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STAFF DATA ON
**CATASTROPHIC HEALTH
INSURANCE**

COMMITTEE ON FINANCE
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RUSSELL B. LONG, *Chairman*



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(11)

CONTENTS

	<i>Page</i>
I. Introduction -----	1
II. Present Situation with Regard to Financing Catastrophic Illness -----	1
III. Description of Committee Approved Amendment-----	2
IV. Comparison with Administration Proposal-----	7
V. Staff Suggestions	
A. Suggested Amendments to 1970 Committee Bill--	9
B. Suggested Clarification of Report Language on 1970 Committee Bill-----	12

CATASTROPHIC HEALTH INSURANCE

1. Introduction

In 1970, the Committee approved by a 13 to 2 vote an amendment sponsored by Senator Long which would establish a Catastrophic Health Insurance Program. During the Senate floor action on H.R. 17550, this Catastrophic Insurance amendment was voluntarily laid aside by Senator Long as part of the attempt to get a stripped down Social Security bill to conference with the House.

In 1971, Senator Long re-introduced the Committee-approved amendment as S. 1376, and in announcing the public hearings on H.R. 1, he asked interested organizations to testify on the proposal.

This pamphlet contains a brief description of present catastrophic insurance coverage, a description of the Committee-approved Catastrophic Amendment, a comparison with the Administration proposal for catastrophic coverage and a series of staff suggestions.

II. Present Situation With Regard to Financing Catastrophic Illness

It is estimated that somewhat over 50 percent of the population under age 65 are covered for health care costs by major medical or comprehensive medical plans. These plans give some protection against the costs of catastrophic illnesses, but 60 percent of the major medical plans limit lifetime benefits to \$15,000 per person; and 70 percent of the comprehensive medical plans limit lifetime benefits to \$20,000. Some plans offer higher lifetime maximum benefits of up to \$150,000 per person.

This type of coverage is quite expensive. Major medical plans typically cost about \$250 per person per year; comprehensive coverage typically costs about \$220 per year. These premiums are in addition to the cost of any basic health insurance coverage the person may have.

Comprehensive and major medical plans usually include high maximum benefits and coverage of a wide range of medical expenses, including inpatient hospital benefits, prescription drugs, physicians' care, and private duty nursing. Most plans have a deductible which ranges from \$50 to \$200 per person to eliminate small medical bills, with a coinsurance feature to encourage the judicious use of medical care.

Most plans have some limitations on coverage relating to mental illness, maternity benefits, and injuries due to accidents. Other restrictions may limit the maximum number of hospital days covered; establish payment limits for ancillary medical services and surgeries; and limit the coverage of nursing home care.

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

III. Description of Committee Approved Amendment

The 1970 Committee amendment would have established a Catastrophic Health Insurance Program (CHIP). The program was intended to complement private health insurance which would continue to insure against basic health expenses. In addition, the program would be structured to take maximum advantage of the experience gained under medicare, using medicare's established administrative mechanisms wherever possible, and incorporating all of medicare's cost and utilization controls.

Eligibility

The amendment would establish a new Catastrophic Health Insurance Program (CHIP) as part of the Social Security Act financed by payroll contributions from employees, employers and the self-employed. All persons under age 65 who are fully or currently insured under the social security program, as well as their spouses and dependent children would be eligible for CHIP protection. All persons under age 65 who are entitled to retirement, survivors, or disability benefits under social security as well as their spouses and dependent children would also be eligible for CHIP. This eligible population constitutes about 95 percent of all persons under age 65.

Persons age 65 or older would not be covered as they are protected under medicare which is a program with a benefit structure generally adequate to meet the significant health care needs of all but a small minority of aged beneficiaries. The largest noncovered groups under age 65 are Federal employees, employees covered by the Railroad Retirement Act, and State and local governmental employees who while potentially eligible for social security are not covered due to the lack of an agreement with the State. (There are a small number of people who are still not covered by social security or other retirement programs; the majority of these are domestic or agricultural workers who have not met the necessary social security coverage requirements.)

Federal employees are, however, eligible for both basic and major medical catastrophic health insurance protection under the Federal Employees Health Benefits Act, with the Federal Government paying 40 percent of the costs of such coverage. To assure equitable treatment of those Federal employees who also are eligible for social security, a provision of the proposal would require the Federal Employees Health Benefits program to make available to Federal employees who have sufficient social security coverage to be eligible under CHIP, a plan which supplements CHIP coverage (such as full or part-payment of deductibles and coinsurance or coverage of services, such as drugs, not otherwise covered under CHIP) : if such a plan is not made available to Federal employees, no CHIP payments would be available for services otherwise payable under the FEHB plan.

Buy-In for State and Local Employees

State and local employees who are not covered by social security could receive coverage under CHIP if the State and local governments exercised an option to buy into the program for coverage on a group basis. When purchasing this protection, States would ordinarily be

expected to include all employees and eligible annuitants under a single agreement with the Secretary. A determination by the State as to whether an individual is eligible for coverage as annuitant or member of a retirement system or otherwise eligible to have such coverage purchased on his behalf would, for purposes of the agreement to provide CHIP protection, be final and binding upon the Secretary. Each State which entered into an agreement with the Secretary of Health, Education, and Welfare to purchase CHIP protection would be required to reimburse the Federal Catastrophic Health Insurance Trust Fund for payments made from the fund for the services furnished to those persons covered under CHIP through the State's agreement with the Secretary, plus administrative expenses incurred by the Department of Health, Education, and Welfare in carrying out the agreement. Payments would be made from the fund to providers of services for covered services furnished to these persons on the same basis as for other persons entitled to benefits under CHIP. Conditions are also specified under which the Secretary or the State could, after due notice, terminate the agreement.

Benefits

The benefits that would be provided under CHIP would be the same as those currently provided under parts A and B of medicare, except that there would be no upper limitations on hospital days, extended care facility days, or home health visits. Present medicare coverage under part A includes 90 days of hospital care and 100 days of post-hospital extended care in a benefit period, plus an additional lifetime reserve of 60 hospital days; and 100 home health visits during the year following discharge from a hospital or extended care facility. Part B coverage includes physicians' services, 100 home health visits annually, outpatient physical therapy services, laboratory and X-ray services and other medical and health items and services such as durable medical equipment.

The major benefits excluded from medicare, and consequently excluded from this proposal, are nursing home care, prescription drugs, hearing aids, eyeglasses, false teeth and dental care. Medicare's limitations on inpatient care in psychiatric hospitals, which limit payment to active treatment subject to a 190 day lifetime maximum, and the program's annual limitation on outpatient services in connection with mental, psychoneurotic and personality disorders are also retained. An additional exclusion would be for items or services which the Secretary of Health, Education, and Welfare rules to be experimental in nature.

Deductibles and Coinsurance

In keeping with the intent to protect against health costs so severe that they usually have a catastrophic impact on a family's finances, a deductible of substantial size would be required. The proposal has two entirely separate deductibles which would parallel the inpatient hospital deductible under part A and the \$50 deductible under part B of medicare.

In order to receive both hospital and medical benefits, both deductibles must be met. If a person were to meet the hospital deductible alone, he would become eligible only for the hospital and extended care benefits. Similarly, if a family was to meet the medical deductible alone, it would become eligible only for the medical benefits. The separate deductibles are intended to enhance the mesh of the program with private insurance coverage.

Hospital Deductible and Coinsurance

There would be a hospital deductible of 60 days hospitalization per year per individual.

After an individual had been hospitalized for a total of 60 days in one year, he would become eligible for payments toward hospital expenses associated with continued hospitalization. The program would thus begin payment with the 61st day of his hospitalization in that year. Only those posthospital extended care services which he received subsequent to having met the 60-day deductible would be eligible for payment.

After the hospital deductible had been met, the program would pay hospitals substantially as they are presently paid under medicare, with the individual being responsible for a coinsurance amount equal to one-fourth of the medicare inpatient hospital deductible applicable at that time. The medicare hospital deductible is presently \$68 and is calculated on the basis of the prior year's average per diem hospital costs. Extended care services eligible for payment would be subject to a daily coinsurance amount equal to one-eighth of the medicare inpatient hospital deductible. (In 1972, the coinsurance amounts to \$17 a day for inpatient hospital services and \$8.50 a day for extended care services.) The coinsurance would rise yearly in proportion to any increase in hospital costs.

Medical Deductible and Coinsurance

There would be a supplemental medical deductible initially established at \$2,000 per year per family. The Secretary of Health, Education, and Welfare would, between July 1 and October 1 of each year (beginning in 1973), determine and announce the amount of the supplemental medical deductible for the following year.

The deductible would be the greater of \$2,000 or \$2,000 multiplied by the ratio of the physicians' services component of the Consumer Price Index for June of that year to the level of that component for December 1972. Thus, the deductible could rise yearly in proportion to any increase in the price of physicians' services.

After a family has incurred expenses of \$2,000 for physicians' bills, home health visits, physical therapy services, laboratory, and X-ray services and other covered medical and health services the family would become eligible for payment under the program toward these expenses. For purposes of determining the deductible, a family would be defined as a husband and wife and all minor and dependent children.

After the medical deductible had been met, the program would pay for 80 percent of eligible medical expenses, with the patient being responsible for coinsurance of 20 percent.

Deductible Carryover

As in part B of medicare, the plan would have a deductible carry-over feature—applicable to both the dollar deductible and the hospital-day deductible—under which expenses incurred (or hospital days used) but not reimbursed during the last calendar quarter of a year would also count toward the satisfaction of the deductibles for the ensuing year. For example, an individual admitted to a hospital with a cardiac condition on December 10, 1974, and continuously hospitalized through February 19, 1975, would not, in the absence of the carry-over provision, meet the hospital-day deductible unless he were to be hospitalized for at least another 10 days in 1975. With a carryover provision, however, the individual described above would meet the hospital deductible on February 8, 1975. Similarly, if a family's first eligible medical expenses in 1974 amount to \$1,200 and were incurred during the months of November and December, and an additional \$3,000 in eligible medical expenses are incurred in 1975, the family would, in the absence of a carryover provision, be eligible for payment towards only \$1,000 of their expenses in 1975. With a carryover provision, however, the family described above would be eligible for payment toward \$2,200 of their expenses in 1975.

Administration

Payments made to patients, providers, and practitioners under this program would be subject to the same reimbursement, quality, health and safety standards, and utilization controls as exist in the medicare program. Reimbursement controls would include the payment of audited "reasonable costs" to participating institutions and agencies, and "reasonable charges" to practitioners and other suppliers. However, it is expected that appropriate modifications would be made to take into account the special features of this program, including a modification to exclude "bad debts" from those costs eligible in computing reasonable cost payments to institutions.

Utilization of services would be subject to review by present utilization review committees established in hospitals and extended care facilities and by the professional standards review organizations which the committee has approved. All of the above controls would be applied to reimbursement of expenses for services rendered under the proposed catastrophic illness insurance program. In addition, the Inspector General for Health Administration (an office established under another amendment which the committee has approved), would be expected to closely monitor the administration of the program and would be expected to provide information and recommendations with respect to increasing the efficiency of the program.

The proposal contemplates using the same administrative mechanisms presently used for medicare including, where appropriate, medicare's carriers and intermediaries. Using the same administrative mechanisms as medicare should facilitate the operation of this program. The proposal also would encompass use of medicare's quality standards, in that the same conditions of participation which apply to institutions participating in medicare would apply to those institutions participating in CHIP. These standards serve to assure the

quality of medical care and their application under this program should have a salutary effect.

The Social Security Administration, utilizing its network of district offices, would determine the insured status of individuals and relationships within families which are necessary to establish entitlement to CHIP benefits. The determination of whether the deductible expenses had been met would also be handled by the Social Security Administration in cooperation with carriers and intermediaries. The proposed administrative plan envisions establishing a \$2,000 minimum expense amount before individual bills would be accepted. This would protect the administrative agencies from being inundated with paperwork.

Financing

The first year's cost of the program is estimated at \$3.1 billion on an incurred basis. The 1970 amendment would have been financed initially on a \$9,000 wage base with the following contribution schedule: 1972-74, 0.3 of one percent of taxable payroll on employees and 0.3 on employers; 1975-79, 0.35; 1980 and after, 0.4. Rates for the self-employed would also be 0.3, 0.35, and 0.4 respectively.

The contributions would be placed in a separate Federal Catastrophic Health Insurance Trust Fund from which benefits and administrative expenses related to this program would be paid. The complete separation of catastrophic health insurance financing and benefit payments is intended to assure that the catastrophic health insurance program will in no way impinge upon the financial soundness of the retirement, survivors, or disability insurance trust funds or medicare's hospital and supplementary medical insurance trust funds. Such separation would also help to focus public and congressional attention closely on the cost and the adequacy of the financing of the program.

To establish an operating fund at the beginning of the program (in recognition of the lag in time between the date on which the taxes are payable and their collection), and to establish a contingency reserve, a Government appropriation would be available (on a repayable basis without interest) during the first 3 calendar years of the program. The amount which could be drawn in any calendar year could not exceed the estimated amount of 6 months of benefit payments during that year.

Relationship With Medicaid

The catastrophic illness insurance program would be supplemental to the medicaid program with regard to public assistance recipients and the medically indigent in the same way in which it would be supplemental to private insurance for other citizens. Thus, medicaid would continue to be the State-Federal program that is intended to cover the basic health needs of categorical assistance recipients and the medically indigent.

In addition, medicaid will continue to play a substantial role in financing the cost of nursing home care, which represents a catastrophic cost to many people, especially the aged. The catastrophic health insurance program would, of course, lessen the burden on the medicaid program to some degree, since those covered by medicaid who are eligible for catastrophic coverage would have a large propor-

tion of their catastrophic expenses covered by this program. This factor will not only help the States to contain the costs of their programs, but may also encourage them to improve coverage of basic services.

Persons Affected by the Program

According to HEW more than one million families of the approximately 49 million families in the United States annually incur medical expenses which would qualify them to receive benefits under the program. Of course, nearly all American families would receive the benefit of insurance protection against the costs of catastrophic illnesses.

These provisions and the taxes to pay for them would become effective January 1, 1974.

IV. Comparison With Administration Proposal

Senator Bennett has introduced the Administration's National Health Insurance Partnership Act—S. 1623. This is a broad program which would require health insurance coverage for all employed persons and their dependents through federally-mandated employer-employee private insurance packages meeting national health insurance standards established by the bill. Additionally, the program would provide certain medical care benefits to low-income families with children through establishment of a Federal Family Health Insurance program (FHIP).

The Administration's overall health insurance proposals contain a catastrophic insurance element, which is compared with the 1970 Committee-approved Catastrophic Insurance amendment below.

General Approach

1970 Committee Provision

A national program of catastrophic health insurance for people under 65, covered under Social Security, would be established. The program would be administered by Social Security and would supplement existing private health insurance. There would be no upper limit on covered benefits.

Administration Proposal

The required private health insurance coverage for employed persons and their dependents would include catastrophic coverage to a lifetime limit of not less than \$50,000 of total hospital and medical expenses per individual.

Eligibility

1970 Committee Provision

All persons under 65 fully or currently insured under Social Security, plus their spouses and dependents. "Buy-In" agreements for State and local governmental employees not covered by Social Security.

Administration Proposal

Employees and their dependents would be covered. Employees are defined as those who have worked 25 hours a week for 10 out of 13 weeks. Pre-existing condition may not be covered for up to 6 months upon a change of jobs.

Benefits

1970 Committee Provision

Same as currently provided under medicare parts A and B, without limitations on the number of hospital days, extended care facility days, or home health visits. Medicare benefits include:

- (1) Hospital care.
- (2) ECF care.
- (3) Home health service.
- (4) Physician service.
- (5) Laboratory and X-ray.
- (6) Physical therapy.

Benefits would be subject to following deductibles and coinsurance:

(1) Hospital deductible of 60 days hospitalization per year per individual, plus \$17 a day coinsurance after 60th day. Post hospital extended care services provided after the 60-day hospitalization would be covered subject to \$8.50 a day coinsurance after the hospital deductible was met.

(2) Supplemental medical deductible initially established at \$2,000 per year per family, with coinsurance of 20% of medical expenses exceeding the deductible.

Benefits not covered under medicare would be excluded, and would not count towards the deductible.

Administration Proposal

Minimum standards would be established for employer-employee policies. The policies must include:

- (1) In-patient hospital services.
- (2) Physicians' services (excluding psychiatrists).
- (3) Laboratory and X-ray services.

Policies would have to cover \$50,000 in lifetime benefit costs per individual. This \$50,000 is subject to a restoration of \$2,000 annually. As currently structured the Administration proposal does not have catastrophic type deductibles because it encompasses both basic and catastrophic health expenses. Presumably, if the Administration chose to mandate catastrophic coverage only, appropriate deductibles could be chosen. Co-insurance of 25 percent of benefit costs up to \$5,000 for each individual is required. After \$5,000 of expenses (of which the individual would be liable for \$1,250 and the program \$3,750 in a year) co-insurance charges above this limit would be waived for two years.

Benefits not listed above would be excluded.

Payments to Providers

1970 Committee Provision

Payments made to patients, providers and practitioners under this program would be subject to the same reimbursement controls as under medicare. Quality, health and safety standards and utilization controls used in the medicare program would apply also.

Administration Proposal

Payments for care would be subject to medicare limits on reasonable costs for institutions and reasonable charges for providers. Quality, health and safety standards and utilization controls used in the medicare program would apply also.

Administration

1970 Committee Provision

Administration of this program would be parallel to medicare, using Social Security, carriers and intermediaries.

Administration Proposal

Employer-employee health insurance policies would be administered and underwritten by private insurance companies.

Financing

1970 Committee Provision

Financed through payroll contributions from employees, employers, and self-employed (0.3% in 1972-74, 0.35% in 1975-79, 0.4% in 1980 and thereafter). Wage base would be \$9,000 initially, rising subsequently. Trust fund for Federal Catastrophic Health Insurance would be completely separate from other trust funds operating under Social Security programs.

Administration Proposal

Employer-employee health insurance plans would be financed by payments from both employer and employee. Employee contributions could be no higher than 35 percent of premium cost initially, and 25 percent after two and one-half years.

In the case of firms with less than 100 employees, there would be no ceiling on the employee contribution.

Cost Estimates

1970 Committee Provision

Latest HEW estimates—\$3.1 billion dollars.

Administration Proposal

Not available.

V. Staff Suggestions

A. SUGGESTED AMENDMENTS TO 1970 COMMITTEE BILL

Catastrophic and HMO's

Problem

The 1970 Committee provision did not specifically address the question of how the Catastrophic Program would deal with Health Maintenance Organizations. Existing HMO's often provide services beyond the catastrophic deductible, yet since they do not operate on a fee-for-service method, the normal system of reimbursing for catastrophic expenses would not be operative.

Proposal

The staff suggests authorizing the Secretary to make per capita payments to HMO's on behalf of enrollees who are eligible for catastrophic HMO coverage. The payments would reflect actual costs on a per capita basis of catastrophic benefits to beneficiaries in the HMO and the degree to which the HMO provides benefits above the catastrophic deductibles.

Kidney Dialysis and Transplantation

Discussion

The catastrophic proposal as presently structured would not cover a high proportion of the costs associated with kidney transplants or home kidney dialysis.

For a kidney transplant, a patient is usually hospitalized about 14 days and incurs covered medical expenses of about \$3,000. This patient would not trigger the hospital deductible, but would receive about \$1,000 (less coinsurance) from the catastrophic program for medical expenses.

For home dialysis, the patient incurs drug costs of about \$1,500, and incurs covered medical expenses of about \$3,500. This patient would receive about \$1,500 (less coinsurance) from the catastrophic program.

The costs of hospital based dialysis are much higher (about \$25,000), and the program would cover a substantial proportion of these costs.

The National Kidney Foundation advises that patients with kidney failure are commonly excluded from private insurance coverage, and would have to meet all deductibles out-of-pocket. Additionally, they point out that, as structured, the catastrophic program might result in patients choosing hospital-based dialysis (the most expensive form of treatment) since this treatment method causes less disruption to his family.

The Committee might want to consider dealing with kidney failure separately from other catastrophic illness in order to improve its coverage under the program; however, this would probably bring requests for similar treatment from groups representing those with other special illnesses.

Alternatively, the Committee might wish to deal generally with the two problems described of the National Kidney Foundation private insurance exclusions, and insuring the use of the most efficient treatment methods.

Private Insurance Exclusions

Problem

The 1970 Committee provision was based on the theory that people can obtain private insurance coverage for basic health expenses (the first 60 days of hospital care, and the first \$2,000 of medical expenses), and the catastrophic deductible was set accordingly. However, private insurance commonly excludes coverage of some medical conditions. For example, many private policies exclude coverage of kidney transplantation and dialysis. Consequently, patients in need of such treatments would be forced to make large out-of-pocket expenses to meet the deductible.

Possible solution

The Committee might authorize the Secretary to waive deductible requirements in whole or part, in cases where private insurance policies generally exclude coverage. For example, if private policies generally do not cover the first 60 days of care and the first \$2,000 associated with kidney transplantation or dialysis, the Secretary could waive or modify the deductible requirements in these cases.

The program would pay from the first day or the first dollar of expenses, or from the point where any private coverage stops. For example, if a person were able to obtain 30 days coverage under private insurance, the program would pay from the 31st day.

In the case of kidney disease the hospital deductible would be waived only for transplant procedures, and the medical deductible would be waived only for transplant or home dialysis. This feature would have the effect of encouraging the most efficient form of therapy and discouraging the very expensive hospital dialysis.

Specialized Treatment Centers

Problem

Highly complex, sophisticated and expensive medical and surgical treatment procedures are often of higher quality and less expensive if they are performed at centers which do such procedures in large volume. For example, the success rate is higher and the expense lower for kidney transplants performed at active transplant centers, than for transplants performed at community hospitals which might do one such procedure every few months.

The Catastrophic Program might encourage more small hospitals to begin performing such procedures, with a consequent increase in cost and decrease in quality.

Proposal

The staff suggests limiting reimbursement for highly complex and expensive surgical and medical treatment procedures, such as kidney transplantation and dialysis, to centers which meet appropriate requirements.

Among these should be a requirement for a minimal utilization rate for the procedure, and a requirement for medical review boards to screen the appropriateness of patients for the proposed treatment procedure.

Limitation on Co-insurance Payments

Problem

The Catastrophic Program has deductibles of 60 days hospital care and \$2,000 medical expenses. After those deductibles are met, the patient is responsible for the equivalent of 25 percent co-insurance on the hospital side, and 20 percent co-insurance on medical expenses.

For those patients with very expensive illnesses, this co-insurance could pose a very large burden. For example a patient with expenses of \$18,000 a year would meet a \$2,000 deductible and would still have to pay about \$4,000 in co-insurance.

Proposal

The staff would suggest putting a limitation on the beneficiary's liability for co-insurance payments. The Committee might choose to limit such payments to \$1,000, or 10 percent of the prior years adjusted gross income (including a spouse's income) whichever was greater. This limitation on coinsurance liability parallels the approach in the catastrophic aspect of the Administration's health insurance proposals. The added cost of this proposal would be \$150 million. However, since the coverage of the disabled under Medicare would save \$100 million under the CHIP program, no additional financing would be required.

Eligibility for People Over 65

Problem

The Catastrophic proposal in 1970 did not include persons over 65, on the grounds that they had coverage under Medicare which was generally adequate to meet the significant health care needs of all but a small minority of aged beneficiaries.

There would nonetheless be a number of people who would exhaust their Medicare benefits, and who would not be entitled to catastrophic benefits available to people below age 65.

Also, since the Committee has added the disabled to Medicare, there is now one group eligible for both Medicare and Catastrophic.

Proposal

The committee may want to consider covering Medicare eligibles under the Catastrophic program. The estimated cost would be \$800 million.

B. CLARIFICATION OF REPORT LANGUAGE ON 1970 COMMITTEE BILL

Problem

There are a few points relating to benefits available under the Catastrophic Program and items which count toward the deductible, which were explained in the Committee bill and report on the Catastrophic Health Insurance Program in 1970 through cross-reference to medicare practices, but which were not stated explicitly.

The 1970 bill and report clearly state that benefits under the Catastrophic program are the same as benefits under Parts A and B of medicare except that there would be no upper limits on hospital days, extended care facility days or home health visits.

Over the past year, a few questions have arisen as to whether or not certain items are covered under Part A or B of medicare.

Proposal

The staff suggests the addition of report language in the following area:

1. *Donor Costs Associated With Transplant Procedures.*—The report might indicate that the costs of a donor organ (including the cost of its removal but not compensation to a donor) should count toward the recipient's deductible or, where the deductible has been met, as a reimbursable cost to the donee. The donor's medical expense would not be reimbursable to the donor.

2. *Hemophiliacs.*—The report should state that the costs of obtaining and processing the "clotting factor" (a blood product administered on a regular basis to hemophiliacs), count toward the deductible and are a reimbursable benefit. The costs of the blood itself would not be covered.

3. *Insurance Premium.*—The report should state specifically that insurance premiums do not count toward the deductible, but that amounts paid out in benefits for an individual under insurance policies do count.

Counting premiums paid for insurance coverage and not counting benefits paid out under private policies might result in the anomaly of a well-insured individual receiving less value from the catastrophic plan than a self-insured individual, thus discouraging the sale of private insurance.

Reasonable Charges*Problem*

The catastrophic program would pay physicians "reasonable charges" as under medicare. Under medicare such charges are usually set by reference to a physician's "customary" charge, and to the "prevailing" charge in the community.

Instances may well arise under the Catastrophic Program where a new or expensive (more than \$2,000) treatment procedure may be developed for which no "customary" charge will exist as it is a new procedure and no "prevailing" charge will exist, since essentially all charges over \$2,000 will be covered by the program.

Proposal

The report should state that since the definition of "reasonable charge" under medicare is not limited to "customary" or "prevailing" charges. The Secretary would have authority to define "reasonable" charges in terms related to the reasonable costs of the treatment procedure and comparable charges for physicians' time and skills.

