments contain little incentive to use less expensive modalities of treatment. For example, it may be less costly to an individual with hospitalization coverage to be cared for an an in-patient than in an ambulatory care program.

3. Gaps in protection

In spite of the growth of private and public programs in the last few decades, many Americans have minimal coverage or none at all. Approximately one out of four lacks coverage against the costs of hospital care and a higher percentage is not insured for physician's services delivered in the home or office.

4. Uneven distribution of services

Nearly five million people work in the health care field. The largest category of personnel involved in the delivery of service are the 1,000,000 aides and orderlies. These are followed by registered nurses (857,000) and physicians (363,000). Since 1950 the number of the latter has increased by approximately 75 percent.

In spite of the size of our nation's medical manpower, approximately 1000 areas of the nation, with around 13 million people, are officially designated Critical Medical Manpower Shortage Areas. Furthermore, the Northeast has fifty percent more physicians per 10,000 population than does the South, and metropolitan areas have more than twice as many physicians per 10,000 population than do non-metropolitan areas.

5. Poor protection against catastrophic Costs

Although more than half the population under 65 has private health insurance to protect them against the high costs of illness, disease or injury, many of these plans provide limited benefits per episode or per lifetime. Long term illness, institutionalization, or the need for home care or highly specialized medical treatment are frequently not covered by such plans. The result is that the expenses attendant to these illnesses may lead to financial ruin for those with coverage. For those without, the process works much quicker. Families which have little trouble paying normal medical bills live in fear that a lingering sickness will force them to mortgage their homes or limit their children's education.

National health insurance offers an opportunity to resolve these problems. It is our position that the United States Congress should adopt a bill which is based on the following principles:

1. Who should be covered?

We believe that access to health care is a necessity, not a luxury, and that any national health insurance plan must include universal coverage. Society in general will benefit by this as healthier Americans will have improved productivity, and a reduction in mortality and the need for disability and other types of social welfare assistance. Beyond this, a healthier population is a goal in and of itself.

Moreover, under less than universal coverage, those who are poor insurance risks could not afford coverage. Where plans are covered by employers, they would be reluctant to hire older or handicapped workers whose insurance costs would be more expensive. The needs of the marginally employed, under-employed or unemployed can only be met by universal coverage.

Coverage should not be limited by a means test which would be expensive to administer, socially divisive and lead to the perpetuation of a "two-tier" health care system. Similarly, age or physical conditions should not be used to determine eligibility.

2. What services should be covered?

The World Health Organization (WHO has defined health as "* * * a state of complete physical, mental and social well-being and not merely absence of disease or infirmity * * *" We believe that part of the reason America's health system falls short of this goal is that our health insurance programs provide coverage which vary significantly from medical service to medical service. While hospital and physician in-patient services are relatively heavily reimbursed by third parties, dental services, prescription drugs and physicians' out-patient services have low rates of reimbursement. Additionally, there is a strong contrast between those who have relatively comprehensive public and/or private benefit packages and others who are personally responsible for nearly all their medical expenses.

Our position is that comprehensive health benefits are a basic right of all Americans and the only effective means of reaching the goal enunciated by WHO. Such benefits must involve a reorientation of the health delivery system towards preventing illness rather than treating it.

It is further recommended that such a program rely on screening and early detection systems. It must, however, be understood that this can only be successful where appropriate and accessible means of treatment are provided. An important component must include a health education program.

3. Out-of-pocket charges?

We oppose out-of-pocket expenditures since these would deter people from seeking the medical treatment they require. Moreover, in the health care arena, it is the physician and not the patient who determines what services are needed. The consumer usually acquiesces to the physician's advice. It is the poor and near poor, not the well-to-do, who will go without health care because of the costs required by out-of-pocket charges. This will increase the inequities already in the system and aggravate the problems of the needy.

4. How should national health insurance be financed?

For several reasons, we recommend that national health insurance be financed out of general revenues. This financing mechanism would have the advantage of raising money through a progressive rate structure, which is based on the ability to pay and taxes unearned income and the earnings of the self-employed. The medical expense deduction already represents a limited indirect subsidization of health care costs (such deductions are worth more to those with higher incomes who are more likely to file itemized income tax returns). Obviously, if financing out of general revenues were adopted, it would have to be accompanied by the elimination of the personal income tax deduction for medical expenses because it would be redundant.

Some would argue that the cost for this program would be high. However, it would have the advantage of offering benefits to the entire population including sectors now excluded from adequate health care because they cannot afford to purchase it. It could also be successful in decreasing the need for costly hospitalization and surgical intervention, both of which are accompanied by the loss of worker productivity, family income and taxes.

We are not unconcerned with the elimination of unnecessary and frivolous expenditures. These must be controlled by education programs and the establishment of medical review boards to eliminate unnecessary operations, overprescription of drugs and other financial abuses. These boards should also be empowered to monitor the licensing of medical progessionals.

5. How should a national health insurance program be administered?

National health insurance will require an administrative structure to handle such functions as the collection of payments, rate setting, cost and quality control, dispersement of funds, standard setting, long range planning and program modifications. A variety of mechanisms, including private insurers, government agencies, or some combination of the two, have been proposed to handle these responsibilities.

The basic question that must be resolved is whether or not the federal government should play a more comprehensive role in processing and auditing claims, possibly by taking over the functions of the fiscal intermediaries (which now perform these many financial responsibilities under Medicare). However, the evidence on the advantages of government versus private administration of national health insurance is inconclusive.

We recommend that whatever administrative mechanism is developed include provisions for appropriate consumer participation at all levels. This would help insure that services meet the needs of those for whom they are intended and that they are provided with dignity and respect.

CONCLUSION

Deeply embedded in the Jewish tradition is the belief in communal and individual responsibility for the neediest of society's members, especially the ill and the poor. We urge this Committee to back a national health insurance proposal which incorporates the following principles: (1) Coverage for all Americans; (2) comprehensive benefits; (3) no out-of-pocket expenditures; (4) financing out of general revenues; and (5) an administrative mechanism which includes effective consumer participation.

The failure to include these principles in any proposal that comes out of the United States Congress will only perpetuate those inequities found in our health care programs.

Statement of the American Association of Oral and Maxillofacial Surgeons

REGARDING CATASTROPHIC HEALTH INSURANCE

As we have previously advised the Subcommittee, in our statement regarding S. 505, any services performed by an oral surgeon or other dentist which he is trained and licensed to perform should be covered services where the same services are covered if performed by a physician. A copy of relevant excerpts from our statement on S. 505 is attached and sets forth the justifications for this equitable principle.

The catastrophic health insurance coverage under certain of the pending bills utilizes provisions of existing Title XVIII, including coverage for physicians' services and the definition of physician. As we have urged in connection with S. 505, the definition of physician (and thus physicians' services) under existing law should be corrected in the pending bills to provide equitable treatment for oral surgeons and medical doctors, and their respective patients, in the case of services which both perform.

In some states the same discrimination in these areas of overlapping practice exists under present Medicaid and the discrimination could arise in all states if any dental coverage does not include oral surgeons' services. The medical assistance portion of the pending bills would continue this discrimination by including for certain purposes the definition of physician in section 1861(r)(1). The definition of physician for these purposes in the pending bills should also be corrected to provide equitable treatment in the case of services performed by both oral surgeons and medical doctors. This should not be viewed as mandating or extending dental coverage but as assuring that a patient will not be denied coverage for services provided by an oral surgeon if the same services would be covered if the patient went to a medical doctor.

Statement of the American Association of Oral and Maxillofacial Surgeons

REGARDING S. 505

The American Association of Oral and Maxillofacial Surgeons ("AAOMS") is the official organization for the dental specialty of oral and maxillofacial surgery. AAOMS represents approximately 3,700 oral surgeons from all fifty states, the District of Columbia and Puerto Rico. Today all members must complete three or more years in an accredited surgical residency in a hospital following completion of four years of dental school. Members practice oral surgery in offices and in hospitals as medical staff members.

There are two important inequities affecting the patients of oral surgeons in the reimbursement provisions under present Medicare laws. Section 35 of S. 505 addresses and would correct one of these inequities.

Section 35 of the bill would cover under Medicare any services performed by an oral surgeon or other dentist which he is trained and licensed to perform where the same services are covered under existing law if performed by a physician. Under existing law, if an oral surgeon is the provider, only surgical services are covered. However, the professional practice of oral surgeons overlaps with that of physicians to a significant extent in nonsurgical matters including, for examples, diagnostic care and treatment of oral infections. Nonsurgical procedures such as these would be covered under the bill where they are performed by an oral surgeon. The bill would not add coverage for any services not presently covered in the case of physicians.

The existing discrimination is based solely upon the academic degree of the provider and has serious consequences for the patient, and is important to the professional life of the oral surgeon. If the patient is aware of the discrimination, his freedom of choice of provider between a physician and an oral surgeon will be prejudiced. If he is not aware of this legal pitfall when he is treated by an oral surgeon, he will be deprived of reimbursement for what surely must appear to him a completely arbitrary distinction.

Section 35 is noncontroversial. The same provision was included in H.R. 5285 in the 95th Congress as reported by the Finance Committee and as passed by the Senate. A similar provision was passed by the House in H.R. 13097 during the 95th Congress. It is also included in S. 507. AAOMS respectfully urges favorable consideration of this provision at the earliest possible time.

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STATEMENT OF THE COUNCIL FOR HOMEMAKER-HOME HEALTH AIDE SERVICES, INC.

This statement is presented by the National Council for Homemaker-Home Health Aide Services, Inc., a national, non-profit 501(c)(3) membership organization, with offices at 67 Irving Place, New York, New York 10003. The National Council's goal is availability of quality homemaker-home health aide services in all sections of the nation to help individuals and families in all economic brackets when there are disruptions due to illness, disability, social and other problems, or where there is need to help enhance the quality of daily life.

MEMBERSHIP

The National Council is comprised of 597 dues-paying members, of which 260 are agencies providing homemaker-home health aide services in 45 states and in several Canadian provinces; 46 are organizations, and 291 are individuals. (1978 year-end figures.) Programs from all auspices—voluntary non-profit, public, and proprietary—are included in the Council's membership. Written and visual materials, conference and other services are available to and used by many organizations, including nonmember agencies providing homemaker-home health aide services in the United States and Canada.

Reference to earlier testimony

The National Council for Homemaker-Home Health Aide Services, Inc., appreciates this opportunity to present material on the recent catastropic health insurance bills, S.350 and S.351. The Council has presented extensive testimony on national health insurance to the House Ways and Means Committee over the past nine years, as well as a statement to D/HEW Secretary Joseph Califano in October 1977.

Throughout the years, the National Council's overriding concern for a national health insurance plan has remained constant: that the federal government provide incentives for development of a continuum of health care nationwide, with home care services an integral part of that continuum. It is interesting to note that—although national support for increased home and community-based health care options to balance institutional resources has risen dramatically over the past decade—federal policy and funding incentives for such services have not kept pace with the demand.

The need for increased home care services

Although home care services are growing rapidly nationwide, statistical projections indicate that the need, both potential and actual, far outstrips the current, available supply. The potential population of service recipients is progressively increasing as more persons live longer with more instances of chronic and/or disabling conditions. It has been estimated that 18 million persons between the ages of 18 and 64, plus 15 million elderly individuals—a total of 33 million persons—have some chronic physical conditions which limit their freedom of movement or make them functionally dependent. Of the 19 million non-institutionalized elderly in this country, 219 million, or 16 percent, are totally unable to carry out their daily activities because of chronic disease or disability.*(1)*

It is highly probable that the incidence of chronic disabling conditions will continue well into the twenty-first century as our aging population continues to grow in both relative and absolute terms. Indeed, the ranks of the elderly can be expected to swell from 23 million in 1978 to 51.6 million by the year 2030—from one out of every ten individuals to more than one in eight.

Projections of actual need indicate that 13.8 percent of the non-institutionalized aged—excluding those with mental illness—require some in-home supportive assistance. Within the disabled population aged 18–64, it has been estimated that 40 percent require some assistance with household chores and ten percent require some personal care.*(2)*

Despite these projections, a scant 12 percent of those aged and disabled persons who require in-home services actually receive them.*(3)* Moreover, a vast number of institutionalized persons could live at home if supportive services were available. Studies of nursing home populations in New York, Massachusetts, and Florida have estimated that from 18 to 40 percent of the institutionalized elderly could be transferred out if appropriate in-home services were provided.*(4)*

A final projection of need for home care might be extrapolated from the experiences of several European countries, where "home help" services (as they are called) are considered important enough to be given strong governmental support. While the United States reports a ratio of one aide for every 4,000 persons, Sweden estimates one home help for every 101 persons; Norway, one for every 119 persons; and The Netherlands, one for every 151 persons. Finland credits its solid network of

home help services with the substantial decline in its infant mortality rate in recent years.

Not only has the need for supportive, in-home services been persuasively documented, but its cost-effectiveness vis-a-vis institutional care has also gained increasing national attention. Coming on the heels of numerous studies revealing significant dollar savings through the use of home-based rather than institutional services, the General Accounting Office has recently declared that, "until old people become greatly or extremely impaired, the cost for home services, including the large portion provided by families and friends, is less than the cost of putting those people in institutions."

Legislative recommendations for catastrophic health insurance

Although the proposed Catastrophic Health Insurance legislation was developed in an attempt to relieve individual and family burdens for long-term medical expenses in as cost-effective a way as possible, the National Council believes that certain potential avenues for cost savings have been overlooked. Therefore, the Council wishes to place before the Senate Finance Committee certain principles which it sincerely hopes will be endorsed by the Committee in the final health insurance legislation.

1. Quality home care services should become an integral part of the continuum of health care available nationwide so that there is a realistic balance in the options available for home care as compared with institutional services.

Although the proposed Catastropic Health Insurance legislation does offer a home health benefit, it appears that such a benefit would be provided in accordance with the Medicare definition of home health care. Yet numerous home care experts have attested to the woeful inadequacy of the Medicare home health benefit, citing in particular its unrealistic acute care orientation in serving an elderly population with predominately chronic care needs.

As presented to the House Ways and Means Subcommittee on Health on June 22, 1978, the National Council urges the following steps be taken to expand Medicare's home health benefit package:

Elimination of the three day prior hospitalization and homebound requirements of Part A of Medicare and the 100 day visit limitation under Parts A and B. These restrictions have prevented many elderly and disabled citizens from receiving needed in-home service and have forced others into costly institutional care at the taxpayers' expense.

Addition of "homemaker hyphen" to the home health aide service currently authorized under Medicare. The National Council's definition of homemaker-home health aide service, which has been adopted by numerous state units and organizations, is an attachment to this testimony.

The delivery of both health and socially-related services is essential if we as a society are to deal effectively and efficiently with the home care needs of our aged and disabled population. Furthermore, authorizing both personal and environmentally-focused services from the same funding source—i.e., Medicare—would prevent the current fragmentation in service delivery which promotes a costly duplication of effort whereby two paraprofessionals often go into one home to provide different aspects of homemaker-home health aide service. This change would also help to free up some funds under Title XX of the Social Security Act to provide service to the still largely unmet long-term care needs of the aged and disabled population.

Deletion of the "skilled" proviso before nursing in the Conditions of Participation. The stipulation that all home health recipients require "skilled nursing" care in the Medicare *Conditions of Participation* should be liberalized somewhat by deleting the "skilled" proviso. Like the prior hospitalization and home-bound requirement, this places unrealistic and unjust emphasis on acute care needs when the majority of older Americans require long-term chronic maintenance care.

The National Council firmly believes that the above-listed obstacles have stimulated overuse of expensive institutional facilities, belying the federal government's objective of cost containment in the health care sector. Eliminating these barriers will achieve a better and more economic balance in our health care delivery system.

2. Basic national standards for home care services, including homemaker-home health aide services, should be required by law.

An important aspect of the need for home care services that is frequently overlooked is the need for adequate basic national standards for all home care services and especially for homemaker-home health aide services. Careful monitoring of adherence to the standards is particularly crucial. Otherwise, it would be alarmingly easy for in-home services to find themselves in the same unfortunate situation as has the nursing home field with respect to quality of service. Frequent incidents of exploitation and mistreatment of vulnerable older persons through homemaker-

home health aide services which have been permitted to operate with no monitoring or accountability have been brought to the National Council's attention.

The only protection for the users of the service, the payers and the personnel involved in its delivery, is through adequate, basic national standards and a monitoring system to insure adherence to these standards.

Except for the monitoring of the standards required in the Medicare and Medicaid programs and those required by the National Council for Homemaker-Home Health Aide Services' approval and accreditation programs, the quality assurance features of homemaker-home health aide services across the country are thin indeed. The current rapid expansion of this service must be accompanied by careful attention to standards and the monitoring of standards by objective third parties under the auspice of either governmental or voluntary non-profit organizations if the rich promise of homemaker-home health aide service is to be realized across the nation. Only a couple of states have taken action to build in the quality assurance protections that are presently lacking at the Federal level with respect to this service.

There is evidence that services which operate in conformity with basic standards are cost-effective. Information from three large cities, two in the United States and one in Canada, indicates that when an agency utilizes adequate professional assessment and supervision it results in higher cost per hour, but in lower costs per case. One way good case planning is cost-effective is that service is limited to the number of hours actually needed. Moreover, the case plan can lead to appropriate use of less costly services such as meals-on-wheels and telephone reassurance.

In summary, basic national standards and an appropriate monitoring system for the standards are essential for the protection of consumers of service and for cost-effectiveness.

Nationwideness of available services should be included in a national health plan

When public funds are involved, there should be no discrimination among persons in like circumstances of need for services. Therefore, home care services, including homemaker-home health aide services, should be located so that they will be available in all jurisdictions.

In 1974, it was found that approximately 50 percent of all counties in the nation had no home care agencies. Although the situation has undoubtedly improved somewhat since that time, lack of organized home care agencies force individuals and families in many communities to seek the services of untrained and unsupervised "self-employed providers," who may actually inflate costs by providing inappropriate care and inhibiting client self-sufficiency. At the other end of the spectrum, the dearth of home care resources in some areas certainly promotes unnecessary and expensive institutional placements.

Therefore, the National Council strongly recommends that the Catastropic Health Insurance Proposal mandate nationwideness of home care services.

SUMMARY

In light of the documented need for and cost-effectiveness of home care services, the National Council urges that the Senate Finance Committee incorporate the following components in whatever national health plan is ultimately ratified: (1) development of a continuum of health care services, with home care a strong and viable component of that continuum; (2) requirement of basic national standards for homemaker-home health aide services; and (3) requirement of nationwideness for home care services.

The National Council appreciates this opportunity to present its views on the Catastrophic Health Insurance Proposals.

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RECOMMENDED WORDING FOR REGULATIONS TO IMPLEMENT PUBLIC LAW 93-647

HOMEMAKER-HOME HEALTH AIDE SERVICES

State plans should provide for homemaker-home health aide services as follows:

(a) Include personal care and home management services for aged, blind and disabled and families with children who are determined by the agency to need the service of trained and supervised homemaker-home health aides.

(b) Be in accord with the recommended standards of related national voluntary non-profit standard setting organizations such as the National Council for Homemaker-Home Health Aide Services, Inc.

Definitions

HOMEMAKER-HOME HEALTH AIDE SERVICES

Homemaker-home health aide services means professionally directed personal care and home management services by trained and professionally supervised homemaker-home health aides to maintain, strengthen and safeguard the functioning of eligible persons in their own homes where no responsible person is available for this purpose. The term professionally directed means individual assessment and implementation of a plan of care.

CHORE SERVICES

Chore services mean services in performing minor home repairs, heavy cleaning, yard and walk maintenance which eligible persons are unable to do for themselves because of frailty or other conditions and which do not require the services of a trained and supervised homemaker-home health aide or other specialist. Chore services may include such activities as: help in lawn care, periodic heavy cleaning, simple household repairs, running errands, etc.

NOTE.—That part of homemaker-home health aide services, sometimes referred to as housekeeper service, is homemaker-home health aide service and should meet the National Council's basic national standards for homemaker-home health aide services.

COOLEY'S ANEMIA FOUNDATION, INC.,
New York City, N.Y., April 2, 1979.

Senator RUSSELL B. LONG,
Chairman, Senate Committee on Finance,
U.S. Senate, Washington, D.C.

DEAR SENATOR LONG: Thank you for the opportunity of sending your our written testimony, for inclusion in the record, regarding the proposed catastrophic national health insurance plans now under consideration by your committee.

Cooley's Anemia is the name commonly used to describe the severe form of a hereditary disease of the blood, which occurs most commonly in individuals whose ancestors were natives of the countries surrounding the Mediterranean Sea. For the committee's information, I have attached a short explanatory fact sheet to this letter, which more fully describes the disease, its effects, and care of patients who have the disease.

We have reviewed your proposed legislation, and the general statements made by the Administration, regarding catastrophic health insurance. We are very concerned about them, Mr. Chairman, because they do not seem to meet the needs of patients with Cooley's Anemia.

This disease is a catastrophic illness, with the annual (every year of the patient's life) cost of routine care being about $8,000 per year, with about $5,500 per year being spent on transfusion and iron chelation (ridding the body's organs of iron deposits which result from constant transfusions to ameliorate the anemia) and even if they do receive these transfusions they will die as teenagers from the toxic effects of the accumulation of iron. For now, the medical problems are being managed as well as possible by improved transfusion of blood, and by the use of chelating compounds and mechanical devices for inserting these compounds in the body. The ultimate aim of research is to correct the basic mechanism which causes the diseases.

The number of patients with this disease are probably less than 1,000 (according to an HEW study just completed), and the number is declining. Outmarriage of populations primarily at risk (Italians and Greeks mostly), in combination with recently developed tests to determine carriers of the disease, will assist somewhat in lessening the number of persons with the disease.

However, our very deep concern now is with the children who have the disease, to maximize their care and quality of life, and to assist the families with their problems, especially the economic burdens entailed. We note also that many of our families do not have health insurance which covers costs of blood products and care. Also, even if there is such insurance, frequently families do not claim the insurance, because they fear that continuous claims will threaten the insurance policy for the whole family, or that in some way employment of the breadwinner himself will be threatened, as an employer sees the costs as they relate to the employer's costs of providing insurance coverage.

We have read your bill, and while undoubtedly it would be a great step forward for a number of populations, it is not really greatly beneficial for those concerned with Cooley's Anemia. We would like to refer to Secretary Califano's analysis of the proposed legislation, to show why it would not be very helpful. As he stated: "Benefits would be similar to those currently offered under Medicare, but would be subject to two deductibles—$2,000 of medical expenses and hospital stays of 60 days. With the cost of a hospital day averaging $215, this could mean that a hospitalized person, without any other hospital insurance, would have to pay $12,900 in hospital expenses before he or she would receive financial protection."

As I indicated earlier in this letter, the cost of care is about $8,000 per year on the average. Because both medical and hospital services are involved, it is probable that the deductible provision would cause most of that cost to be borne by those who have borne it in the past, the families of those who are ill.

We urge you to consider another conceptual framework to the legislation. For those who are chronically ill (and there are a large number of diseases which cause people to be chronically ill, and which require high costs year after year) there might be a separate program, which might provide that for the first year of illness, or at the most for the first two years of illness, that a small deductible be established, but for those who have chronic illnesses lasting beyond that time, that comprehensive federal insurance then take up all costs, beyond that first or second year.

It seems to us that the current legislation is really written primarily for the poor, the aged, those on welfare, and the unemployed, and also for those who are employed who may suffer what might be termed "single incident" catastrophic illness, which might have a severe adverse affect in one year, or at most in two years (let us say in the case of a heart attack or similar illness). After all, if it is reasonable to protect these people from catastrophic economic loss if they have massive bills one year, or perhaps two years, is it not also reasonable to protect those families which have chronic massive bills?

We do hope that you will consider our concerns. If you feel that a meeting with you or between you (or your staff) and representatives of the Foundation would be useful, please let us know, and we would be pleased to meet with you. We would bring whatever statistics or information that we have, and which you would require, to make a better judgment on this matter.

Sincerely,

CARMINE GEONIE,
Chairman, Legislative Committee.

COOLEY'S ANEMIA

Cooley's Anemia is the name commonly used to describe the severe form of a hereditary disease of the blood. It was Dr. Thomas B. Cooley, an American physician, who described this as a separate and specific type of blood disease about 1925.

This disorder occurs most commonly in individuals whose ancestors were natives of the countries surrounding the Mediterranean Sea. In the United States patients are of Italian, Greek, Turkish, Southern France, North African, Chinese, Spanish, Irish and Israeli descent.

The disease, also called Mediterranean Anemia or Thalassemia, is inherited according to Mendelian laws and it is known that the severe form (Thalassemia Major) occurs in a child born of parents both of whom must be carriers of the trait. According to this accepted concept, approximately one quarter of all children born of marriages of two individuals with the trait, will have the severe form of the disease. Another twenty-five percent of the offspring will be perfectly normal, and fifty percent will be carriers themselves. Any such hereditary situation, of course, is valid in statistical sense only, and may not be referable to one family where instances are known of only one affected (anemic) child out of ten, or the reverse, where three out of three children may be affected.

Because individuals with the trait or minor form of the disease are not in any significant way handicapped physically, and in whom the only manifestation may be

detectable changes in the size and shape of the red blood cells, it is of great importance to distinguish between Thalassemia major and Thalassemia minor. Individuals with Thalassemia minor have a normal life span and enjoy normal health, whereas individuals with Thalassemia major may succumb to the disease in a matter of one or two decades. The trait never increases in severity or converts to the severe form of Cooley's Anemia.

Thalassemia major usually becomes manifest during the first year of life. Both sexes are equally affected. The earliest signs may be pallor, listlessness, loss of appetite, and irritability. Examination of the patient, by a physician, usually reveals an enlargement of the spleen and liver to some degree, pallor of the skin and mucous membranes, and sometimes a slight degree of jaundice (yellow coloration) of the whites of the eyes. Blood examination will usually show typical changes in the shape, numbers of the erythrocytes (red blood cells), and a variety of alterations from the normal in special properties of the blood cells, in addition to a severe anemia.

There are probably several defects which lead to the anemia. For example, there undoubtedly is a reduction in the rate at which red blood cells are formed in the marrow and released to the blood vessels. Those cells that are produced are defective in that they do not survive in the blood vessels for more than one-third to one-half of the normal life span of red cells, which should be about 90 to 120 days. There are complications which develop in certain individuals which further reduce the rate of blood cell production and survival time of the formed cells. In these patients the greatly enlarged spleen may be the cause of this additional hindrance.

As a result of the chronic state of anemia, the children with this disease are greatly handicapped. Bone growth is poor—they are, therefore, usually small for their age. Because of abnormalities of the bone marrow, there are alterations of the skull and other bones, so that a characteristic facial expression is found, which give many of these children the appearance of being related. The bones are more fragile than normal, and fractures occurring almost spontaneously are quite common. The anemia causes easy fatigability, and a lack of pep and energy. Frequent nose bleeds is a common finding in many patients. When anemia is severe, low grade fever may be noted. There is no particular increase in susceptibility to infections.

At present the only effective treatment is the proper administration of blood transfusions to alleviate the constantly recurring anemia. There are other specific treatments for various complications of the basic disease.

There seems to be a continuous spectrum in the degree of severity of the disease from those children who require blood transfusions as often as once a week to those who rarely need transfusions. Some children die within a few years and others are known who are alive in their twenties. There is no known cure.

THE NATIONAL HEMOPHILIA FOUNDATION,
New York, N.Y., April 2, 1979.

Hon. RUSSELL B. LONG,
Chairman, Committee on Finance,
U.S. Senate, Washington, D.C.

DEAR CHAIRMAN LONG: Thank you for responding to our written request to testify at the hearings on the proposals presently before your Committee regarding the matter of catastrophic health insurance. As you requested, here is our written statement.

We will not deal in detail with each of the particulars in the bills before you, but rather would prefer to make our concerns known in a more general way, so that they may be considered in relation to the entire approach being taken not only in the legislation currently before you, but also, as we gather, from the approach being taken by the Administration.

Mr. Chairman, S.350 and S.351, the major bills before the Committee now, deal with a form of catastrophic health insurance, and the inclusion in such legislation the extension of federal programs to the poor, aged, unemployed, and others, and also includes a program for those who are employed, by providing for a federal voluntary certification program for private health insurance designed to encourage private insurers to make such coverage available in all parts of the country.

The Administration opposes these bills for a number of reasons, and has set forth, generally, its own plan, which has not yet been sent to you for formal consideration.

In terms of those of us who are interested in care for hemophiliacs and in assuring that catastrophic health care costs for the patients do not continually keep many of the families in constant fear of bankruptcy and of falling into poverty, neither your bill nor the Administration's proposals meet the evident needs.

The National Hemophilia Foundation knows that there are between 12,000 and 18,000 hemophiliacs in this nation (probably closer to the higher figure, as a recent HEW directed survey has indicated), and that care costs can range from several thousand dollars to as high as $25,000 every year; in other words, every year is a catastrophic cost year for the families of hemophiliacs.

As you may know, hemophilia is a hereditary, blood-clotting disorder which affects males almost exclusively. A deficiency in one of the blood's clotting factors causes the hemophiliac to bleed, internally, from a simple bump or bruise or even spontaneously. When the bleeding is uncontrolled, blood will accumulate at the joints and in tissues causing damage which may literally leave him "crippled by his own blood."

The hemophiliac does not bleed harder or faster than anyone else; the deficiency in his blood causes him to bleed for a longer time because an effective clot does not form. He will not bleed to death from a minor external cut either; application of a bandaid and pressure will stop this bleeding just like anyone else. It is the internal bleeding which requires special treatment.

It should be noted that more than one male child per family may become a victim of the disease, and the costs of care indicated in this letter are for one individual, and would be increased incrementally for each additional child with the disease in the family.

Your proposals, and those of the Administration, approach the health care cost question from the point of view of being concerned with the non-chronically ill who face catastrophic costs. For example, those with heart attacks, or other major, but relatively short-time, illnesses, are frequently cited as examples of those patients whose costs should not be allowed to wipe out a family's total savings and assets. But the proposed legislation does not at all deal with the family which is faced with a continuing chronic illness cost.

Perhaps we can be more specific. Secretary Califano of HEW testified before you on March 27, 1978, and stated in his analysis: "Benefits would be similar to those offered currently under Medicare, but would be subject to two deductibles—$2,000 of medical expense and hospital stays of 60 days. With the cost of a hospital day averaging $215, this could mean that a hospitalized person, without any other hospital insurance, would have to pay $12,900 in hospital expenses before he or she would receive financial protection."

Let us look for a moment at the financial problems relating to care patterns of hemophiliacs.

There is the hospital cost, the medical cost for physician treatment, and the costs of surgery. Then there is the cost of the various persons who must also provide care, including nurses, psychologists, social workers, aides, and others. Transfusions, the administration of various forms of the blood factors to prevent or stop constant bleeding (some provided by home care methods), surgery, costly dentistry, and other medical procedures are frequently necessary. Preventive care, now possible to control the disease, is very expensive.

(There is no cure for hemophilia; a child born with this disorder will suffer from it all of his life. But thanks to advances in the treatment of hemophilia, today's hemophiliac can live a nearly-normal life if he gets proper treatment.

A control, called the clotting factor, can be administered to the hemophiliac at the first sign of bleeding. The clotting factor, concentrated from the blood of normal donors, supplements the hemophiliac's own deficient clotting factor, making his blood capable of forming the clot needed to stop the bleeding. Unfortunately, while treatment controls this bleeding episode, it is only a temporary measure. Soon the clotting factor dissipates and the hemophiliac may have a bleeding episode which will require more infusions.)

As to expense: it is estimated that hemophilia is the most expensive chronic disease, now that the government supports renal dialysis. For a severe hemophiliac, cost of blood products alone can cost as much as $26,000 a year, every year. You don't have to be descended from kings to get the disease which has been inaccurately called the "Disease of Royalty" but you may need a king's treasury to pay for it.

These costs are present, every year of a hemophiliac's life. And, because of the new preventive procedures now available, hemophiliacs are living longer, more fulfilling lives. But many cannot afford this continuous care.

We request that you consider including in your bill a provision for what we might call chronicare, that is, a specialized catastrophic insurance system for those families who have a member of the family who is chronically ill; and we further propose that you consider a one-time, one year (or at the most a two-year) deductible, not to exceed $1,000 per year, for both medical expenses and hospital stays. Additionally,

we hope that you will continue to permit that expense to be deducted from taxable income.

We believe that it would be very important to hemophiliacs that blood and blood products would be covered, as well as home care and ambulatory care. (We should add that not only hemophiliacs would be helped by such provisions, but also those with leukemia, aplastic anemia, Cooley's Anemia, and sickle cell disease. Further, there are numerous victims of other genetic diseases and chronic diseases who would also benefit by such provisions.)

In fact, Mr. Chairman, although the program you propose may be helpful for those who have more than $2,000 per year in medical expenses (and there are many), and those who have more than 60 days hospitalization per year (and there are a few who have that many, and most seriously affected hemophiliacs have a number of days so spent) in total your proposed catastrophic program will not lessen the constantly heavy outlay for a large number of hemophiliacs.

Permit us, please, to make some observations about the problems we face in meeting expenditures for medical care:

1. Most Blue Cross/Blue Shield programs do not provide for coverage for hemophilia medical care, because of the fear of these programs of the constant yearly costs for care.

2. Because it is considered by most insurance plans to be a pre-existing condition, families who do not have medical insurance coverage, but wish it, and families who because of changes in jobs or location are forced to change programs of coverage, frequently cannot be included in new programs.

3. Breadwinners in hemophiliac families and employed hemophiliacs themselves are constantly in dread of unemployment, much more so than the average American, especially if unemployment requires a change in job, because a changed job frequently means a change in medical plan. The high rate of unemployment in the nation today affects hemophiliacs more than other Americans: it is frequently hard for a hemophiliac to get a job, because of the institutionalized myths surrounding the illness and sometimes he is the first to be let go from a job when economic conditions worsen.

4. Many private health insurance contracts often do not cover preventive, home care, and ambulatory services—those which are in fact among the most beneficial and cost-effective. Thus, they do not cover any populations for these matters, much less hemophiliacs. It is important to note that blood and blood products, especially, usually are not covered.

5. We find that families of hemophiliacs have moved from one state to another, simply to take advantage of opportunities presented by some states for more adequate care, and other families have moved to states which have federally-assisted comprehensive care and treatment programs.

6. We all know that the cost of health care is increasing more than the average double-digit inflation rate, and certainly far above the average income increase in hemophiliac families.

According to Secretary Califano, health care costs for an average family of 4 in 1979 will be $2,372, and will grow to $4,064 in 1984, only five years from now. Just think of what that will mean to the hemophiliac and his family!

Senator Long, we are very hopeful that you will consider these matters when your Committee moves to mark up this legislation. On behalf of those who suffer from hemophilia, and their families, and undoubtedly on behalf of all those who suffer chronic disease's effects both physically and financially, we appreciate the consideration you will give to our concerns.

Enclosed is a small booklet "What You Should Know About Hemophilia" for the use of you and your staff.

Sincerely,

ANN WALSH,
Legislative Committee Chairman.

STATEMENT OF THE AMERICAN ACADEMY OF OPHTHALMOLOGY AND THE AMERICAN ASSOCIATION OF OPHTHALMOLOGY

Mr. Chairman, Members of the Subcommittee on health, thank you for this opportunity to submit testimony on behalf of the American Academy of Ophthalmology and the American Association of Ophthalmology. Our specific interest today concerns legislation now pending before your subcommittee to expand Medicare reimbursement policies for aphakic patients.

The American Academy of Ophthalmology is comprised of 9,000 physicians who have achieved board-certification in the specialty of ophthalmology. Founded in

1896, it is the largest organization representing ophthalmology in the United States. The American Association of Ophthalmology, which was founded in 1956, represents 5,500 ophthalmologists in the United States.

In our extensive review of the proposed coverage for services furnished by optometrists in connection with treatment of aphakic patients, we have concluded that this amendment would extend the role of optometrists into an area of medicine where they are not qualified by training, experience, or licensure. We therefore must oppose this extension of coverage.

We would like to clarify our understanding of the phrases "treatment of aphakia" and "treatment of aphakic patients". The optical treatment of aphakia is by spectacles, contact or implant lenses. Reimbursements for spectacles and contact lenses are already authorized under Medicare as prosthetic devices when prescribed by a physician or an optometrist. No extension of coverage is therefore necessary for this type of "treatment". Other "treatment" for aphakia is the surgical procedure of lens implantation which is covered by Medicare when performed by a qualified ophthalmologist.

Optometrists can provide spectacles or contact lenses following surgery, but not intraocular implants as they require placement in the eye at the time of the surgical removal of the cataract. No optometrist is licensed to perform surgery.

We advise the subcommittee not to provide reimbursement for optometrists or any class of providers who are not prepared educationally or professionally to provide such services. If "treatment" as used in this amendment is to cover other eye services being low vision aids, telescopic, and other similar devices, then this subcommittee should consider the cost involved as such costs may be substantial. If treatment refers to any medical or surgical condition arising independently of or as a complication of cataract surgery, optometrists are not licensed to, nor qualified by training to administer it to the aphakic patient.

The fact that treatment is not defined causes us great concern. A possible problem after fitting of contacts or spectacles for an aphakic patient is the danger of infection. Since infection requires drug therapy and optometrists are licensed to use therapeutic drugs in only two states, the use of the word treatment in the proposed legislation could have serious consequences. All things being equal, eye infection of any kind is much more serious in an eye that has been operated on for a cataract than in one which has not. Eye infection of any kind in the aphakic patient constitutes an emergency that requires immediate diagnosis and treatment.

In summary, Mr. Chairman, patients who have had cataract surgery and are aphakic require medical treatment. The incidence of ocular disease in aphakic patients is such that those patients require evaluation and treatment by physicians. The optometrist lacks the medical education, clinical training, and licensure to safely and effectively provide any treatment in addition to spectacles and contact lenses.

It is the recommendation of the American Academy of Ophthalmology and the American Association of Ophthalmology that it would be inappropriate to further extend Medicare reimbursement coverage for services by optometrists.

HEMATOLOGY-ONCOLOGY, P.C.
New Haven, Conn., March 28, 1979.

Senator RUSSELL B. LONG,
Chairman, Senate Finance Committee,
Washington, D.C.

Dear Senator Long: We would like to submit the following statement for the record on your hearings on the catastrophic medical insurance bill. : David S. Fischer, M.D. for the Conn. Oncology Association.

As an organization for Cancer specialists, we encounter the problems of chronic illness in our daily experiences. With treatment it is gratifying to see more cancer patients improving. However, the costs of cancer care are enormous whether the patient responds or fails. Many families are wrecked financially and have to sell their homes and discontinue their children's education. Some patients elect to die rather then have their family incur the costs of treatment.

From this perspective we see the problem of catastrophic illness as a national problem as well as a personal tragedy. We therefore urge the Congress to pass legislation to cover catastrophic illness once the patient has had an out of pocket expense exceeding $1,000.00 per year.

We have previously suggested that further cost savings to the taxpayer can be achieved and greater benefits to medicare beneficiaries can be given by revising the statutes to pay for cancer chemotherapy given by injection by a medical practioner

and covering the costs of that medication at 100 percent rather than at 80 percent so that the patient does not have to be hospitalized. This would save the very considerable costs of hospitalization since many of the injectable anti-cancer drugs are so very expensive that the patient cannot afford the co-insurance. In addition we have urged that there be a clarification of section 1862(a)(1) to indicate that medicare should pay for the hospitalization of patients receiving drugs distributed by the National Cancer Institute even though those drugs have not yet been commercially approved by the Food and Drug Administration. It seems apparent from the intent of Congress that cancer patients should not be denied treatment felt to be reasonable and necessary by one agency of the Department of Health Education and Welfare just because another agency of the government has not gotten around to an evaluation and approval. It would seem that within the meaning of section 1862 the determination by the National Cancer Institute that a drug is reasonable and necessary should be definitive. To do otherwise would force patients to receive drugs that are less efficacious simply because they have been around longer and have had time for the Food and Drug Administration to evaluate them and to be denied by economic forces a superior drug simply because that agency has not fully evaluated it and approved it, even when a top scientific agency of the Federal government, the National Cancer Institute has not only approved the drug but is actually supplying it and paying for it so that medicare does not incur the costs of the drug but only the hospitalization which is required to administer the drug.

Sincerely yours,

David S. Fischer, M.D.

Statement of the Blue Cross and Blue Shield Associations

The Blue Cross and Blue Shield Associations appreciate the opportunity to share with you our thoughts on catastrophic health insurance.

The Blue Cross and Blue Shield Associations, which operate under a single Chief executive and staff, are the national coordinating agencies for the 69 Blue Cross and 70 Blue Shield Plans in the United States. The Plans provide privately underwritten coverage to about 85 million Americans, and serve almost another 20 million as fiscal agents or intermediaries for the Medicare, Medicaid and CHAMPUS programs. Thus, the Plans serve about half the U.S. population.

The opportunity to provide all elements of the population with protection against financial ruin due to health care costs is an extremely attractive one, particularly if it can be achieved through the maximum utilization of private sector financing and administration with an appropriate minimum of government regulatory intervention. We know that the private sector is capable and willing to cooperate with government in meeting the need for catastrophic levels of protection.

Catastrophic insurance appeals to a widespread constituency, it would protect everyone and it could be provided at a relatively modest cost. Since large numbers of employed persons already have catastrophic protection the added fiscal impact on the private sector would be less than that of a comprehensive program and the growth in government spending and bureacracy would also be considerably less. Finally, the mandating of catastrophic coverage would preserve a desirable level of flexibility in the overall delivery and financing of health care so that constructive adaptation and change can continue to occur.

Despite the obvious merit and widespread appeal of the concept of catastrophic health insurance there are also some problems to be considered, particularly in the design of free standing or other catastrophic programs not coordinated with basic health insurance benefits. Rather than comment in detail on the several bills before the Committee, we would like to list a few of the problems inherent in catastrophic proposals which we hope you will be mindful of as you proceed with your deliberations.

Catastrophic coverage tends to emphasize the wrong end of the spectrum of health care by motivating extraordinary, expensive methods of treatment instead of promoting more cost effective investment of limited health care dollars in preventive and primary care, ambulatory services, home health services, alternative delivery systems, etc.

Catastrophic-only programs do not deal with gaps which may exist in basic insurance coverages below the catastrophic level. These gaps may prevent services being sought when they would be most appropriate and result, long-term, in a need for more health care than would be necessary had treatment been received earlier.

Unlimited coverages would tend to exacerbate problems of over-specialization and geographic maldistribution by drawing manpower and resources toward the more

lucrative professional specialities and urban medical centers. They do not deal with the need for appropriate health system development and efficiency.

Program beneficiaries are more likely to be confused by potentially complicated deductible and copayment requirements if catastrophic benefits are administered separately from basic benefits. When individuals must coordinate separate benefit programs, they often fail to claim all the benefits to which they are entitled.

None of these problems are beyond resolution. Their solution lies essentially in designing a coherent program involving not only catastrophic protection but mandating or certifying complementary basic benefit levels, accompanied by cost effective coordination of the two elements, preferably by the same carrier.

Ideally, the Blue Cross and Blue Shield Associations believe that for the ultimate level of effectiveness in serving beneficiaries, containing benefit costs and facilitating administration, catastrophic protection should be an integral element of a comprehensive package of basic health care benefits. As a practical matter, however, we recognize that while much of the population could be provided catastrophic protection in that manner, it is not feasible at present to mandate that level of truly comprehensive coverage.

A desirable early increment, therefore, in an eventual comprehensive national health plan might be to provide a catastrophic layer for existing private and government benefit programs. The mandated catastrophic program for the self-supporting population could be accompanied by a "certified" level of compatible and affordable basic benefits which would be purchased voluntarily by employers or individuals and encouraged by tax deductions.

Certified basic coverages could provide for continuation of protection for those who become unemployed. By extending coverage in such cases for 90 or 180 days, and by requiring coverage of an insured's dependents, the number of uninsured persons in the population would be significantly reduced. At least part of the remaining uninsured population could be reached through reform of the Medicaid Program.

We strongly support the Committee's interest in improving the Medicaid program through requiring greater uniformity in benefits and eligibility. It should be a matter of national conscience that coverage for the low income population through Medicaid is inconsistent from state to state. The highest priority should be given to improvements for these low income groups. The uneven patterns of available services and the variations found in the effectiveness and efficiency of health programs for the poor should not be allowed to continue. We believe that much can be achieved by involving the private sector in programs for low income and high risk groups through voluntary pooling of risks.

We hope that these general comments will prove useful as the Committee on Finance considers catastrophic health insurance legislation. We look forward to providing any assistance or technical comments you may desire in the course of your discussions.

Remarks of Beatrice R. Burgess, Union, W. Va.

OUTLINE OF REMARKS

Introduction—My interests and concerns.

I. Need for medical health care to meet need of catastrophic costs.

II. Disproportionate amount spent on catastrophic.

III. Most medical care needs of older adults are not in catastrophic area.

IV. Catastrophic is most expensive part of health care system.

V. Catastrophic emphasizes in-patient care.

VI. High deductibles and co-insurance place unfair burden on low and middle income persons, who are paying for higher income persons.

VII. High deductibles become access barrier for low income persons.

VIII. This approach cuts down diversity of approaches.

IX. Lack of basic philosophy for meeting health care needs.

X. Canadian experience could help us avoid costly and unfruitful mistakes.

XI. Plan inadequate, need for comprehensive health care plan.

For seven years I have served the people of Monroe County, West Virginia as a Church and Community Worker for the United Methodist Church. The great needs of the elderly have been one of my great concerns, leading me to become involved in statewide and national advocacy on their behalf. I have served as president of the Council of Senior West Virginians and for two years have been on the Board of Directors of the West Virginia Health Systems Agency. At this time I serve as chairperson of their health care cost containment committee. However, I wish to

speak to you about the health care needs of the elderly as their friend and co-worker. My people are an agricultural county, almost one-third are older adults and almost one half of those are below the poverty levels.

It is good that the Congress is addressing the needs of the people of this nation in health care. The catastrophic costs of catastrophic health care has become an accepted fact of life today. Many families are completely bankrupted as they go through an experience. I wish to speak to the effect of the proposed catastrophic health insurance bill on older adults.

In West Virginia we spend 20 percent of our Medicaid funding on the medically needy, persons who can manage well under normal circumstances, but who cannot handle unusual medical costs. Yet we discover that the costs of these services are given to only 10 percent of the persons served. This means that the high cost of health care is in competition for the older health care needs for older adults and low-income persons. As these costs rise great pressure will be put to cut the costs of other services to older adults.

Only about 2 percent of the health care needs of older adults comes under the catastrophic heading. Yet they have many other types of needs which are as urgent as the catastrophic.

From my work with the Health Systems Agency I know that catastrophic care is highly labor intensive and also highly technologically intensive. If this bill is passed, more and more medical dollars will go into the most costly portion of the entire health care spectrum. This, by its very nature will add to the costs. Patient days will be stretched so they will become eligible, Research will be developed to take care of this part of health care since that is where the money is. The fires of spiralling health care costs will be fueled greatly by this approach to health care costs.

By its very nature, catastrophic emphasizes in-patient care. This is also the highest cost health care. Many of our present health care costs could be greatly reduced if lower levels of health care were reimbursed by the third-party payors. Outpatient and home health care, plus other lower levels of services would greatly reduce expenditures. A doctor does not have to be the only medical care provider.

The high deductibles and co-insurance proposed indicate that your committee is not aware of the income levels of the people in other parts of our great country—or does not care. Inflation continues to rise at a level far above the general level of inflation for food, heating the home and drugs and transportation—the only things which many older adults can afford, and each of which is necessary to maintain life itself. A very high number of our older adults are now cutting their food intake to pay their fuel bills. The study is not complete, but it is already startling. And these are not lazy, shiftless people, these are people who have worked hard all their lives at farming, and were not poor, many of them, until they became older adults. The Social Security deductibles for Medicare will effectively deny access to many older adults whose income is just above the SSI eligibility limits. To continue to think that deductibles and co-insurance are a necessary part of any health care plan is not to take into consideration the economic straits of too large a number of the American people—particularly the older adults.

The lower and middle income levels pay too great a portion of the health care for upper income persons through a system of allocation of funds according to population. Our older adults in West Virginia are in medically underserved areas, and sometimes when the services are available, they have no access to the services through lack of transportation. For the year 1970 California older adults on Part B Medicare were receiving as average of $12.38 per person per month for health care costs; Florida $10.58 Nevada $10.30, four states in the $9 bracket, five in the $8 bracket, seven in the $7 bracket, 16 in the $6 bracket, 13 in the $5 bracket, with Kentucky, South Dakota and West Virginia having the lowest reimbursement, West Virginia's being $4.49 per person per month. What a travesty!

In the following table 1970 figures for catastrophic health care costs show that the burden placed on lower income families is disproportionately high.

Family income	Gross expenses greater than $5,000	Family outlay greater than $1,000	Family outlay greater than 15 pct of family income	Income distribution of all families
Under $2,000 (percent)	5	1	38	10
$2,000 to $3,499 (percent)	8	4	25	11
$3,500 to $4,999 (percent)	3	6	13	9
$5,000 to $7,499 (percent)	20	13	14	16

Family income	Gross expenses greater than $5,000	Family outlay greater than $1,000	Family outlay greater than 15 pct of family income	Income distribution of all families
$7,500 to $9,999 (percent)	8	12	4	15
$10,000 to $14,999 (percent)	18	28	3	22
Over $15,000 (percent)	38	37	4	17
Number of families	47	209	451	3,765

Definitions Expenses—all amounts paid by or on behalf of family· insurance, government plans, personal cost. Outlays—Paid out-of-pocket for deductibles, co-insurance, exclusions, etc.

There needs to be a diversity of approaches to catastrophic illness. This bill will encourage uniformity at the high levels of cost.

The greatest need for health care is to develop a basic philosophy for what the care will be, and then to add services until the entire program is in place. This is the experience of the Canadian system, according to Dr. K. C. Charron, former chairman of the Ontario Council of Health, in a paper to a 1977 health care symposium. Dr. Charron also explores the importance of seeing which elements of the total plan are phased in first and the time sequence so that distortions are not built into the system.

With no thought being given, through this plan, to the total health care needs of the American people, the distribution of services, the various mechanisms for lowering health care costs, I urge this committee to avoid putting the most expensive part of the plan into place. There will be not another part, if this happens. We cannot afford to emphasize the most expensive costs in this time of runaway inflation. The people of America deserve the right to good and comprehensive health care. This proposal does not address itself to it, and I urge you to favor the bill which does, the Kennedy-Corman bill. It will be less expensive in the long run.

Statement of American Optometric Association

The American Optometric Association would like to submit a brief statement of philosophy concerning catastrophic health insurance, and to offer several refinements in the major provisions of S. 350 and S. 351 insofar as they pertain to health care expenses counted toward meeting the deductible and expenses actually reimbursed. Additionally, and as noted, these refinements are applicable to the "federalized" medical assistance and private health insurance certification features of the bills.

Philosophy

This Association shares the concerns of a growing number of citizens over the escalating costs of health care. These costs have, in many instances, compelled families to exhaust their life savings and oten to face the unwanted reality of becoming welfare recipients.

Many of these costs reflect significant advances in health care technology. Such relatively new techniques as kidney dialysis, heart transplant and laser beam eye surgery were expensive to develop and are costly to administer. Thus, although the cost of living has increased significantly over the last five years, the cost of health care has risen even more during the same period.

This Association is sympathetic to the need to protect this nation's citizens form the costs of catastrophic health care. We agree in principle that after a certain dollar threshhold is passed, a person or family should have the assurance that further health care costs will not force them onto the welfare rolls.

However, an additional dimension must be included in any catastrophic health care plan. It is not necessarily the cost of one particularly expensive mode of treatment that has a catastrophic impact on a family; it is the cost of this treatment combined with any other health care costs that a family may need to incur as if the major health care expenditure were not present. Thus, we recommend in principle that:

1. The term "catastrophic" be viewed as a total financial impact concept rather than as a singular major health problem of major cost, and
2. All reasonable and necessary health care expenses be counted toward meeting the deductible in any catastrophic health care plan; that all such expenses be covered once the deductible has been reached; and, that all licensed health provid-

ers be approved to provide those services which they are authorized by law to provide in their respective jurisdictions.

The American Optometric Association believes that this view of the true nature of catastrophic health costs will ensure that every citizen continues to receive necessary preventive and maintenance health care despite the presence of a major health problem.

More specifically, we would like to constructively critique the approaches taken in S. 350 and S. 351 toward the issues of meeting the deductible and reimbursing health care costs. We would then like to offer refinements consistent with the intent of the bills and in keeping with our critique.

MEETING THE DEDUCTIBLE

S. 350 and S. 351 provide that in meeting the deductible of $2,000 per family, only those expenses which a family incurs of the type which Medicare currently reimburses would be counted. Although there is a benefit in incorporating by reference an existing health care program, we respectfully cite the following deficiencies in utilizing Medicare for this purpose:

1. Medicare does not cover a number of health care areas, such as routine physicals, dental care, vision care, psychological services, medicines and drugs.

2. Even when it covers a health care service, Medicare is often arbitrary and discriminatory as to which providers may be reimbursed for those services. A good example of this discrimination is in the field of eye care. Whereas an eligible Medicare patient with signs or symptoms of eye disease or injury can be reimbursed for an eye examination provided by an ophthalmologist, should he or she select an optometrist for the same services, the care would not be reimbursed. This is an arbitrary distinction that conflicts with nearly every other federal health program as well as freedom-of-choice laws governing public health programs and private health insurance policies in nearly every state. Thus, to adopt Medicare's rules as the basis for meeting the deductible would be to expand this arbitrary, discriminatory system to the entire population.

3. Utilizing the Medicare model would make it more attractive for a person to select a provider whose services are reimbursable.

Again utilizing our example of optometry, the many persons with signs or symptoms of possible eye disease or injury would benefit financially by selecting an ophthalmologist over an optometrist: the ophthalmologist's eye exam would count toward the deductible, the optometrist's would not.

The ramifications of such an irrational policy are manifold. Among them is the reality that the federal government would be placing a premium on the use of certain providers as opposed to others, conflicting with federal health manpower production objectives which contemplate the production of a lesser number of medical specialists such as ophthalmologists.

Similarly, persons would find that the federal government would be counting surgical treatment of eye muscle problems toward meeting the deductible; whereas, vision therapy, the less costly optometric mode of treatment which presents a diminished risk and higher success probability to the patient, would be excluded.

4. It seems particularly ironic that preventive health services, which are specifically excluded by Medicare, would not count toward meeting the deductible, whereas "crisis care" expenses would be.

REIMBURSEMENT

The proposed legislation would reimburse, after a family reaches the deductible, expenses of the type which are covered by Medicare. The deficiencies of this approach are the same as for its use in meeting the deductible, only greater. It would apply Medicare's inadequate scope, discriminatory reimbursement, irrational favoritism, and non-preventive policies as an actual schedule of coverd benefits for all age groups. In the eye/vision care area, it would create a virtual federally-sanctioned monopoly for doctors of medicine bolstered by identical incentives toward reaching the deductible.

For these reasons, the American Optometric Association must recommend against utilizing the current Medicare model in judging whether health care expenses should be counted toward catastrophic eligibility or catastrophic reimbursement.

RECOMMENDATIONS

In lieu of applying Medicare coverage and reimbursement policies to the catastrophic health insurance features of S. 350 and S. 351, we would recommend that the committee consider the following:

1. Count toward the deductible those health care expenses that are now tax-deductible under the income tax provisions of the Internal Revenue Code. This system works, is familiar to most Americans, and meets the criteria of a model that easily could be applied to this new program. Significantly, its utilization would eliminate the need for a person to construct a second set of itemized health care expenditures, picking and choosing those which fall within Medicare's often-aribitrary idiosyncracies. He or she could merely submit a copy of Schedule "A" of the income tax return. Finally, this feature of near-universality of eligibility of health care expenses parallels the spend-down system contemplated for determining eligibility under the medical assistance plan in S. 350.

2. After a person or family becomes eligible for catastrophic coverage, reimburse the same types of expenses that would be counted toward meeting the deductible, i.e., those that qualify for consideration for income tax deduction. If this is not possible, and it is necessary to reimburse only a more limited scope of care, then reimburse those services that would be covered by Medicare while permitting a person to select any qualified provider, as determined by state licensure laws to perform a covered service.

This last feature also deserves inclusion in the federalized medical assistance plan (S. 350) and should be a requirement for the certification of any private health insurance plan (S. 350 and S. 351). Its incorporation will ensure the consumer the widest access to health care and promote a maximum degree of competition and cost effectiveness.

The American Optometric Association respectfully recommends your consideration of these suggestions as constructive refinements of the major features of S. 350 and S. 351.

U.S. SENATE,
Washington, D.C., April 25, 1979.

Hon. RUSSELL B. LONG,
Chairman, Committee on Finance,
U.S. Senate, Washington, D.C.

DEAR MR. CHAIRMAN: I am enclosing herewith copies of testimony I have received from Hawaii on the catastrophic health insurance legislation which is currently pending before the Committee.

I would greatly appreciate your including the testimony in the official hearing record on the legislation.

Aloha and best wishes.

Sincerely,

SPARK MATSUNAGA.

HOSPITAL FINANCIAL MANAGEMENT ASSOCIATION, ALOHA CHAPTER
Honolulu, Hawaii, March 26, 1979.

Hon. SPARK M. MATSUNAGA,
U.S. Senator,
Washington, D.C.

DEAR SENATOR MATSUNAGA: We the Hawaii Chapter of HFMA read S-350, the Catastrophic Health Insurance and Medical Assistance Act of 1979.

The general opinion is that something should be done to prevent a person going bankrupt as a result of medical expenses and poor health condition. However, it would appear that the approach taken by S-350 is inflationary and too costly. We would suggest the following changes:

(1) Do as Hawaii has done—require employers to provide general medical care insurance for all employees working 20 or more hours a week. This would cover most medical cost incurred.

(2) For catastrophic health insurance, it was felt a major medical plan whereas a patient pays 20 percent and insurance pays 80 percent of medical cost incurred would be better. The patient's medical cost, however, should not exceed $10,000 per annum. S-350 has deductibles that are too low.

People have to share in the cost of health care. For the government to continue to pay for health care bills like the Medicare system is too inflationary. Everyone just uses the program thinking it is free. Also, regulations under Medicare and Medicaid are becoming to costly to monitor. Hospitals are saying it costs over $10 to bill a Medicare patient. This $10 could be better spent taking care of patients rather than for compliance.

Keep the government out of it. Let employers and commercial insurance companies develop a plan under general guideline laws established. Follow the Hawaii plan and mandate major medical insurance.

Hope this helps.

Aloha,

ALDEN G. HATCH,
Past President.

UNIVERSITY OF HAWAII AT MANOA,
SCHOOL OF NURSING,
Honolulu, Hawaii, April 11, 1979.

Hon. SPARK M. MATSUNAGA,
U.S. Senate,
Washington, D.C.

DEAR SPARKY: Thanks very much for sharing with me Senate Bill 350 regarding the Catastrophic Health Insurance and Medical Assistance Act of 1979.

In these days of fiscal responsibility and accountability, the citizen is presented with some problems regarding additional expenditures in the federal budget. However, as a health professional, I know only too well that persons are stripped of their financial independence because of catastrophic illness. So, needless to say, I am in a position of dilemma regarding the Catastrophic Health Insurance legislation.

Let me also share with you some other feelings I have regarding this legislation. There is desire as I read in the literature to increase the number of HMOs. No time has been given these new kinds of agencies to determine whether or not they can reduce catastrophic illness. Another item which needs to be considered is the same percent of the national health dollar spent for prevention. Would an expenditure greater than at present possibly reduce catastrophic illness? It seems to me that there are a number of unanswered questions in regard to already existing legislation and to enact additional legislation to take care of catastrophic illness is premature. Will the expenditures of money for catastrophic health insurance though considered at 10 to 15 million in its beginnings grow so large that we would be unable to support this kind of activity? It seems from what I've read we are already having difficulty with social security funding and what will happen in the next several decades is a question. I also wonder if the responsibility for catastrophic illness doesn't rest with the states rather than with the federal government. If states ended up by having to pay for large amounts of catastrophic illness, they might make efforts, as we have in this state, to look at alternatives in delivery of health services, alternatives to illness with the hope that catastrophic bills would be reduced.

Making these statements leave me with a slight amount of discomfiture as I know that there are many who suffer from catastrophic illness and the financial consequences. However, I do believe there is a point at which we must act responsibly and say "No, there is no more money to pay for these activities." I guess my question is "Has that point been reached?" That decision I will have to leave up to you in your wisdom and greater knowledge of the national fiscal picture.

Again, thanks for letting me respond and I wish you well in your deliberations.

Sincerely yours,

HELEN H. BURNSIDE, Ed. D., R.N.,
Dean, School of Nursing.

HAWAII PSYCHIATRIC SOCIETY,
Honolulu, Hawaii, April 10, 1979.

Senator SPARK M. MATSUNAGA,
U.S. Senate,
Washington, D.C.,

DEAR SPARKY: Sorry for the delay in commenting on S.350 and S.351, but after reviewing them and discussing the commentary from the American Psychiatric Association, we would like your support in the issues raised by Dr. Jane Preston in her testimony of March 29, 1979 before the Senate Finance Committee.

We feel that she has explicated many of the issues which your committee must consider regarding the discriminatory provisions of that bill regarding psychiatric care.

The Hawaii Psychiatric Society supports S.350 and S.351 with the reservations outlined by Doctor Preston's testimony. We have appended to this letter a copy of the testimony and hope you will give it due consideration.

With best wishes and my warmest aloha.

ROBERT C. MARVIT, M.D.

HAWAII PSYCHOLOGICAL ASSOCIATION,
Honolulu, Hawaii, April 19, 1979.

Senator SPARK M. MATSUNAGA,
Prince Kuhio Federal Building,
Honolulu, Hawaii

DEAR SENATOR MATSUNAGA: Thank you for your letter requesting our comments on Senate Bill 350 (R. Long, D. Louisiana).

We would like to commend the authors of this bill for their endeavor to provide insurance for persons with low income against the high costs of catastrophic illness. The need for this kind of insurance has been apparent for some time.

While many of the benefits of the bill appear to be adequate, we have serious questions regarding the scope of benefits allowed for mental health treatment. Specifically, the bill covers only treatment "provided by a psychiatrist" and only treatment "provided on an inpatient basis." We would like to call your attention to information related to the cost-saving features of including mental health benefits provided by psychologists and outpatient services.

Gary R. VandenBos, Ph.D., Administrative Officer, Mental Health Policy, American Psychological Association, reported by letter on 1/8/79, to Terry Brauer, Assistant Director, Consumer and Professional Relations Division, Health Insurance Association of America, the following data:

"As you know there are various fears repeatedly expressed about adding mental health benefits to particular policies or including psychologists as independent providers. However, there is little to support these frequently voiced objections. The research literature strongly supports the effectiveness of psychotherapy, the cost-saving features of including mental health benefits, and the fact that the rate of utilization of mental health services is a stable and predictable event."

"One of the first questions raised about mental health benefits is whether or not psychotherapy works. Such a question is easily 15 years out-of-date. There is general consensus within the research field that psychotherapy as a general category of treatment is effective (Bergin, 1971; Emrick, 1975; Kellner, 1967; Meltzoff & Cornreich, 1970). Smith and Glass (1977) reviewed 400 controlled evaluations of psychotherapy and found convincing evidence of the efficacy of psychotherapy: the typical therapy patient, after therapy, is better off than 75 percent of untreated individuals. Volumes II, III, and IV of the Report of the President's Commission on Mental Health add additional support to this conclusion.

Another one of the questions generally raised regarding the coverage of psychotherapy is whether or not mental health is "insurable." It has been argued that if mental health benefits were available they would be inappropriately over utilized, that utilization rates would be unpredictable, and that costs would be excessive. Despite these oft-stated fears, there is virtually no data to support such a negative value. There is a growing mass of evidence to the contrary (Cummings, 1977; Goldensohn, 1972; Spiro, Crocetti, and Siassi, 1975). Rates of the utilization of mental health services tend to be stable and low. Dörken (1977) found outpatient mental health utilization rates averaging less than 2 percent in a ten-state analysis of CHAMPUS claims, and this rate was stable in three separate years. The utilization rate of such benefits under the Federal Employees Health Benefits Plans operated by Blue Cross-Blue Shield has consistently averaged under 3 percent (NIMH, 1976). The length of treatment by outpatient psychotherapy has repeatedly averaged between 6 to 12 sessions, and it has been demonstrated many times that 80 percent of all psychotherapy patients successfully complete their treatment in twenty or less sessions (Dörken, 1977; Meltzoff & Kornreich, 1970). The HMO studies I will discuss next also support the insurability of mental health benefits.

Research on the inclusion of mental health benefits within HMOs has been particularly exciting. These studies have gone beyond simply demonstrating that psychotherapy works and illustrating the well-known utilization rates/length of treatment data. HMO studies have focused on the "offset" or cost savings of including mental health coverage. Cost offset studies have tended to be conducted in HMOs because this is one of the few settings in which researchers can ethically (and readily) have access to all of the data needed for this type of analysis. Goldberg, Krantz, & Locke (1970) assessed the impact of short-term outpatient mental health coverage on the utilization of general medical services at the Group Health Association of Washington, D.C. (GHA) and found a resulting 30 percent reduction in the use of the general health services. Similar data has been reported from

HMOs in New York (Fink, 1969), Oregon (Uris, 1974), and Maryland, Wisconsin, and Massachusetts (Regier, 1977).

Cummings & Follette (1967, 1968, 1976) report on twenty years of research at Kaiser-Permanente on the impact of psychological services on general medical utilization. They report that emotionally distressed individuals (not necessarily "psychiatricly" diagnosed), are high utilizers of general health services. They found significant declines in medical utilization when such patients received psychological services, as compared to a control group of similarly distressed persons who did not receive such services. These decreases remained constant during the five years after the termination of psychotherapy, and additional psychotherapy was not required to maintain this lower level of utilization. The National Institute of Mental Health recently reviewed twenty studies on the impact of mental health treatment on medical care expenditures and found that nineteen of the twenty studies found a reduction in medical utilization after mental health intervention. The only supposedly negative study involved subjects from a medically underserved minority population. Reductions in medical utilization for the 19 studies ranged from 11% to 85%, averaging over forty percent.

High-quality and systematic research on the mental health/health "offset" has apparently not been done by insurance companies, or, if such studies have been conducted, the data has not been widely available. One exception to this is a report conducted by Blue Cross of Western Pennsylvania (Jameson, Shuman, & Young, 1976). The study was undertaken when they were adding mental health benefits. Examining the claims of patients who utilized psychological services, they found that total costs to the insurer were lowered. Comparing a 21-month time span prior to involvement with the mental health services to a 26-month time span after such contact, they found that the total cost (both physical and mental health) per patient per month decreased over 30%.

Psychological treatment is effective and cost-efficient in treating problems other than simply mental health, drug, and alcohol problems. Behavioral psychologists are increasingly treating problems previously thought of as general medical problems. Kellner (1975), a physician, reviewed the published studies of psychotherapeutic intervention with such conditions as bronchial asthma, peptic ulcers, and migraine headaches and concluded that such treatment was effective. And, I would note, often at a rate far less expensive than medical intervention. Olbrisch (1977) in reviewing the empirical data relating psychological intervention with physical health and costs concluded that psychological intervention does influence physical health and that crisis intervention techniques can help patients cope with specific stressors. One area in which psychological intervention is proving increasingly useful is in the emotional preparation of patients for surgery. Patients receiving such psychological preparation have fewer complications, shorter post-surgical stays, better recovery rates, and lower insurance expenditures.

In recent survey for the Washington Business Group on Health, Goldbeck (1977) found that 78 of 79 polled corporations included mental health coverage within their health care benefits. Their reasons for providing such coverage noteworthy: (a) lowered employee absenteeism, (b) improved employee productivity, (c) fewer instances of severe mental illness requiring sick leave/sick leave benefits, (d) reduced hospital utilization, and (e) possibilities of lower total insurance premiums.

Attention should be given to the multiple ways in which savings can be realized by employers and insurance companies when mental health services are available, particularly outpatient services. Not only can the personal/emotional lives of employees and/or their families be improved, physical health be improved, and expenditures by insurance companies lowered, but employers can reduce absenteeism and improve production. The Kennecott Copper Corporation developed a system of innovative industry-initiated service delivery. Their program is called "Insight." It includes an innovative mix of early detection, confidentiality, and consumer choice. Anyone can contact the 24-hour Insight office to get immediate service or to report a problem affecting an employee. The anonymity of the caller as well as of the person referred is guarenteed. If the referred person accepts services from the program, help is given; if he or she declines, the program politely backs off. The often conflicting needs for consumer choice/confidentiality and early detection are preserved by these policies and procedural decisions. Several of their health services research studies have been reported. They found that involvement in the program reduced medical/surgical costs by 55 percent, improved employee work attendance by 52 percent, and reduced corporation costs related to the absenteeism of these employees by 74.6 percent (Jones, 1973).

Similar experiences have been reported in a variety of areas and industries. The Oldsmobile Division of GM located in Lansing, Michigan obtained a 52 percent

reduction in lost manhours and a 33 percent reduction in sickness and accident benefits through and active employer-initiated referral system (Alander & Campbell, 1975). Reductions in hospitalization ranging from 46 percent to 73 percent were obtained with naval personnel (Edwards, 1977). Improved job performance and decreased sickness and accident disability payments are realized from such an active program on the part of the Illinois Bell Telephone system employees (Hilker, undated).

Contrary to the usual assumptions that adding providers adds costs, the inclusion of psychologists as providers of mental health services lowers costs. There are many reasons why this is the case. Even today in private practice, psychologists still charge fees somewhat less than psychiatrists. Most importantly, psychologists generally practice differently than psychiatrists and these differences result in lesser costs. The primary differences lie in the fact that psychologists are less likely to utilize expensive hospitalization in their treatment plans, and psychologists are more likely to concentrate on real long term change in mental and behavioral processes rather than utilize methods which produce temporary effects (i.e., psychoactive medications). For example, Karon & Vanden-Bos (1972, 1975, 1976) found that even in the treatment of schizophrenics it was both more clinically effective and cost-effective to provide psychotherapy to such patients than to just provide "routine psychiatric treatment" (e.g., medication). Moreover, cost of treatment provided by psychologists were between 21 percent and 37 percent lower than the cost of the total treatment provided/ordered by psychiatrists, and at the same time patients of psychologists demonstrated greater clinical improvement than the patients of psychiatrists. Recently, McGuire (1978), a Boston University economist, argues that expanded recognition of psychologists would help to contain costs in the mental health field. In testimony before the Michigan House Mental Health Committee, a system analyst from a regional Health Systems Agency (HSA) presented data on the cost containment aspect of direct reimbursement of psychologists. Clifford (1978) projected a four million dollar state-wide savings resulting from unneeded, duplicative, and costly "formal" (but non-functional) supervision of psychologists by psychiatrists, and a 32 million dollar per year savings in reduced hospitalization because of the emphasis of psychologists on outpatient treatment.

Clearly, outpatient mental health benefits should be viewed in a different light than inpatient mental health treatment. If the incentive for employers, providers, and consumers is on active outpatient treatment and prevention, total health care expenditures are less and all parties benefit. It might be possible to offer discounts to employers who initiate effective referral programs which insure that emotional distress gets treated in inexpensive appropriate manners rather than as a costly somatization of that emotional distress.

To encourage such a cost-saving use of outpatient mental health benefits, the initial use of such benefits should be without deductibles and without copayments. After some initial period a progressively increasing copayment could be added to discourage those few cases of inappropriate overutilization. Such outpatient benefits should emphasize prevention, early detection, and an active treatment process involving dynamic and behavioral processes. Out patient services should be directly accessible (i.e. without requiring medical screening or referral).

I have tried to respond to some of the most frequently mentioned reasons for not including mental health benefits in health insurance packages. I would be pleased to respond to other issues or concerns which you and/or your colleagues might raise. There certainly is more data which can be cited."

We would like to mention, in addition to the above, the Colorado Study currently being conducted by the Senate Finance Committee, at the request of HEW, studying the independent reimbursement policies for psychologists.

In conclusion then, the training that a clinical psychologist receives clearly does prepare him or her to diagnose and treat the psychological problems inherent in long term, chronic, terminal illnesses. And as the literature cited above has demonstrated, services delivered by psychologists can be cost reducing, both on an inpatient and out patient basis. We, therefore, would greatly appreciate your considering the inclusion of psychologists as independent providers in S.B. 350.

Thank you kindly for your attention.

Sincerely,

JOHN A. GRIFFITH, PH. D.,
President, Hawaii Psychological Association.

BARBARA B. SLOGGETT, PH. D.,
Chairman Legislative Committee, Hawaii Psychological Association.

HAWAII MEDICAL SERVICE ASSOCIATION,
Honolulu, Hawaii, April 10, 1979.

Hon. SPARK M. MATSUNAGA,
U.S. Senate,
Washington, D.C.

DEAR SENATOR MATSUNAGA: Thank you for your letter of March 7th and for keeping me informed regarding the introduction of legislation on catastrophic health insurance, S.350.

This bill seems to contain few changes from Senator Long's 1977 bill, which we addressed in our letter to you of August 22, 1977 and our testimony at the HEW Regional Hearings on NHI in October 1977. Copies of these are attached for your reference.

Basically, our position remains the same. While we agree that this or some other form of catastrophic legislation will be of benefit to some individuals, most people today, especially the great majority in Hawaii, are presently covered by health insurance including some form of catastrophic coverage.

In Hawaii, virtually everyone is covered far in excess of 60 days of hospitalization and major medical expenses up to and well beyond $2,000.

For these people, a program covering only catastrophic illness will be of little value. For those individuals without health insurance or with limited health insurance, they are most likely to be unable to afford the deductible under a catastrophic program.

Another major concern regarding S.350 or any health insurance legislation is the need for strong controls over the cost and use of medical services. Without these controls, we can only expect expanded costs.

The possible effect of extending full financial coverage for services over 60 days and $2,000 would be to eliminate any restraint or incentive to hold down the cost or use of further services. An alternative might be to increase the threshold or to address only "out-of-pocket" costs beyond coverage provided by one's own health insurance.

Thank you for the opportunity to comment on this proposed legislation.

Sincerely yours,

ALBERT H. YUEN,
Executive Vice President.

HAWAII MEDICAL SERVICE ASSOCIATION,
Honolulu, Hawaii, August 22, 1977.

Hon. SPARK M. MATSUNAGA,
U.S. Senate,
Washington, D.C.

DEAR SENATOR MATSUNAGA: In response to your letter dated August 1, 1977, we would like to present for your consideration a general approach to the design of a health insurance program by addressing the four questions presented to you by Secretary of HEW, Mr. Joseph A. Califano, Jr. A program of this magnitude will require the resolution of many detailed problems and, certainly, we will not attempt to address every question that has been raised on this subject.

1. How broadly should coverage extend?

Coverage should essentially extend to all U.S. residents, grouped into four categories for the purpose of NHI legislation. The four groups are:

(a) *The employed and self-employed—*

Coverage for the employed and self-employed should be provided by mandatory employment related health insurance. A similar program is in operation in Hawaii and has resulted in nearly universal coverage for workers without need of government financing or involvement other than in the role of monitoring. The program should provide a level of employer contribution which assures that the program is not a financial hardship on employees.

(b) *The left employed,* individuals temporarily between jobs—

Individuals temporarily out of work should be covered for a limited period of time by automatic extention of coverage by their former employer. This would assure continuous coverage by individuals when they are between jobs.

(c) *The long-term unemployed and categorical needy,* individuals receiving Federal/State aid including Unemployment Insurance—

This group consisting of long-term unemployed and the present categorically needy groups under Medicaid should be included under one program. Premium contributions by these individuals will by necessity be limited and in no case should their premium contribution be any greater than would be required of an employed individual. For most of these individuals full financial participation by a government unit will be required.

(d) *Individuals not in the job market,* individuals not eligible under any of the first three groups:

This last group encompasses those unemployed individuals not considered part of the labor market or eligible for Medicaid categorical aid, as presently defined, for reasons such as excess home value, but are nevertheless in need of health insurance. A new category would be created for the purposes of health insurance aid with the individual's premium contribution limited or eliminated based on the individual's circumstances.

2. What type of health care should it cover?

Provision should be made for a mandatory minimum basic level of medical, surgical and hospital benefits including coverage of catastrophic illness. Emphasis should be on coverage for ambulatory and outpatient care; outpatient psychiatric treatment; preventive health measures such as immunizations; and full maternal and child care benefits. Expansion of benefits would come in increments and would eventually include such things as health appraisals, drug, dental and vision benefits. By encouraging early detection and treatment of illness, we can avoid long, costly hospital stays brought on by ignoring problems until they reach the crisis stage. We believe that the low hospital utilization experience in Hawaii demonstrates the effectiveness of such a program.

We are aware that many have advocated the beginning step of enactment of a Catastrophic Health Insurance program. While we can appreciate this point of view, we believe that such an approach will have limited effectiveness. Those individuals presently covered by health insurance, which is the great majority of people, are not in need of a program covering only catastrophic illness. Those individuals presently without health insurance or with limited health insurance are those most likely not to be able to afford the deductible under a catastrophic illness program. There is also the possibility that a deductible catastrophic program will become like the problem of low-threshold, no-fault auto insurance. In low-threshold, no-fault or deductible catastrophic insurance the patient is encouraged to escalate his medical bills in order to receive any benefit. We propose a program that would discourage over-utilization and encourage the use of the most economical mode of treatment.

Health Education programs in the schools and throughout the community as well as patient education programs, should also be introduced through accompanying legislation under companion bills.

3. How can it be administered more efficiently?

The program should be a joint effort between the federal and state government and the private health plan sector.

The federal government would basically set performance standards for private health plan carriers to meet. It should also establish guidelines for a mandatory minimum basic package of benefits, and encourage innovation and a degree of competition among private health care plans. The state government would approve all health care carriers and benefit programs available in their state. They would also monitor the programs for compliance.

Programs for the employed and nonemployed categories would be administered by existing or future qualified, federal or state approved private carriers. Carriers approved under the NHI program would operate on a nonprofit or limited profit basis only.

4. How can high quality care be assured at a reasonable cost?

Controls should include a limit on allowable costs to health care providers through prospective payment and negotiated fees; the publication and dissemination to the public of fees charged by individual doctors and hospital charges; appropriate, mandatory co-insurance provisions (rather than front end deductibles) to keep patients aware of their responsibility to use benefits wisely; the encouragement of alternate forms of health care delivery such as HMO's and use of paraprofessional personnel; strong and effective licensing of providers; rational planning and strict "certificate of need" laws to maximize the use of existing facilities and properly allocate community resources in the future.

Strong controls on the use of services and facilities should include thorough claims review, analysis of physician treatment patterns and patient utilization

review systems within hospitals and extended care facilities. The presently emerging PSRO's may accomplish this expanded role or complement the activities of health insurers.

National Health Insurance could be phased in with a minimum of effort and cost to the taxpayer and make full and proper use of the existing private health insurance sector. This would allow for timely future development and adjustments and provide the American people with an immediate adequate and effective level of health protection.

We sincerely appreciate this opportunity to provide you with our views and ideas regarding the design and implementation of a National Health Insurance program. We have also received a request for our views on this subject from Senator Daniel Inouye's office and have provided him with this information.

If we could be of any further service to you, please let us know.

Sincerely yours,

A. H. YUEN,
Executive Vice President.

STATEMENT TO THE HEW REGIONAL HEARINGS ON NATIONAL HEALTH INSURANCE BY MR. MARVIN B. HALL, SENIOR VICE PRESIDENT, Hawaii Medical Service Association

My name is Marvin B. Hall and I am Senior Vice President for the Hawaii Medical Service Association. The Hawaii Medical Service Association, known in Hawaii as HMSA, is a member-owned community service organization providing health care protection to almost 500,000 members in Hawaii. HMSA also acts as the government's fiscal agent in the administration of Medicare, Medicaid and CHAMPUS programs in Hawaii serving an additional 200,000 people. HMSA thus serves three out of every four people in Hawaii through the administration of comprehensive health care benefit programs.

We appreciate this opportunity to provide you with our views and ideas regarding the design and implementation of a national health insurance program. A program of this magnitude will require the resolution of many detailed problems and certainly we cannot attempt to address all the questions that must ultimately be resolved. However, we would like to present for your consideration a general approach to the design of such a program.

Most of our comments are based on methods that are presently being used effectively in Hawaii by the major health care contractors working within the framework of Hawaii's Prepaid Health Care Act.

CONCEPT

HMSA supports the concept of a joint effort between the private health plan sector and the state and federal government.

The fact that private health plans presently cover as large a percentage of the population as they do, estimated to be 90 percent of the eligible market, is conclusive proof that health plans are able to perform and are accepted by the public.

Here in Hawaii, the majority of our population has had financial access to a very high level of quality medical care for many years. This has been due mainly to the availability of very comprehensive and reasonably priced third party benefit programs.

With the enactment in 1974 of the Hawaii Prepaid Health Care Act, Hawaii became the first state to mandate a comprehensive prepaid health care program for its employed residents. This resulted in over 95 percent of Hawaii's population being protected by comprehensive and catastrophic health care coverage through private health plans or existing government programs. The remaining uncovered population, while not easily identifiable, has access to health care coverage through available private or government programs.

The major private health plans in Hawaii, competitively covering about 75 percent of the people of Hawaii, have been successful in holding down the cost of health care. On HMSA's part, the design of our benefit programs, strongly supported by an aggressive cost control program has resulted in a broad, statewide health care program at a cost substantially lower than comparable programs on the mainland. And this has been accomplished in a state with the second highest cost of living in the nation.

HMSA's fee-for-service programs emphasize early diagnosis and prompt treatment on an outpatient (ambulatory) basis, requiring less hospitalization and considerably reducing costs. This program has reduced the annual level of inpatient hospitalization for HMSA's members to 390 days per 1,000 members against a national average of approximately 900 days per 1,000 persons. This low rate is equal to the level of

hospitalization experienced by HMSA's own Health Maintenance Organization and other HMO's across the country and represents major cost savings.

The federal government, we believe, should establish guidelines for a mandatory minimum basic package of benefits, set performance standards for private health plan carriers to meet, and encourage innovation and increased competition among private health care plans. Recent studies, supported by FTC hearings, have shown that a highly competitive environment promotes efficiency among private health plans resulting in lower costs.

The state government should approve all health care carriers and benefit programs available in their state. They should also monitor the programs for compliance.

Publicly funded programs for the nonemployed categories would be administered by federal or state approved private carriers.

Under this approach, additional costly government administration would be minimized and immediate and full use made of the existing private health insurance system which is presently meeting the needs of most Americans.

COVERAGE

Coverage should essentially extend to all U. S. residents, grouped into four categories for the purpose of NHI legislation. The four groups are:

(a) The employed and self-employed

Coverage for the employed and self-employed and their families should be provided by mandatory employment related health insurance. A similar program is in operation in Hawaii and has resulted in coverage for almost all workers without need of government financing or involvement other than in the role of monitoring. A minimum level of employer contribution should be established which assures that the program is not a financial hardship on employees.

(b) The left employed—individuals temporarily between jobs

Individuals temporarily out of work should be covered for a limited period of time by automatic extention of their health plan coverage by their former employer. This would assure continuous coverage by individuals when they are between jobs.

(c) The long-term unemployed and categorical needy individuals receiving Federal/ State aid including Unemployment Insurance

This group, consisting of long-term unemployed and the present categorically needy groups under Medicaid, should be included under one program. Premium contributions by these individuals will by necessity be limited and in no case should their premium contribution be any greater than would be required of an employed individual. For most of these individuals full financial participation by the government will be required.

(d) Individuals not in the job market, individuals not eligible under any of the first three groups

This last group encompasses those unemployed individuals not considered part of the labor market or eligible for Medicaid categorical aid, for reasons such as excess home value, but are nevertheless in need of health insurance. A new category needs to be created for these individuals with their premium contribution limited or eliminated based on the individual's circumstances.

Those persons eligible for Medicare would continue their present coverage with a benefit level equal to or better than any minimum program enacted under NHI.

BENEFIT STRUCTURE

Provision should be made for a mandatory minimum basic level of medical, surgical and hospital benefits including coverage of catastrophic illness.

We are aware that many have advocated as a beginning step the enactment of a Catastrophic Health Insurance program. While we can appreciate this point of view, we believe that such an approach will have limited effectiveness. Those individuals presently covered by health insurance, which is the great majority of people, are not in need of a program covering only catastrophic illness. Those individuals presently without health insurance or with limited health insurance are those most likely not to be able to afford the deductible under a catastrophic illness program. There is also the possibility that a catastrophic program will become like the problem of low-threshold, no-fault auto insurance in which the patient is encouraged to escalate his medical bills in order to receive the benefits. We propose a program that would discourage over-utilization and encourage the use of the most economical mode of treatment.

To accomplish this, special emphasis should be placed on covering outpatient and ambulatory benefits: in the doctor's office; in skilled nursing facilities, intermediate care facilities; home health care; outpatient psychiatric care; minor surgery done in doctors' offices, clinics or special ambulatory (outpatient) surgical units attached to hospitals; lab and x-ray testing done outside the hospital; outpatient prescription drug coverage and outpatient treatment for alcohol and drug abuse. All these outpatient benefits should be covered under NHI's basic benefit structure.

The benefit package should also recognize the value of preventive health measures such as proper immunization programs for the whole population; patient education programs; and health education programs in the schools and throughout the community. They should be incorporated into the basic benefit structure or introduced through accompanying legislation under companion bills.

Prevention of disease and illness and proper health maintenance is potentially more cost effective than increasing expenditures on curative treatment. The basic benefit package should reflect this fact.

The benefit structure should make selective and appropriate use of co-insurance provisions. Mandatory co-insurance provisions should be established at levels which do not financially hinder persons from seeking immediate and necessary medical treatment. Levels set too high could indirectly cause an increase in the cost of eventually needed health care. At the same time, they should be sufficient to discourage unnecessary or excessive use of benefits and keep the public aware and more directly involved in the cost of health care.

The state government should be able to require, at its discretion, a level of benefits above the minimum required by the federal government. In no instance however, would benefits offered under the NHI program in a state be less than the federally-established minimum package.

FINANCING

Hawaii's own successful statewide Prepaid Health Care Act is financed primarily on a premium cost sharing basis between employers and employees. This has eliminated the need for the State to become involved in any major financing of the program. A national program can, with some modification, be financed in a similar manner to cover most Americans.

The employer could be mandated by federal legislation to pay an appropriate portion of the cost of health insurance for both the employee and his/her dependents, with the employee paying the remainder. Health insurance itself would be bought from competing, approved private carriers offering only health plans approved by the State government and which fall within federal guidelines.

A person leaving a job, for whatever reason, would continue to be covered under his prior employment health program. After a period, persons who have left employement would have the opportunity to voluntarily continue their health coverage, sharing the premium cost with the federal government. The individual's portion of the cost would depend on his income level but would never exceed that portion required of an employed person.

The long-term unemployed would be covered by the federal government from general tax revenues on a mandatory cost sharing basis depending on their income level. Many of these people would be receiving some form of federal/state aid (including Unemployment Compensation) or would be on Medicaid or Medicare depending on their status, income level and age. Eventually, Medicaid and Medicare could be integrated into the NHI program.

Finally, people outside of the job market but not covered by Medicare, Medicaid or other government aid programs would be given the opportunity to participate on a cost-sharing basis with the federal government in the same manner as those persons who have left employment and are temporarily between jobs.

COST CONTROL AND REIMBURSEMENT OF PROVIDERS

Controls should include a limit on allowable costs to health care providers through prospective payment and negotiated fees; appropriate, mandatory co-insurance provisions (rather than front end deductibles) to keep patients aware of their responsibility to use benefits wisely; the encouragement of alternate forms of health care delivery such as HMO's and use of paraprofessional personnel; strong and effective licensing of providers; and rational planning and strict "certificate of need" laws to maximize the use of existing facilities and properly allocate community resources in the future.

Strong controls on the use of services and facilities should include thorough claims review, analysis of treatment patterns and patient utilization review systems.

The presently emerging PSRO's may accomplish this expanded role or complement the activities of health insurers.

QUALITY CONTROL

To be effective, an NHI program should encourage and reinforce efforts to improve the quality of health care. Methods, and systems to enforce them, need to be established in the areas of (a) physician performance, (b) hospital/institutional performance and (c) health carrier performance.

Professional Standards Review Organization (PSRO) efforts could be expanded and intensified to include all medical services, including physician services for private as well as government program patients.

Strong utilization review systems need to be established within hospitals, skilled nursing facilities and other institutions to review the appropriateness of hospital admissions, length of stay and level of care received by patients. Proper, rational use of institutional facilities and services is an integral part of quality control and should be monitored by federal or state agencies or approved intermediaries.

Before a health carrier itself could be approved to operate within the National Health Insurance system, it would have to meet specific state/federal performance standards covering operating efficiency, claims service, and fiscal integrity.

HEALTH DELIVERY AND RESOURCES

The traditional health care delivery system, and still the most common today, is the fee-for-service system. Individuals go to any physician or medical facility for service and the health insurance carrier pays all or a percentage of the fee of the doctor or hospital rendering treatment to the covered patient.

Most of HMSA's members are covered under this system. HMSA has proven that a properly designed fee-for-service program, coupled with an emphasis on ambulatory care and early treatment as well as a strong committment to cost control, can effectively reduce the need for expensive hospitalization, control health care costs, and compete favorably with any type of health delivery system.

We believe that both the traditional fee-for-service system and the newer HMO type systems should be included under any National Health Insurance legislation and competition encouraged between them. The consumer of health care could then choose the system best suited to his particular needs. As the health care delivery system is improved through competition and innovation, better use can be made of existing and future resources.

Health planning also needs to be strengthened and improved at all levels—community, state and federal. Health planning is a demanding, professional function solidly based on expressed community needs. Individual and local community ideas—often conflicting or competing with ideas and suggestions from other groups in the state—must be sifted and weighed, and compromises struck. This requires a planning body that is sensitive to local needs but objective in analyzing them and setting statewide priorities. An effective, workable state health plan must ultimately reflect the wishes of the majority translated into financial and administrative goals which are attainable.

Given continually limited financial resources, a strong State Certificate of Need Law is imperative to prevent costly, unneeded duplication of hospital beds, facilities and services. Waste and misuse of health facilities and services caused by poor planning is a luxury we can no longer afford.

Effective planning at the state level provides, in turn, the proper basis for an effective national health delivery system.

ADMINISTRATION

Administrative functions under any future National Health Insurance legislation should be shared between the state government, the federal government and approved health insurance carriers.

Approved health insurance carriers would continue to offer to the public various benefit programs including both fee-for-service and HMO-type programs. Any benefit program offered under the NHI program would meet specific minimum government standards. Carriers involved in the NHI program would also have to be approved by the government.

The administration of the Hawaii Prepaid Health Care Act is a joint effort of the state government and private health carriers. The State sets health benefit standards and approved private health carriers administer the program. The total cost to the State has been minimal, yet the people of Hawaii have the most comprehensive, effective and affordable mandatory health program in the nation.

CLOSING REMARKS

In closing, we believe National Health Insurance could be phased in with a minimum of effort and cost to the taxpayer by making full and proper use of the existing private health insurance sector. This would allow for timely future development and adjustments and provide the American people with an immediate, adequate and effective level of health care protection.

In the final analysis, however, an improvement in the health of our citizens requires solutions outside of medical care. Good health depends on more than money, or medical technology, or the kind of health delivery system we choose. National Health Insurance alone will not solve our health care problems for good health ultimately rests on sensible, healthy lifestyles.

Thank you.

THE CHAMBER OF COMMERCE OF HAWAII,
Honolulu, Hawaii, April 6, 1979.

Hon. SPARK MATSUNAGA,
U.S. Senate,
Washington, D.C.

DEAR SPARKY: In response to your request for an opinion on S.350, the Catastrophic Health Insurance and Medical Assistance Act of 1979, we are pleased to enclose a policy statement approved by our Executive Committee at its meeting of April 5, 1979.

If we can be of further assistance to you in this area, please do not hesitate to contact us.

Sincerely,

ROBERT B. ROBINSON,
President.

THE CATASTROPHIC HEALTH INSURANCE AND MEDICAL ASSISTANCE ACT OF 1979

The Chamber of Commerce of Hawaii commends the U.S. Senate Finance Committee for its investigation into the potentials for more widespread protection of all Americans from catastrophic health care and medical costs. The debate on whether or not the Federal Government can provide comprehensive national health insurance is likely to continue for several years. In our opinion, the cost for such a comprehensive program and the administrative problems it would entail are so great that its adoption would require a major shift in the application of our national resources. It is highly unlikely that Congress will soon reach a decision on comprehensive health insurance, especially in current economic circumstances.

In the meantime, the most common and distressing aspect of the impact of current health care and medical costs on the American public is that brought about by catastrophic, long-term health emergencies which can impoverish all but the wealthiest of families. Protection from such occurrences, while of prime concern to individuals, could also provide substantial public benefit through a reduction in its long-term liabilities for dependent citizens. Further, elimination of all but well-defined catastrophic risks should greatly reduce the cost and administrative difficulties of such a program.

The Chamber is not prepared at this time to comment on specific provisions in S. 350, S. 760, S. 748, or such other proposals of similar intent which may come before the committee, but we wish to express our opinion that the committee is directing its attention in a most appropriate area. While we believe that the fully private system in effect in Hawaii has demonstrated its own success, we recognize that some form of national program is desirable.

[Mailgram]

HAWAII MEDICAL ASSOCIATION,
Honolulu, Hawaii, April 11, 1979.

Senator SPARK MATSUNAGA,
Russell Senate Office Building,
Washington D.C.

DEAR SPARKY: Continuing dialogue is in process and letter will follow in reply to your correspondence of March 7. HMA can not support S.350. The needs for catastrophic coverage can be met by private insurance industry through appropriate structuring. Coverage of all citizens irrespective of need is wasteful and inappropri-

ate. Financing through payroll means more Federal bureaucracy. S. 350 intends major private insurance alternatives to catastrophic public program but with rigid criteria in the bill. Carriers may have difficulty unless more options and flexibility are provided. Title II medical assistance program has worthy elements, specifically copayment and an extension to medically needy not covered by welfare and current medicaid. Disagree on federalization of the medicaid program beyond local input and control. Thank you for inviting us to comment.

Sincerely,

GEORGE GOTO, M.D., *President.*

HUMAN RESOURCES DEVELOPMENT CENTER, INC.,
Honolulu, Hawaii.

Hon. SPARK MATSUNAGA,
Senator, Hawaii,
U.S. Senate, Washington, D.C.

DEAR SENATOR MATSUNAGA: Thank you for your letter of March 7, 1979 concerning S. 350, the Catastrophic Health Insurance and Medical Assistance Act of 1979. I would like to ask your support for inclusion of psychologists as independent providers under this Act.

As you know, psychologists have been shown to provide quality patient care and reduced cost per patient when compared with psychiatric services (this was clearly demonstrated in the CHAMPUS Denver Colorado study recently completed). Consequently, it would be beneficial both in terms of treatment quality as well as cost effectiveness for psychologists to be independent providers.

I thank you for all your support in the past and hope that you will continue your support in the future.

Mahalo and aloha,

RICHARD P. KAPPENBERG, PH. D.

LICENSED PRACTICAL NURSES ASSOCIATION OF HAWAII, INC.,
Honolulu, Hawaii, March 31, 1979.

Hon. SPARK MATSUNAGA,
U.S. Senate,
Washington, D.C.

DEAR SENATOR MATSUNAGA: Thank you very much for your interest regarding the Hawaii Licensed Practical Nurses Association's position on S.350, Catastrophic Health Insurance.

We find the proposal generally to be inadequate in its scope and benefits. Our primary consideration is that it fails to differentiate between health care and medical care. Nurses, especially licensed practical nurses are uniquely qualified to deliver health care.

We also are distressed that the Catastrophic Health Insurance proposal does not call for any kind of preventive health care. We know that it is less costly to keep a patient well than it is to treat one when he is sick.

We also have serious concerns regarding the lack of nursing care as a prescribed benefit. We would hope to see the inclusion of nurses as providers of health care, and that nursing care be a direct benefit. We believe that the limitations on the limited nursing care included in the legislation are too severe and will only serve as a stop gap measure rather than reduce dependency for expensive health care.

Our concerns for specific utilization review procedures are enhanced by the bill's lack of review or standars for health providers.

I know your great concerns in the area of health care, and we in Hawaii know that we can count on you to seek legislation that will be both comprehensive and economical. We see that health care today must depend on all health care practitioners and providers, and not just physicians.

We fully realize the enormous cost of a program such as this, and the need for phasing in health insurance programs. But, we believe that it is in the best interests of the consumer to have such limited services available.

Aloha and best wishes.

Sincerely yours,

LOUISE F. SAMUEL.

THE RESEARCH CORPORATION OF THE UNIVERSITY OF HAWAII,
Honolulu, Hawaii, March 23, 1979.

Hon. SPARK M. MATSUNAGA,
U.S. Senator,
Honolulu, Hawaii

DEAR SPARKY: Thank you for sending me the document S. 350, the Catastrophic Health Insurance and Medical Assistance Act of 1979, with your letter of March 7, 1979.

I had just returned from a 2-week trip from Bangkok where I was a WHO consultant for the 8th WHO Meeting of Directors or Representatives of the Schools of Public Health of the Afro-Asian Regions. I have just been able to catch up on the work at the office before having a chance to read Senator Russell Long's proposal.

The Congressional Record statement presents a clear description of the proposal. S. 350 provides an immediate alternative to meeting some of the critical health care needs of the people of this nation. As Senator Long said, "It is time to stop talking about how serious injuries have all but wiped out lifetime savings and property by catastrophic illness." His proposal is to do something about this problem. I agree that his approach could be accomplished with less cost to the federal budget than a national health insurance. In addition, I believe that the States should be the governmental body to provide for the health needs of its people through a pluralistic approach as we do in Hawaii—involving the private and public sectors. When most of the States have as much insurance coverage in health for its people as we do in Hawaii, then we would be ready for a national health insurance scheme. Senator Long's proposal S. 350 provides immediate aid for extraordinary costs for health emergencies and I would support his proposal.

Thank you for sending me this material.

Sincerely,

RICHARD K. C. LEE, M.D.,
Executive Director.

MARCH 20, 1979.

Senator SPARKY MATSUNAGA,
U.S. Senate,
Washington, D.C.

DEAR SENATOR MATSUNAGA: Thank you very much for inviting me to comment on S. 350, the Catastrophic Health Insurance and Medical Assistance Act of 1979.

After 5 years, I am no longer Chairman of the Hawaii State Planning and Advisory Council on Developmental Disabilities. However, I am a very active member of the Council. I regret to have to tell you that the Hawaii Council has never taken an official position with respect to S. 350, or any National Health Insurance proposal. Needless to say, the Hawaii Council is interested in improving the general health of Hawaii's developmentally disabled citizens.

As you know, I am a parent of a severely retarded daughter (age 25) and am vitally interested in a health care delivery system that will render appropriate health care services to the developmentally disabled (or handicapped) persons. At the same time, I am very actively involved in the insurance business, of which a good share is health insurance. So, you can say, that I have interests on both sides of the so-called controversy—the sociological aspect and the fiscally-responsible, free-enterprise aspect. Obviously, there are many, many sound arguments for both sides of the controversy. And, obviously, there are many unsound and highly emotional arguments for both sides.

In my estimation, the position of the Health Insurance Association of America represents the most responsible position on National Health Insurance. Their positions, whether it be on basic hospital-surgical-medical or catastrophic health expenses, encompasses the sociological as well as free enterprise considerations. I wouldn't go so far as to say they have always had this posture, but I do believe that they have come to accept the sociological responsibilities within the last 2 or 3 years.

As an individual who has interests on both sides of this issue, I do hope that I have been able to shed some light on this issue.

Aloha,

LAMBERT K. WAI.