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# ADDITIONAL HEALTH CARE BENEFITS

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COMMITTEE ON FINANCE
UNITED STATES SENATE
RUSSELL B. LONG, *Chairman*

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# ADDITIONAL HEALTH CARE BENEFITS

## A. Introduction

At its meeting on March 23, the Committee instructed the staff to develop further material relative to additional health care benefits which the Committee might consider with respect to H.R. 1. The Committee expressed specific interest in:

1. Shifting or reduction of the Part B premium.
2. Coverage of drugs under Medicare.
3. Catastrophic health insurance.

### BACKGROUND—ACTION ALREADY TAKEN BY COMMITTEE

#### Major Changes in Part A Hospital Plan

The principal action taken by the Committee, thus far, in broadening Medicare, was its approval of extension of coverage to 1,500,000 disabled persons.

H.R. 1 also contains a number of provisions relating to the benefit structure under Part A of Medicare. One amendment would require hospital copayments by beneficiaries between the 31st and 60th days of hospitalization. Another would increase the number of lifetime reserve days under Medicare from the present 60 days to 120 days. The costs of the increased copayment are estimated to offset the costs of the increased lifetime reserve days. In considering the increased copayment provision, the Committee decided to delete the House amendment and retain present law, on the basis that the additional copayments would hit those aged with prolonged hospitalization, who can least afford increased out-of-pocket costs.

In a subsequent action on March 23, the Committee decided against an increase in lifetime reserve days and in favor of reducing the 50 percent copayment on present lifetime reserve days to 25 percent. The net effect of the Committee's actions with respect to hospital copayments and lifetime reserve days thus far is an additional cost of about $90 million over present law.

The Committee also approved a liberalization of the definition of eligibility for care in an extended care facility. Instead of the present requirement that the patient be in continuous need of skilled nursing service, the Committee defined eligibility as a regular daily need for skilled nursing and/or rehabilitative services which, as a practical matter, can only be provided in that institutional setting. Estimated cost of the improvement is $65 million.

#### Major Part B Changes

Part B of Medicare is currently financed 50 percent from general revenues and 50 percent from premiums paid by the elderly who choose to enroll. The total cost of Part B in fiscal 1973 is estimated at $2.8

billion with $1.4 billion coming from general revenues and $1.4 billion from Part B premium payments. The costs of Part B in 1974 are estimated at $3.9 billion due to increasing costs and the inclusion of the disabled under Medicare. (The present monthly premium payment of $5.60 is scheduled to increase to $5.80 on July 1.)

The Administration has recommended changing the financing of Part B. Specifically, they recommend funding the total cost through the Part A payroll tax. In other words, Part B would be paid for with 50 percent employer and 50 percent employee taxes rather than the present 50 percent general revenues and 50 percent premium financing.

In H.R. 1 the House did make some major changes in the financing of Part B. The rate of any annual increase in the Part B premium for older people was limited to not more than the percentage by which Social Security cash benefits increased during the prior 12-month period. In addition, the House increased the Part B deductible from $50 to $60. The Finance Committee approved the limitation on any increase in the Part B premium. However, the Committee chose to leave the Part B deductible at $50. Increasing the Part B deductible (as the House bill proposed) would have shifted $95 million of additional expenses to the elderly.

In summary, with respect to Part B, the Committee has neither increased nor decreased the beneficiary's liability under present law, although it has voted to limit the rate of any future premium increases to the elderly.

## B. Shifting of Part B Premium to Payroll Tax

In fiscal 1973 older people will pay a total of $1.4 billion in Part B premiums. Each enrollee will pay $5.80 monthly, with the Government matching an equal amount. Medicaid now pays such premiums for the indigent and many of the medically-indigent elderly. If the Part B premium were to be eliminated now, the aged would save $1.4 billion and the Government would have to assume additional costs of $1.4 billion initially. The Administration has proposed to fund this new expenditure out of the Part A payroll tax and to shift the current general revenue expenditure to the Part A payroll tax also effective with fiscal 1974.

As mentioned, the total costs of Part B in 1974 are estimated at $3.9 billion due to increased costs and the addition of the disabled to Medicare.

### STAFF RECOMMENDATION

The Part B premium is a budgetable amount for older people which serves to enhance cost consciousness with respect to use of medical services. States presently "buy-in" to Part B in behalf of indigent older people; thus, the premium does not represent a burden to poor older people.

If the Committee desired to relieve older people of almost $2 billion of medical care costs, starting in fiscal 1974, it might want to consider providing that relief in the area of non-budgetable costs rather than budgetable items such as the Part B premium.

For example, alternatives could include making older people eligible for catastrophic health insurance and/or authorizing Medicare coverage (under Part A) of a specific range of prescribed drugs utilized in the treatment of chronic and prolonged illness.

## C. Coverage of Drugs Under Medicare

The estimated costs of covering drugs under Medicare range widely according to the extent of coverage and the administrative mechanism which might be selected. Costs can be reduced by use of copayments, deductibles and/or restricting the benefit to certain maintenance drugs.

Two general approaches are currently before the Committee. The Montoya amendment covers all drugs with a $1 copayment per prescription. The costs of this proposal are estimated by H.E.W. at $2.6 billion. Alternatively, coverage of all such drugs with a $1 copayment and a $50 deductible would lower the cost of the Montoya proposal to $1.7 billion annually.

The other broad approach is to provide coverage for drugs generally utilized in treating chronic conditions. This approach would relieve the most serious drug costs problem, i.e., those elderly who need to take drugs continually for a chronic condition and, therefore, have high expenditures. This approach is embodied in the Hartke amendment which would cover maintenance drugs with a $1 copayment. The costs of this proposal have been estimated at over $1 billion annually.

The cost of that proposal could be reduced by restricting the list of covered drugs.

Drugs coverage could be financed through either Part A or Part B. If coverage were financed through Part B, it would be paid for through general revenues and premium contributions. If funded through Part A, it would be financed through employer-employee payroll tax contributions.

### AMENDMENT NO. 464 (MONTOYA)

Amendment No. 464 would expand the present scope of benefits authorized under Part A of Medicare to include reimbursement to participating licensed pharmacies for most outpatient prescriptions and other pharmaceutical services provided to beneficiaries. Reimbursement would be made to such vendors for "qualified" prescription drugs and for certain non-prescription drugs determined to have a special life-sustaining value.

The amendment establishes within H.E.W. a Formulary Committee which would be responsible for preparing, maintaining and disseminating a Formulary of the United States. Only drugs included in this Formulary would be deemed to be "qualified" for purposes of reimbursement under the Medicare program. The Committee would be composed of nine persons, the majority of whom are physicians. Two of the members would be officials of the Department, while the remaining seven would include persons of recognized professional standing and distinction in the fields of medicine, pharmacology and pharmacy.

The amendment entitles a beneficiary to have paid on his behalf the costs of qualified drugs listed in the Formulary and supplied to him by a participating pharmacy. A $1 copayment would be charged the beneficiary for each qualified prescription dispensed. Participating pharmacies, in turn, would be reimbursed by Medicare for the drugs and the services rendered.

Pharmacies would be reimbursed on the basis of a "maximum allowable cost", less an amount equal to the copayments collected by the vendor for each qualified drug. In the case of a qualified prescription drug, maximum allowable cost would mean the lesser of (1) an amount determined by the Formulary Committee plus a reasonable fee; or (2) the actual, usual or customary charge at which the dispenser sells or offers the drug to the public. In the case of a nonprescription drug, the maximum allowable cost would mean those charges which do not exceed the usual or customary price at which the dispenser offers or sells the product plus a reasonable billing allowance. In determining the maximum allowable cost for prescription drugs, the Committee would take into account the various prices at which such drugs are sold to dispensers, including the amounts for the lowest or lower cost drugs that have been determined to be of proper quality and which are generally available. Each participating pharmacy would file with an intermediary or other agency designated by the Secretary to administer the benefit a fee to cover the costs of professional service, a fair profit, and other costs reasonably related to the provision of services to beneficiaries. The program would recognize, for purposes of reimbursement, all except the top 10 percent of the fees so filed. A fee above the 90th percentile of all fees filed would be reduced to the amount at the 90th percentile. The Secretary could require the filing of information to justify recognition of any fees falling between the 50th and the 90th percentile or in any case where there occurs a high volume of prescriptions dispensed by a participating pharmacy.

### AMENDMENT NO. 893 (HARTKE)

Amendment No. 893 would expand the present scope of benefits authorized under Part A of Medicare to include reimbursement to a provider of drugs for certain outpatient prescription pharmaceutical services provided to insured beneficiaries. Reimbursement would be made to such providers only for drugs listed by the Secretary as those for which payment can be made under Medicare.

The amendment establishes an Expert Committee on Drug Coverage to advise the Secretary regarding which drugs should be included on the Secretary's list for purposes of Medicare reimbursement. The list would include only those drugs determined by the Secretary, with the advice of the Expert Committee, to be useful in the treatment of diabetes, high blood pressure, or cardiovascular, respiratory or kidney diseases or conditions. The Expert Committee would consist of five members, not in the employ of the Government, who are outstanding in the fields of pharmacology geriatrics and other branches of medicine.

The amendment entitles a beneficiary to have paid on his behalf the costs of drugs appearing on the Secretary's list and supplied to him by a provider of drugs. A $2 copayment would be charged the beneficiary for the first time any particular prescription is filled and $1 each time the prescription is refilled. Participating providers of drugs would be reimbursed on the basis of the "reasonable" charges for listed or covered drugs, less an amount equal to the copayments collected by the provider for such drugs.

The "reasonable charge" for a covered drug would equal an acquisition allowance plus a dispensing allowance The Secretary would

establish the method or methods for determining the acquisition allowance, giving consideration to the cost to providers for acquiring the drug by its established name. The Secretary would also establish methods for determining dispensing allowances for covered drugs, giving consideration to such factors as overhead, costs of professional services and a fair profit.

### STAFF ALTERNATIVE

If the Committee believes it beneficial to include some type of drugs coverage under Medicare, a restricted approach would be to limit coverage to specified drugs which are necessary for the treatment of the most common, crippling or life-threatening chronic diseases of the elderly.

This approach would have three advantages:

1. It would result in the Medicare dollar being targeted toward patients with chronic conditions who need drugs on a continuing basis over a lengthy period of time;
2. It would substantially simplify administration of a drugs benefit, including the opportunity for effective control at relatively low administrative cost;
3. It would substantially lower the cost of providing a drugs benefit.

The approach outlined essentially draws upon elements of both the Montoya and Hartke proposals currently before the Committee. The benefit would be financed through the Part A payroll tax, as are the Montoya and Hartke proposals and would require a co-payment as in both proposals. It would utilize formulary and reimbursement mechanisms similar to that contained in the Montoya approach. It would take from the Hartke approach the concept of focusing on maintenance drugs for chronic conditions.

The Hartke approach would cover drugs necessary for the treatment of diabetes, high blood pressure, chronic cardiovascular disease, chronic kidney disease and chronic respiratory disease. The staff suggests the addition of arthritis, gout, rheumatism, cancer, glaucoma, tuberculosis, and thyroid disease to this list of chronic conditions.

These chronic conditions have not been arbitrarily chosen. Table No. 1 lists the most common, chronic conditions of the elderly in order of the number of prescriptions related to the condition. The staff approach would cover the most serious and most common chronic conditions amenable to long-term drug treatment with the exception of mental and nervous conditions and gastrointestinal disorders. These latter diagnoses are excepted because the drugs used in their treatment (tranquilizers, antidepressants, antacids, antispasmodics and antidirraheals) are drugs which are used by many people for general reasons and are, therefore, difficult to control (for example, they could be acquired for use by non-beneficiaries); as opposed to drugs such as insulin or digitalis which are used only by those who have a specific need for them.

The staff proposal, however, would further limit reimbursement to certain drugs used in the treatment of these conditions. In other words, people with chronic heart disease often use digitalis drugs to strengthen their heartbeat, anticoagulant drugs to reduce the danger of blood clots and drugs to lower their blood pressure. These types of drugs

would be covered under the suggested approach as they are necessary in the treatment of the heart condition and they are not types of drugs which would be used by people without heart conditions.

Other drugs which might be used by those with chronic heart conditions (such as sedatives, tranquilizers and vitamins) would not be covered as they are drugs which are generally less expensive, less critical in treatment and much more difficult to handle administratively, as many patients without chronic heart disease may also utilize these types of medications.

The staff recommendation is designed to establish a basis for coverage of drugs capable of administration at reasonable cost. In this form and scope it is an approach capable of providing significant help and of orderly future expansion if that were later decided.

In summary, the staff drug alternative is as follows:

**Eligibility**

Medicare beneficiaries (including disabled and buy-in) with one or more of the following conditions:

—Diabetes
—High blood pressure
—Chronic cardiovascular disease
—Chronic respiratory disease
—Chronic kidney disease
—Arthritis, gout, and rheumatism
—Tuberculosis
—Glaucoma
—Thyroid disease
—Cancer

**Benefits**

Would include those drugs generally:

—Necessary over a prolonged period of time for treatment of the above conditions;
—Generally subject to use only by those with the above conditions.

This recommendation would exclude drugs not requiring a physician's prescription (except for insulin), drugs such as antibiotics which are generally used only for a short period of time, and drugs such as tranquilizers and sedatives which may be used by eligible beneficiaries but also by many other persons.

An illustrative list of the covered drugs is the following:

| *Therapeutic Category:* | *Drug Entity* |
|---|---|
| Adrenocorticoids | (e.g., Cortisone, Dexamethasone, Hydrocortisone, Prednisone) |
| Anti-arrhythmics | (e.g., Quinidine) |
| Anti-coagulants | (e.g., Dicumarol) |
| Anti-hypertensives | (e.g., Reserpine) |
| Anti-neoplastics | (e.g., Cyclophosphamide, Fluorouracil, Mercaptopurine, Methotrexate, Vincristine) |
| Anti-rheumatics | (e.g., Phenylbutazone) |
| Bronchial dialators | (e.g., Isoproterenol) |
| Cardiotonics | (e.g., Digitoxin, Digoxin) |
| Coronary vasodialators | (e.g., Nitroglycerin) |
| Diuretics | (e.g., Hydrochorothiazide) |
| Gout suppressants | (e.g., Colchicine) |
| Hypoglycemics | (e.g., Insulin) |
| Miotics | (e.g., Pilocarpine) |
| Thyroid hormones | (e.g., Thyroid) |
| Tuberculostatics | (e.g., Aminosalicylate, Isoniazid) |

**Reimbursement and Cost Controls**

The proposal would utilize a reasonable charge reimbursement method, and would incorporate the formulary approach in the Montoya bill but limiting Formulary Committee membership to five instead of nine persons. The only Government member would be the Commissioner of Food and Drugs. Participating pharmacies would file either their usual and customary markups or professional fee schedules as of June 1, 1972 which would then be applied to the estimated acquisition cost of the drug product. The usual and customary charge, including mark-up or professional fee could not exceed the 75th percentile of charges by comparable vendors in an area for similar quantities of the dosage form of the drug. Outpatient drugs dispensed by a participating hospital or extended care facility would be reimbursed on the regular Part A costs basis. Increases in prevailing mark-ups or fees would be limited in a fashion essentially parallel to that applicable to physicians' fees.

**Financing**

— Part A Medicare payroll tax.

**Cost**

—$700 million with a $1.00 co-payment per prescription. There would be a reduction in Federal-State medicaid costs of $100 million as a result of this Medicare drug coverage.

## D. Catastrophic

Bluebook #6 contains an extensive discussion of the catastrophic proposal.

Two possible changes to the catastrophic proposal have been mentioned—expansion of the program to cover the aged, and inclusion of a drug benefit.

The Catastrophic Health Insurance proposal as approved by the Committee in 1970 has an overall cost of $3.2 billion. This program would cover persons under age 65.

If the Committee chose to include the aged under the Catastrophic Health Insurance proposal, it would add an estimated $900 million annually to the cost for a total of $4.1 billion. The actuary believes the $900 million additional cost of including the aged under the catastrophic program might be lowered by as much as $300 million if the amendment included specific administrative mechanisms and criteria for excluding coverage of in-hospital custodial care.

During the March 23 Executive Session, the Committee asked for the estimated cost of catastrophic if the program were to also include drugs coverage. Coverage of drugs for both deductible and benefit purposes under the catastrophic proposal would add $200 million to the proposal making the total cost of the catastrophic program $3.4 billion including drugs, for those under 65, and slightly over $4.3 billion if the program were to include the aged and a drug benefit.

## TABLE 1.—DESCENDING ORDER FOR NUMBER OF PRESCRIPTIONS USED IN TREATMENT OF ILLNESSES AMONG THE AGED

(Excluding mental conditions and gastro-intestinal disorders)

| Diagnosed conditions: | *Number of Rx's in thousands* |
|---|---|
| Heart | 46,512 |
| High blood pressure | 19,681 |
| Arthritis and rheumatism | 17,343 |
| Genito-urinary conditions | 9,127 |
| Diabetes | 8,085 |
| Colds, coughs, throat conditions, and influenza[1] | 7,504 |
| Other disorders of circulatory system | 4,776 |
| Chronic skin diseases[2] | 4,362 |
| Injuries and adverse reactions[1] | 4,000 |
| Neoplasm | 3,701 |
| Eye | 3,683 |
| Emphysema | 2,766 |
| Anemia and other blood conditions[2] | 2,581 |
| Asthma and hay fever | 2,547 |
| Other respiratory conditions | 2,415 |
| Sinus and bronchial conditions | 2,138 |
| Ear | 2,113 |
| Pneumonia | 1,531 |
| Thyroid | 1,491 |

[1] Not included in staff proposal because of generally short-term nature of condition and need for prescriptions.

[2] Not included in staff proposal because the drugs can be broadly utilized without assurances of control. For example, this includes, vitamins, liver extract, iron, skin ointments, etc.

TABLE 2.—PROPOSALS FOR ADDITIONAL HEALTH CARE BENEFITS

| Proposal [1] | Calendar year 1974 costs (millions) | Groups affected |
|---|---|---|
| 1. Combine financing of HI and SMI.[1] | $3,889 | Aged and disabled save $5.80 per month. |
| 2. Cover Rx drugs (similar to amendment 464, Montoya). | 2,620 | Aged and disabled pay $1 copay per Rx. |
| 3. Same as No. 2 with $50 deductible. | 1,710 | Aged and disabled pay deductible and copay. |
| 4. Cover long-term maintenance drugs. | 930 | Aged and disabled pay $2–$1 copay. |
| 5. Alternate proposal to cover specified maintenance drugs. | 700 | Aged and disabled pay $1 copay per Rx. |
| 6. Cover Rx drugs, except drugs of marginal necessity $2–$1 copay. | 2,130 | Aged and disabled. |
| 7. Catastrophic health insurance—1970 committee proposal. | 3,200 | All persons under age 65. |
| 8. Same as No. 7, plus aged.. | 4,100 | All ages. |
| 9. Same as No. 8, with drugs covered. | 4,300 | DO. |

[1] Except for proposal No. 1 (which would be effective, July 1, 1973) the proposed effective date would be Jan. 1, 1974. Costs for No. 1 include tentative committee decisions regarding Part B of Medicare and represent additional Hospital Insurance expenditures for costs otherwise met through Part B premiums and general revenues.