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Background Material on

Health Insurance

Descriptions of Bills Pending in Committee and the Administration Proposal

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Prepared by the Staff of the

COMMITTEE ON FINANCE
UNITED STATES SENATE

RUSSELL B. LONG, *Chairman*

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Introduction

National health insurance has received increasing attention in recent years. Major interest has been focused on proposals that would provide protection against health care costs associated with major illness or accident. Proposals covering catastrophic health costs recognize that most people now have health financing protection against the cost of the more usual episodes of illness but that a very expensive illness can cause the financial ruin of most families.

A second factor leading to interest in catastrophic insurance is the realization that comprehensive national health insurance (which should by definition include protection against catastrophic medical expenses) may not be enacted or affordable. A number of persons have advanced the view that in the interim the most pressing needs should be addressed, i.e., assurance of adequate catastrophic protection for the population perhaps coupled with improvements in existing programs for the aged (medicare) and the poor (medicaid). Opponents of this approach feel that enactment of a catastrophic bill alone would not provide adequate health insurance protection for the whole population (particularly for that portion which currently has no health insurance coverage at all) and in addition would delay enactment of a truly comprehensive program.

Definition of "Catastrophic"

Catastrophic medical costs are broadly defined as large unpredictable health care expenses. These are usually associated with a major illness or serious injury. Studies commonly employ two methods to determine whether an individual's expenses are catastrophic in nature. The first uses levels of absolute expenditures as a standard while the second defines expenditures as being "catastrophic" if they are large relative to an individual's income.

Large absolute expenditures, the traditional insurance definition of catastrophe, have been measured in various ways. The most common, the uniform expenditure definition, specifies a fixed expenditure within a stipulated period of time as the threshold for catastrophic cost, for example, $2,000, $5,000 or $10,000 per year. Another method (utilization of services) defines the threshold as a specified amount of service within a stipulated time period, for example, a specified number of hospital days per year. The utilization of services definition is normally used to refer to institutional care in hospitals or nursing homes. Certain specific diseases have also been presumed to entail certain catastrophic expenses. For example, the "Social Security Amendments of 1972" provided protection for persons suffering end-stage renal disease (kidney failure), a group of patients whose per capita medical expenditures average some $25,000 a year.

The second principal measure of catastrophic health expenses, which is used by some government programs, is income-related. In general

parlance, expenditures which exceed ten or fifteen percent of an individual's gross income are considered catastrophic. For the income-related definition, either actual out-of-pocket expenses or total incurred expenses (including those paid by insurance or other sources) are used. The Federal income tax law uses the out-of-pocket definition by permitting deductions for expenses that exceed three percent of gross income only if they are not otherwise reimbursed.

A variation of the income-related method uses the protected income concept. Under this approach, a base income level is considered necessary for daily living expenses, exclusive of medical care costs. Expenditures are considered catastrophic when they reduce income below this protected level. Some medicaid programs offer coverage to certain poor persons not otherwise program eligible (the "medically needy") when they incur medical expenses equal to the difference between their income and the protected standard (this is known as the medicaid "spenddown").

Incidence of Catastrophic Expenses

The number of persons expected to incur catastrophic medical expenses in a given year depends on whether the absolute expenditure or income-related definition of catastrophic is used. In January 1977, the Congressional Budget Office issued a paper, "Catastrophic Health Insurance", which outlined the scope of the problem under each definition.

Under the uniform expenditure definition (which is the most common measure of absolute expenditures), the CBO estimated that 7.0 million persons under age 65 would incur expenses in excess of $2,500 in fiscal year 1978; while 2.5 million nonaged persons would incur expenses in excess of $5,000 in the same period. While those incurring over $5,000 were estimated to account for only 1.3 percent of the nonaged population, their catastrophic expenses of $13.1 billion would account for over 15 percent of the total health expenditures for the nonaged.

Little information is available on the number of persons experiencing a catastrophe under the utilization of services definition (a variant of the absolute expenditure definition). The CBO did estimate that more than 90 percent of hospital stays would be less than 30 days (not necessarily a catastrophic limit) while only 11 percent of nursing home stays would end within this period. In fact almost three-quarters of nursing home stays would exceed 100 days. The CBO projected that for fiscal year 1978, persons hospitalized for at least 60 days would have estimated aggregate expenditures of $4.1 billion, while persons in nursing homes for at least 60 days would have aggregate expenditures of $17.7 billion. The principal population group experiencing extended stays, particularly in nursing homes, is the aged.

If the income-related definition were used to measure catastrophic expenses, a larger portion of the population would meet the criteria. The CBO estimated that 21.4 million families (or 28 percent of total families) would incur expenses exceeding 15 percent of family income in fiscal year 1978. However, ninety percent of these costs were expected to be paid by third-party sources (private insurance, public programs, philanthropy, and industry). If only out-of-pocket expenses were con-

sidered, an estimated 6.9 million families (or 9 percent of total families) were expected to have expenses exceeding 15 percent of family income. The burden would fall primarily on the low income with 2.3 million or 28 percent of those families with incomes under $5,000 incurring catastrophic expenses. This reflects both the lower absolute dollar figure which would trigger catastrophic expenses for this group and the better insurance coverage held by higher income families.

Principal Causes of Catastrophic Expenses

Under any of the measures of catastrophe, expenses associated with long-term care, particularly in nursing homes and similar institutions, are the most frequent causes of catastrophic expenses, particularly for the aged. Such expenditures are often not covered under private health insurance plans and only limited coverage is available under public programs. The CBO report estimated that by fiscal year 1978, 90 percent of all persons admitted to nursing homes would incur charges in excess of $5,000. For the non-aged population, the report estimated that two-thirds of catastrophic expenditures (defined as exceeding a $5,000 threshold per capita) would be related to stays in short-term general hospitals. When the income-related definition of catastrophe is used, the low income would be the most likely to incur high expenditures relative to family incomes even though these amounts are not generally high in absolute terms. For example, if 15 percent of income were used as a catastrophic threshold, a family with $4,000 in income and $600 in medical expenses would be considered as having catastrophic expenses.

Existing Coverage

Attempts to determine the number of persons with adequate protection against catastrophic medical expenses are difficult. While this is in part due to the lack of adequate data, the more important reason is that policies providing what could be viewed as strictly catastrophic coverage are rarely sold alone. Generally, any protection that is available for large unpredictable health expenditures is included as a part of or an adjunct to basic health insurance policies. Therefore, it is important to examine the major types of health insurance policies offered to determine those for whom catastrophic protection may be available. It should be noted both that the extent of coverage (and therefore catastrophic protection) varies between plans and that the protection offered may not precisely meet the generic descriptions of "catastrophic" discussed earlier.

Persons most likely to have some form of catastrophic expense protection are those full-time employees in the regular work force and their dependents. Many of these persons are covered under *major medical expense insurance policies* or *comprehensive major medical insurance policies*. These policies are distinguished as follows:

(1) *Major medical.*—This type of insurance is usually intended to supplement basic hospital or basic-hospital-surgical medical insurance programs. It is often referred to as a supplementary major medical policy. When written alone (i.e., without a plan providing basic coverage) such a policy may be referred to as a catastrophic policy. Major medical policies involve a large deductible (i.e., the amount of covered medical expenses that must be incurred by the insured before benefits

become payable). This type of plan usually specifies the fraction of the bill, up to the benefit limit (which is generally high), that will be paid by insurance (usually 80 percent). The insured is responsible for the remaining portion, know as the coinsurance amount (e.g., 20 percent).

(2) *Comprehensive major medical.*—This type of policy integrates basic coverage and major medical insurance in a single policy. It involves relatively low deductibles (e.g., $100) and high maximum payment limits. The insured is normally responsible for specified copayment amounts.

The two types of policies outlined above are often referred to by the single designation of major medical policies. They are generally considered to offer the best protection against catastrophic medical costs; however the degree of protection actually offered depends on the scope of covered services, out-of-pocket expenses which must be paid by the insured and the maximum benefit levels. Both types of major medical insurance are characterized by large benefit maximums ranging from $10,000 up $250,000 and in some cases an unlimited amount. The insurance, after the initial deductible has been met, generally reimburses the major part of all charges for hospital, doctor, medical appliances, prescribed out-of-hospital treatment, drugs and medicine. The insured person pays any required coinsurance amount. Some plans include a limit on the amount of coinsurance (e.g., $500) an individual must pay either per cause or per calendar year. After this limit is reached, the policy will pay 100 percent of covered expenses either for the remainder of the illness or injury or for the remainder of the calendar or policy year (and sometimes the next year also). Such payments cannot exceed the benefit maximums of the policy. Payments also may not be made for any items or services not covered under the terms of the policy (typical exclusions include long-term custodial care and some dental and mental health care).

The "Source Book of Health Insurance Data, 1977–1979," prepared by the Health Insurance Institute, estimated that a total of 93.2 million individual persons (91.3 million under age 65) had some type of major medical expense protection through private insurance companies in 1976. This included 88.5 million individuals (86.7 million under age 65) who had group policies. Further breakdowns of these figures involve some duplication since some people hold more than one policy. In 1976, 66.8 million persons (65.5 million non-aged) were protected under supplementary major medical group policies; 31.6 million (30.8 million non-aged) were protected under comprehensive major medical group policies; and 6.7 million (6.5 million non-aged) had major medical coverage under individual or family policies. Major medical expense protection policies were defined by the Institute as any policies with benefit maximums of at least $10,000. It could be argued that policies with benefit maximums at the lower end of the scale (i.e., near $10,000) do not provide truly catastrophic coverage. However, the trend appears to be toward larger benefit maximums. The Health Insurance Association of America (HIAA), in recent testimony before the Senate Finance Committee, noted that of new group policies sold in 1978, 88.5 percent contained benefit maximums of $100,000 or more.

In addition to those who have major medical insurance plans sold by private insurance companies, those individuals with high benefit

hospital expense plans, Blue Cross-Blue Shield plans and other plans also have protection against catastrophic costs. The Health Insurance Institute "Source Book" noted that when all of these types of plans were considered, an estimated 147.6 million persons (144.4 million persons under age 65) had coverage with maximum benefit levels of at least $10,000 and therefore were covered for catastrophic health expenses in 1976.

Estimates prepared by the Congressional Budget Office ("Catastrophic Health Insurance") projected that 103 million persons in 1978 would have "good" catastrophic protection through major medical plans, comprehensive major medical plans, and HMO's. While only 15.6 percent of those with family incomes below $5,000 were expected to have such coverage, 69.8 percent of those with family incomes of $30,000 or more would have such protection.

The CBO report noted that an estimated 37.5 million persons would have basic hospital insurance with no major medical coverage in fiscal year 1978. Of this group, 69 percent were estimated to have full service benefits (which provides full coverage for a specified number of hospital days) while 31 percent had indemnity coverage (which pays a fixed dollar amount per day regardless of cost). Persons with hospital service benefits are better protected against catastrophic hospital costs than those with indemnity coverage; however, neither group has adequate protection against all catastrophic health costs. In addition, the 19 million persons in families with incomes below $10,000 who have only individual private health insurance policies were generally considered to have poor protection against such costs.

(3) *Public programs.*—Public programs also provide some protection against catastrophic expenditures. The medicare program (which will cover an estimated 27 million aged and disabled in fiscal year 1980) provides good protection for basic health expenses but does not always adequately cover catastrophic costs. Less than one percent of the aged have hospital stays which exceed medicare limitations; however, for stays beyond 60 days, the beneficiary becomes liable for daily coinsurance payments. The program's coverage of other institutional services is less complete. Protection is available for 100 days of post-hospital skilled care in skilled nursing facilities. Thus, the primary catastrophic expense of the elderly—truly long-term institutional care—is not addressed by the program. As a whole, medicare only covers about 40 percent of the aged's health expenditures. However, the underlying basis of medicare and its financing is for a short-term acute care hospital program.

Roughly half of the aged have purchased supplemental private insurance protection (known as "Medi-gap" policies); typically, however, these policies only supplement the program's basic protection.

Many of the low-income elderly as well as certain other categories of poor persons (blind, disabled, and members of families with children) have health care protection under medicaid. While medicaid coverage varies considerably from State to State, a significant number of the estimated 23 million recipients have adequate catastrophic protection.

Public direct care programs, including the Veterans' Administration system, State long-term care institutions (psychiatric and chronic disease hospitals), and Federal hospital systems for Indians and

Alaskan Natives, are an important source of care for persons with catastrophic expenses who have insufficient resources to seek treatment in private facilities.

Uncovered Population

The preceding discussion has focused on those persons who have some form of protection against at least some health care costs. There are, however, a number of persons who have no health insurance protection of any kind either against basic hospital and medical expenses or against any catastrophic expenditures. This population is hard to identify and poses the greatest problems for those attempting to design a catastrophic health insurance program. Protection cannot generally be made available to them solely through an expansion or modification of existing insurance policies and public programs.

The Congressional Budget Office issued a paper in March 1979, "Profile of Health Care Coverage: The Haves and Have-Nots" which indicated that 11–18 million persons or an estimated 5–8 percent of the population would have no public or private health care coverage in 1978. Based on 1976 data, the report noted that over half of the uncovered population would be in families with incomes below $10,000. Many of these persons are not eligible for medicaid because they do not meet the program's categorical requirements (age, blindness, disability, or a member of a family with children) or their income is in excess of the State's standards. Many low-income individuals work for employers who do not offer group health insurance and such persons do not believe that they can afford individual policies. Approximately 20 percent of the uncovered are age 19–24 (though they represent only 11 percent of the population). The high number of uncovered in this age group is attributable to several factors including the fact that many insurance companies do not cover children over 18 unless they are in school, many are unemployed or in jobs which do not offer coverage, and many are generally healthy and not motivated to purchase insurance. The CBO report further noted that although less than 10 percent of the employed lack coverage, they account for over one-third of the uncovered population. Generally these persons work in industries characterized by relatively low wages, high proportions of part-time or self-employed workers, and large seasonal fluctuations in employment. Further, some of these individuals work in firms that have health insurance plans with long waiting periods before coverage is gible for continuation of benefits). The vast majority of the uncovered were without coverage in 1976; it anticipated that the percentage would be higher in periods when the aggregate employment rate was lower since fewer would be on temporary layoffs (and potentially eligible for continuation of benefits). The vast majority of the uncovered are family members rather than single persons. Over half of the uncovered not in the labor force are in a family with a covered head of household. Similarly, 50 percent of the uncovered unemployed are in a family with a covered head of household. In some instances the covered family member has not availed himself of the option of extending his insurance coverage to other family members, while in other instances, policy limitations prevent such extensions.

DESCRIPTIONS OF BILLS PENDING IN COMMITTEE AND THE ADMINISTRATION PROPOSAL

S. 350 (Long, Ribicoff, et al.)

The "Catastrophic Health Insurance and Medical Assistance Reform Act"

and

S. 351 (Long, Talmadge, et al.)

The "Catastrophic Health Insurance Act"

General Concept and Approach

Both bills would provide catastrophic health insurance protection, effective January 1, 1981, for all legal U.S. residents through (1) a federally administered public plan for the unemployed, welfare recipients, the aged, and persons who do not opt for private insurance coverage, or (2) a private catastrophic insurance plan allowed as an option for employers and the self-employed. S. 350 (but not S. 351) also provides, effective October 1, 1981, for establishment of a uniform national program of basic benefits for low-income persons and families. Both bills further provide for a voluntary Federal certification program for basic private health insurance to encourage private insurers to make basic coverage generally available to the public.

Catastrophic Health Insurance

COVERAGE

Under the Catastrophic Health Insurance Plan, every individual who is a resident citizen or a lawfully admitted resident alien would be entitled to catastrophic health insurance benefits under either the public plan or the private plan for employers and the self-employed. All employers, including Federal, State, and local governments, would be required to provide for all their full-time employees (who work more than 25 hours per week) and their employees' spouses and dependent family members the health insurance protection as specified in the bill. At their option, employers could also include part-time and temporary employees. An employer would be obligated to continue coverage for 90 days after an employee left his employment unless the employee obtained coverage under another employer plan. Federal, State, and local governments would be considered employers for purposes of the catastrophic program.

The unemployed, welfare recipients, the aged, and all others not covered under an employer or self-employed private catastrophic plan would be covered under the public plan.

BENEFIT STRUCTURE

The catastrophic plan would cover the same kinds of services as currently provided under Medicare, except that there would be no

upper limit on hospital days or home health visits. Benefits excluded from medicare would also be excluded under this program. Medicare's limitation on skilled nursing care would also be retained. The Catastrophic Plan would apply different limits on inpatient and outpatient mental health services from those currently applicable under Medicare (i.e., 190-day lifetime maximum in psychiatric hospitals, $250 maximum payable for outpatient mental health care); the catastrophic plan would cover (1) unlimited inpatient services, consisting of a course of active care and treatment provided in an accredited medical institution, (2) unlimited mental health care services provided on a partial hospitalization basis by an accredited medical institution or qualified community mental health center, (3) unlimited outpatient services provided by a qualified community mental health center, and (4) five visits to a privately practicing psychiatrist during any 12-month period, unless additional visits have been approved in advance by an appropriate professional review mechanism on the grounds that the patient would require institutional care in the absence of such additional outpatient visits.

The catastrophic health insurance program would provide institutional benefits only after an individual had first been hospitalized for a total of 60 days in one year (this feature of the program is called the "hospital deductible"), and medical benefits only after an individual or a family had incurred medical expenses of $2,000 for physicians' services, home health visits, physical therapy services, laboratory and x-ray, and other covered medical and health services (this "medical deductible" would be dynamic in character, adjusted annually to reflect changes in the Consumer Price Index and other economic factors). The plan would have a deductible carryover feature under which days spent in a hospital in the last three months of one calendar year could be counted toward satisfaction of the hospital deductible in the following calendar year; similarly, covered medical expenses incurred in the last three months of one calendar year could be counted toward meeting the $2,000 medical deductible for the next year. Once the hospital and medical deductibles had been met, the individual would not be charged for services covered under the program. However, following the first period of any 90 consecutive days during which the individual incurred less than $500 in medical expenses, catastrophic benefits would temporarily terminate until such time as the individual once again satisfied the medical deductible by incurring $2,000 in additional medical expenses. Similarly, 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.

ADMINISTRATION

The public Catastrophic Insurance Plan would be administered by the Social Security Administration in a manner parallel to the administration of Medicare. The private catastrophic plan would be administered by a qualified private insurance carrier of the employer's choice. The Secretary of HEW would be responsible for approving the employer plans and the self-employed plans administered through private carriers. To be approved as a carrier for private catastrophic

insurance, an insurance carrier would have to comply with various Federal requirements, including a requirement that the carrier establish claims determination procedures which comply with sec. 503 of the Employee Retirement Income Security Act of 1974 and are consistent with those procedures employed by the carrier in its noncatastrophic health insurance business; to assist carriers in meeting this requirement, the Secretary would allow carriers reasonable access to claims data developed under Medicare's hospital insurance program. Carriers would also be exempted from certain antitrust laws as they might otherwise pertain to a group of carriers entering into a pool, reinsurance, or other residual market arrangement.

FINANCING

The Catastrophic Insurance Plan would be financed through a one percent tax on the payroll of employers and the income of the self-employed now subject tothe social security tax. No employee contribution would be allowed. Amounts collected as taxes would be deposited in a Federal Catastrophic Health Insurance Trust Fund. An employer or self-employed individual who opted for a private, rather than public, catastrophic health insurance plan would have the amount of the premium for private coverage deducted from his one percent payroll tax liability; he would, however, remain liable for payment to the Federal Government of any difference between the amount paid as premiums for a private plan and the one percent Federal tax liability. Publicly-insured employers and self-employed individuals would be eligible for a catastrophic health insurance tax credit equal to 50 percent of the amount paid as payroll tax liability. Similarly, privately-insured employers and self-employed persons would also be eligible for a 50 percent tax credit on the amount paid for private catastrophic insurance premiums, as well as a 50 percent tax credit on any additional amount paid to meet the one percent Federal payroll tax liability.

Employers and self-employed persons opting for private coverage would pay premiums directly to the carriers. The bill requires that the employer plans administered through private carriers must make available to the employer certain arrangements for the pooling of risks among various employee groups of different employers, so that premiums can be determined on a class, rather than an individual, basis.

Each year, a five-member Federal Actuarial Committee would prepare a Table of Values of Catastrophic Health Insurance Coverage for the following year, indicating the actuarial value of one year's catastrophic health insurance coverage for one individual. This Table could be used by the employer as a guideline by which to evaluate the actuarial value of catastrophic health insurance coverage (and the premium charged therefor) offered through private carriers. The Committee would also review the marketing and rating practices of private carriers providing employer and self-employed plans for catastrophic insurance.

PAYMENTS TO/STANDARDS FOR PROVIDERS OF SERVICES

Providers of services under the Catastrophic Insurance Plan and the Medical Assistance Plan would be reimbursed on the same basis as

under Medicare. Reimbursement controls would include the payment of audited "reasonable costs" to participating institutions and agencies, and "reasonable charges" to practitioners and other suppliers. Payments to skilled nursing facilities and intermediate care facilities would be reimbursed on a "cost-related" basis.

Payments made under the Medical Assistance Plan, along with any required copayment from the patient, would have to be accepted by providers and practitioners as payment in full for the services rendered, and no persons accepting such payment could charge additional amounts for these services.

Both programs would apply the same standards for providers of services as under Medicare. Both plans would also incorporate the quality, health and safety standards, and utilization controls which exist in the Medicare program, including review of services by institutional utilization review committees and Professional Standards Review Organizations (PSROs).

RELATIONSHIP TO OTHER PROGRAMS

The Catastrophic Insurance Plan would supplement benefits provided under Medicare for persons covered by that program. The Catastrophic Insurance Plan would also be the primary payor in cases where an individual was also entitled to have payment made under either Medicare or, in the case of S. 350, the Medical Assistance Plan. Payments under the Catastrophic Plan, could not be denied or reduced because benefits for services covered under that plan were also payable or had been paid, under any other public or private insurance or health benefits plan.

Medical Assistance Plan for Low-Income People (S. 350 Only)

The medical assistance plan for low-income and medically indigent persons would be administered through the medicare program. It is designed to mesh with the catastrophic plan, as well as other public and private health plans. The program would be financed jointly from Federal and State general revenues.

COVERAGE

The benefits of the program would be available to citizens and aliens admitted for permanent residence whose annual family income is below the following amounts without regard to their age, family status, employment, or State of residence.

Individual	$3,000
Family of two	4,200
Family of three	4,800
Family of four	5,400
Family of more than four[1]	5,400

[1] Plus $400 for each additional member.

A family is defined as two or more persons related by blood, marriage, or adoption living in the same home.

The types of income counted for eligibility would include both earned and unearned income—including wages, self-employment in-

come, support and maintenance, annuities, pensions, veterans payments, workmen's compensation, social security, and unemployment insurance. Also included are rents, dividends, alimony and inheritances. Excluded from consideration are small gifts and certain funds received for educational purposes such as scholarships, loans, and fellowships.

By regulation, procedures may be established under which specified gross amounts of income from a trade, business, or farming may be considered sufficiently large to disqualify families even though their income technically falls within the limits. These procedures could be similar to those under the present supplemental security income (SSI) program for the aged, blind, and disabled.

In addition, families who meet all the requirements for eligibility under a State medicaid program at the time the assistance plan started would automatically be eligible under the plan if their income was within 105 percent of the States' income requirements for medicaid.

Spend-Down Provisions

Families with income higher than the specified amounts could still qualify for benefits under the "spend-down provision." Under this provision, the family's income for the purpose of eligibility is considered its actual income reduced by the amount of incurred medical expenses the family is legally obligated to pay out-of-pocket, that is, expenses not covered by a private or government plan. (Thus a family of four with annual income of $6,000 would qualify after they incurred out-of-pocket medical expenses of $600.) These medical expenses could be expenses actually paid or the reasonable charge for the services, if not yet paid. The types of medical expenses considered for computing the spend-down include a broad range of services including all the types of services covered under the proposal, and many not covered such as dental care, prescribed drugs, and eyeglasses. It would also include expenses for health insurance premiums and one-half of the taxes and/or premiums paid by a self-employed person under the catastrophic health insurance provisions. Eligibility under the spend-down provision may be determined on a prospective basis if the future income is determinable and a family member can be expected to need institutional care.

Determination of Eligibility

While eligibility is based on the family's annual income as indicated above, the determination of its annual income would be based on its rate of income in the 2-month period before the date of application for benefits and its estimated prospective income for the 2 months after application. Prospective income would be based on current income and other relvant factors.

When an application is approved, eligibility for benefits would usually start the first day of the month in which the application is filed, but eligibility could be extended backward for as many as 3 months before the month of application, if the family was qualified during this earlier period and incurred covered medical costs.

In most cases, an application would be filed to establish eligibility for a coverage year which would be the 12-month period beginning April 1st of each year. Once approved, eligibility would continue

throughout the coverage year unless family income increased to an amount more than 20 percent above the income limit for the family size. Also, a change in eligibility resulting from one member leaving the family would be disregarded during the coverage year.

If at the time eligibility for a family terminated, a member of the family was an inpatient in a hospital or a skilled or intermediate nursing facility, eligibility for that member would continue until he was discharged.

BENEFITS

The benefits of the program are listed below. There are no limits on the amount of services or any cost sharing required, except as indicated.

Institutional Services

Inpatient hospital services: 60 days in benefit period.
Skilled nursing facilities.
Intermediate care facilities.

Personal Services

Physicians' services: $3 copayment for each of first 10 outpatient visits per family.
Laboratory and X-ray.
Home health services.
Prenatal and well-baby care.
Family planning, counseling and supplies.
Periodic examinations: For children under age 18.
Outpatient physical therapy.
Immunizations: By regulation.

Other Services and Supplies

Medical supplies and appliances.
Ambulance services.

Services in an intermediate care facility would be available to patients who do not require services in a hospital or skilled nursing facility, but who have a physical or mental condition which requires care (in addition to room and board) available only through institutional facilities.

The types of mental health services covered under the medical assistance program would include the same services as under the catastrophic program (including inpatient hospital care, partial hospitalization, and out-patient services) subject to the same conditions and limitations, except of course for the deductible requirements. In addition, care for mentally retarded persons in public institutions would be covered if the patient is receiving active treatment; this coverage would be provided under the provisions applicable to intermediate care facilities.

The mental health benefits under medical assistance would also cover prescription drugs provided on an outpatient basis. (Outpatient drugs are otherwise not covered under the proposal.) The drugs must be prescribed by a physician who could be a physician in an approved mental health center or a private psychiatrist. In either case, the drug would be covered only if the physician determines that the patient can be expected to need institutional care unless he receives the prescribed drug. The covered drugs would be limited to those included on a list,

established by DHEW, which would indicate the mental condition for which it is effective and the appropriate dosage.

Copayment

The $3 copayment requirement would apply to persons under the medicare program only to the extent this amount is less than the regular cost sharing required under medicare. The $3 copayment would not apply to any physician visits for well-baby care, health examinations for children, or family planning services.

A special copayment requirement would also apply to individuals, who are not a member of a family, after the 60th continuous day spent in a long-term facility. The amount of this copayment would be equal to the amount of the patient's monthly income, less $50. (A similar requirement would apply in a situation where all members of a family have a stay exceeding 60 days.)

Other Benefits

For persons under the medicare program, the medical assistance program would pay the cost of the premium required to enroll in the supplementary medical insurance part of medicare. For self-employed persons subject to the tax on earnings under the catastrophic insurance provisions, the medical assistance program would pay one-half of the amount of these taxes and, for those self-employed electing a private plan, one-half of the combined total of the State actuarial value and any remaining taxes due.

RELATIONSHIP TO OTHER GOVERNMENT AND PRIVATE PROGRAMS

The present medicaid program would be abolished and replaced by the new program. The medicare program would continue.

The bill states its intent that the proposal not be construed to preclude States from providing protection for its residents against health costs, or individuals from obtaining (through collective bargaining or otherwise) protection against the cost of health services.

Payments under the medical assistance program would be secondary to all other government and private health programs and plans, including the proposed catastrophic program, medicare, and workmen's compensation programs. Thus, where a person has coverage under another public or private plan, the medical assistance plan would pay only for services or any cost sharing not covered by the other plan. However, the medical assistance program would pay for services for its eligible beneficiaries in any State which has established a State medical assistance program designed to supplement the Federal program by providing higher income limits for eligibility.

Under penalty of law, the bill prohibits employers, who provide group health insurance for their employees, to exclude an employee because he is potentially eligible for benefits under the medical assistance proposal.

In the event a person was eligible for enrollment in a health insurance plan (for example, an employment-related group plan) under which the enrollees' contribution was 25 percent or less of the total premium, but did not enroll, benefits payable under the medical assistance plan would be reduced by $250 in a benefit period. A similar reduction would apply to persons who fail to enroll in the supplementary medical insurance (SMI) part of medicare.

FINANCING

The program would be financed jointly by the Federal and State governments under an agreement between each State and the DHEW. Unless the State entered into this agreement, persons living in the State would not receive benefits under the proposed medical assistance or catastrophic programs.

The State contribution would be as follows: (1) an amount equal to the State's payments under the medicaid program for those types of services covered under the medical assistance proposal and (2) again, for services under the new medical assistance proposal, one-half the payments it would have made under medicaid if its eligibility requirements were the same as the medical assistance requirements (which of course would be applicable only to States with less liberal requirements). This formula would be based on the State's medicaid spending and eligibility requirements in the year before the new medical assistance program began (or 1 year earlier, whichever is larger). The State contributions determined under this formula would be a fixed amount payable each year and would not rise in future years. The amount of this fixed payment would be reduced, each year, by one-half the State's expenditures in the year for kinds of health services not covered by medical assistance, if those services had previously been covered under the State medicaid program and were of a kind eligible for Federal matching grants.

The balance of the cost of the proposed program would be financed from Federal general revenues. All funds would be held in a special medical coverage trust fund.

ADMINISTRATION

The medical assistance program would be administered in a manner similar to the medicare program and utilizing its administrative mechanisms. As under medicare, private carriers would act as fiscal intermediaries responsible for administration of claims and payments to providers of services. The bill includes a provision, relating to the medical assistance program, authorizing the consolidation of the activities of these carriers in areas with small populations if necessary to improve quality and efficiency.

As under medicare, State agencies would be responsible for determining whether providers of services meet the conditions for participation under the two proposed programs.

Persons eligible under the proposed medical assistance could enroll in a health maintenance organization and receive their services from these organizations, on a basis similar to that authorized for medicare beneficiaries under P.L. 92–603.

The Private Basic Health Insurance Certification Program

The stated purpose of the health insurance certification provisions is to encourage and facilitate the availability of basic health insurance at a reasonable premium charge. These provisions would (1) establish procedures for certification by the DHEW of private basic health insurance meeting specified requirements, (2) permit the marketing of this insurance through insurance pools and reinsurance and similar ar-

rangements, (3) encourage the States to establish facilitation programs to assist in marketing certified insurance, and (4) permit the DHEW to offer directly certified health insurance in States where it is not available.

REQUIREMENTS FOR CERTIFICATION

To qualify as a certified policy, a health insurance policy must meet specified requirements concerning coverage, benefits, premium rates, and other matters.

Coverage Requirements

Policies based on family status must be made available—for a single individual, a married couple, and a family—each at appropriate premium rates. A family policy must cover dependent unmarried children under age 22 and must automatically cover any newborn and newly adopted children. A policy covering an employment group must meet the following additional requirements:

(1) continue coverage for at least 31 days after the end of employment.
(2) offer employees leaving employment a reasonable opportunity to convert to, or otherwise obtain, certified nongroup coverage, and,
(3) provide an annual enrollment period to permit enrollment of employees who previously failed to elect coverage.

Benefit Requirements

A certified policy must cover at least the following services, but could include additional services and could reduce the cost sharing requirements.

(1) Hospital inpatient care for at least 60 days, with a maximum deductible of $100 per person and no other cost sharing.
(2) Physicians services in the home, office, and institutional settings for at least the first $2,000 in physicians charges in the year. The maximum deductible could be $50 per person for a year (with credit toward the deductible given for expenses incurred in the last 3 months of the preceding year) and the maximum coinsurance rate would be limited to 20 percent of charges.

The policy could exclude routine physical examinations, cosmetic surgery, and charges for psychiatrists services exceeding $400 in a year.

Other Provisions

A group policy could not exclude any preexisting conditions (conditions or illnesses in existence at the time the patient was first enrolled under a policy) or require a waiting period before preexisting conditions are covered. A nongroup policy could not exclude preexisting conditions except pregnancy and could require a waiting period up to 90 days after enrollment.

A policy could exclude payment for charges to the extent they are not reasonably priced. A charge would always be considered reasonable if not higher than the allowable charge for the same service under the medicare program or the proposed catastrophic program.

A policy could exclude payment for services covered under workmen's compensation programs, medicare, and the proposed cata-

strophic program. It could also exclude services for which the patient has no legal obligation to pay, such as those provided by the VA.

Benefit-Premium Ratios

As one of the requirements for certification, the DHEW would establish, for each policy, a maximum ratio of the amount of benefits and other expenses to the amount of the premium charged (similar to a retention ratio). In determining the ratios, consideration would be given to the nature of the carrier offering the policy, including its profit or nonprofit characteristics, and the number of subscribers in a group. For individual policies, the ratios would be based on those established for the smallest groups. In determining the ratio for a particular policy, consideration would be given to the average ratio for similar carriers offering certified policies. After its initial determination of the ratio for a policy, the Department would periodically review and evaluate experience under the policy to determine if the policy continues to meet these requirements.

Group Practice Plans

The requirements for certification would not specifically apply to comprehensive-prepaid group practice plans, but special requirements would be developed that would be equivalent on an actuarial and benefit basis to the general requirements.

ADMINISTRATION OF THE PROGRAM

A carrier which wishes to offer certified insurance must agree to offer to all individuals and families in each geographic area of the State in which it does health insurance business (1) a policy which meets the requirements for certification described above and (2) a policy which when combined with an approved private catastrophic plan meets the requirements for certification. The carrier could offer these policies through insurance pools or other arrangements described below.

Carriers would submit policies to the DHEW for approval as certified policies. If HEW determines the policy meets the requirements, it would certify the policy for use in States which have established a qualified basic health insurance facilitation program. (These programs are described below.) Carriers with certified policies would be required, under HEW regulations, to periodically report information concerning the policy to the Department and procedures would be established for continuing review by the Department of compliance with the certification requirements.

States which have established a qualified facilitation program could, at their option, agree with DHEW to make determinations on behalf of the Department of the qualifications of health insurance policies for certification. These duties would be performed by State insurance departments which would be reimbursed by the DHEW for their reasonable expenses in carrying out these duties.

Emblem of Certification

The Department would designate an emblem of certification showing that a policy is certified. Carriers could use this emblem and other indications of certification in advertising the policy to the public.

A carrier which (1) offers certified insurance in all areas in which it does business and (2) uses effective procedures, through means con-

sistent with practices in the insurance industry, to control utilization and costs of services under its policies would be given the status of an approved carrier. Beginning 3 years after the start of the program, only approved carriers could qualify as intermediaries or carriers under the medicare program or the proposed medical assistance program.

Antitrust Laws

The bill would suspend Federal, State, and local antitrust laws to permit carriers to enter into insurance pools, reinsurance arrangements, and similar contracts and combinations (which may now be illegal under some of these antitrust laws) for the specific purpose of offering certified health insurance. These arrangements must be approved in advance by the DHEW.

Basic Health Insurance Facilitation Program

States would establish basic health insurance facilitation programs by enacting laws and regulations establishing insurance pools, reinsurance or similar arrangements for use by carriers offering certified health insurance. The premium charged for certified insurance under these pools or arrangements must be between 125 and 150 percent of the average rate in the State for a group of 10 persons. All carriers doing health insurance business in the State must be required to participate in these arrangements and share any losses in proportion to their business in the State. The DHEW would examine the laws and regulations of the States and determine whether they have qualified facilitation programs.

Insurance Offered by DHEW

Three years after enactment of the bill, the DHEW would report to the Congress on the extent to which certified insurance is available in each State and the extent of coverage under these certified policies in each State.

Also 3 years after enactment, the DHEW would establish a special program which would offer certified health insurance to residents of those States which have not established qualified facilitation programs and in which no approved certified insurance is available. This special program would be administered by the Department using the same payment methods and mechanisms used under the medicare program. The premium charge for this insurance would be an amount designed to cover the cost of the insurance, including its benefit and administrative costs and necessary reserves. As needed, Federal revenues could be appropriated to establish a contingency reserve for the program; these funds would be repayable to the Treasury without interest. An insurance revolving fund would be established to handle the funds of the program.

OTHER PROVISIONS OF THE BILL

The bill includes additional provisions all of which affect the medicare program and most of which also affect the proposed catastrophic, medical assistance, or basic health insurance certification programs.

Benefit Provisions

Types of immunizations considered appropriate under DHEW regulations would be covered under the medicare and catastrophic in-

surance programs. Payment for these immunizations under medicare and the government-administered catastrophic program would be made on the basis of a scheduled allowance (fee schedule).

Payment under medicare for treatment of mental disorders on an outpatient basis, now limited to 50 percent of charges up to a maximum of $250 in a year, would be liberalized to 80 percent of charges up to a maximum of $400. This change would make the medicare provision comparable to that under the basic health insurance certification program.

Reimbursement Provisions

Both the medicare and medicaid laws require that skilled nursing homes be reimbursed on a basis related to costs, but the amount of reimbursement is generally not the same because the method of determining costs used by the medicare program is generally not the same as the methods used by each of the State medicaid programs. The bill would permit the medicare program to pay the same rates to SNF's as are paid by the various State medicaid programs or, to take into account any additional services and requirements under medicare, up to a maximum of 10 percent additional.

The bill expresses the policy of Congress that philanthropic support for health care should be encouraged especially to support innovation efforts to improve health care access and delivery. The provisions for reimbursement of hospitals and other institutions under medicare, the government-administered catastrophic insurance programs, and the medical assistance program would treat philanthropic contributions as follows:

(1) Grants, gifts, and endowment income which are unrestricted by the donor would not be considered operating income to the institution and thus would not be deducted from operating costs for determining reimbursable costs.

(2) Grants, gifts, and endowment income designated by the donor for paying operating costs would be considered operating income and would be deducted from operating costs.

(3) Investment income from grants and gifts would be considered an offset against the interest expenses of the institution and would be deducted from interest expense, but only if the grant or gift is unrestricted and is commingled with other funds and then only up to the maximum of the total interest expenses of the institution.

Eligibility Under Medicare

Under present law, persons age 65 and over who are not insured for hospital insurance coverage under medicare may voluntarily enroll by paying a premium which is based approximately on the actuarial value of this coverage. Under the bill, the enrollee would pay one-half this premium and the Federal Government would contribute one-half (financed from Federal general revenues).

Under present law, persons must be insured for medicare (or be a dependent of an insured person) to be eligible for benefits under the renal (kidney) disease provisions of the medicare program. This insured status requirement would be removed for persons not meeting it on the date the bill is enacted. The cost of benefits for this group of uninsured persons would be financed from Federal general revenues.

S. 748 (Dole, Danforth, Domenici) The "Catastrophic Health Insurance and Medicare Improvement Act of 1979"

General Concept and Approach

The catastrophic health insurance proposal has three key parts. First, those eligible for medicare will have their protection improved by expansion of their present benefits. Second, full-time workers and their families will be assured of the availability of adequate private insurance protection through their place of employment. Third, those who are not otherwise covered may choose to have the Federal Government serve as a facilitator and in some instances a financial back-up in contracting with private insurance companies for catastrophic coverage. This latter plan is designed primarily for low income families not covered by medicaid, however, all except those covered by medicare and medicaid would be eligible for participation.

I. Catastrophic Health Insurance—Medicare Program

Medicare would be amended to provide coverage for catastrophic illness. Beneficiaries would be eligible for such benefits after certain limits on health care expenses are reached. Once eligibility has been established, medicare will pay all usual and customary charges or reasonable costs incurred for services covered under part B of title XVIII.

COVERAGE AND BENEFITS

Catastrophic coverage would begin for medicare beneficiaries when they have incurred $5,000 in expenses for certain covered services in any 15 month period (consisting of one calendar year plus the last 3 months of the preceding calendar year) or have incurred $1,000 in out-of-pocket expenses for coinsurance of covered medical services in any such 15 month period. The deductibles will be indexed to the medical care component of the Consumer Price Index and other health care economic measures.

Catastrophic benefits would terminate following the first period of any 90 consecutive days during which the individual incurred less than $500 in covered medical expenses. A new catastrophic benefit period would begin at such time as the individual once again satisfied the deductible.

The proposed plan would provide catastrophic coverage for institutional care for medicare beneficiaries by eliminating current copayment requirements and limitations for hospital and skilled nursing facility services. Limitations on the number of days covered for inpatient hospital services would be deleted and all copayment requirements after the 60th day would be eliminated. The plan would also eliminate the copayment requirement for services in skilled nursing facilities.

Once the catastrophic test has been met, medicare will pay 100 percent of the usual and customary charge or reasonable cost, whichever is appropriate, for services covered under part B of medicare such as doctor bills. Since medicare usually pays 80 percent of such charges, this provision would serve to protect the medicare beneficiary from additional out-of-pocket expenses during a catastrophic medical episode.

Certain prescription drugs, while not normally a covered expense, would count toward calculating the deductible to meet the catastrophic test and would be covered under the catastrophic program after the deductible has been met. This limited drug benefit would include payment for drugs traditionally used on a long-term basis for chronic problems such as hypertension. A medicare formulary committee will be created to compile, publish and make available a medicare formulary.

FINANCING

The financing mechanism for these modifications in medicare benefits will be unchanged from the existing financing mechanism for the medicare program.

II. Catastrophic Health Insurance—Medicaid Program

COVERAGE AND BENEFITS

State medicaid programs will be required to provide catastrophic coverage without cost-sharing, for their beneficiaries. States would have to protect their beneficiaries after 60 days of hospitalization or $5,000 of incurred expenses for medical services as covered under the State medicaid program. States will be able to "buy in" to a private insurance plan for those benefits if they so choose.

FINANCING

The financing mechanism for services paid directly by State medicaid programs will be unchanged from the existing Federal-State sharing under medicaid. The financing of premium subsidies provided for medicaid catastrophic insurance will be through general revenues with Federal cost sharing as in the current medicaid program.

III. Catastrophic Health Insurance—Private Employers

COVERAGE AND BENEFITS

All employers, excluding States and their political subdivisions, will be required to offer their employees group health insurance with minimal catastrophic benefits. These plans will include coverage for inpatient hospitalization after the 60th day of hospitalization and payment for certain services (physician and other medical services) which are identical to those provided under part B of medicare without copayment after $5,000 in medical expense for those services has been incurred.

The minimal coverage would have to be offered to all who have been employed for 30 days and work at least 25 hours per week, without regard to health status. The plan must also provide coverage for the

member employee's spouse, and for any of his unmarried dependents (as defined by IRS) under the age of 26, who are not otherwise covered under a plan, without regard to any pre-existing medical condition. Coverage must continue for any such dependent who becomes totally disabled prior to age 26, for so long as he remains totally disabled, or until such time as he qualified for benefits under other public programs.

Employees would be free to choose to participate or not.

The policy would have to offer an open enrollment period of at least 30 days annually. In addition, the policy must offer an open enrollment period of one calendar month to employees experiencing a change in circumstances including unemployment of a spouse covered under another employer's group plan, death of a spouse, marriage, divorce and addition of a new dependent.

The plan must permit those who have been members of an insured group to convert, without proof of insurability or reference to prior medical conditions, to individual coverage. There would be no mandated employer contribution after conversion.

Employers must provide coverage of a widow or widower of a covered employer for up to 3 months after the death of a covered employee. Employers must offer coverage to an unemployed former employee for up to 3 months after termination of employment. An option must be offered to former employees to convert the group policy to coverage under an individual policy.

FINANCING

Catastrophic insurance for employees is financed by a combination of employer and employee contributions to premiums paid to private insurance companies. The plan calls for a cost-sharing arrangement which would limit the employees' share of the premium to a maximum of 25 percent of the cost of catastrophic coverage. The employee would have the option of paying his share of the cost through a payroll deduction system.

There are provisions to continue coverage during periods of unemployment. The employer would be required to continue his contribution for a maximum of 3 months after which the employee could continue coverage at his own expense.

The plans also provides a hardship subsidy to the employer based on increase in payroll costs due to compliance with this law. This subsidy is financed through Federal general revenues as an employer tax credit. Employers shall be entitled to certain tax credits based upon the amount of an employer's excess payroll costs in a taxable year which exceed 102 percent of what his payroll costs would have been had he not upgraded the insurance protection of his employees to comply with this act. The tax credit shall equal 50 percent of that excess payroll tax in the first year and shall equal 10 percentage points less for each of the succeeding 4 years.

ADMINISTRATION

The bill includes provisions to allow tax deductions for premium costs for both the employer and employee. The employer would be allowed to claim a business expense for health insurance premiums only if the policy contains the requisite catastrophic coverage.

As under current law, employees would be able to deduct one-half of the cost of their premiums (up to $150).

In order to qualify for tax deduction purposes, however, the plan must include the minimum catastrophic benefits defined by this act.

Employers would be subject to a civil penalty for not offering an appropriate plan to their employees. The Secretary shall determine the amount of the penalty, not to exceed 100 percent of the amount he determines would be the additional expense incurred by such employer to comply with this requirement, on a monthly basis. The penalty shall continue to be assessed for each month during which such employer fails to comply. Employees would also be able to bring a private action against any employer who fails to make available the required catastrophic coverage, for amounts that would have been payable under such coverage.

IV. Catastrophic Health Insurance—Private Individuals

COVERAGE AND BENEFITS

U.S. citizens and lawful residents, except those covered by medicare, medicaid or approved private insurance, can purchase a private catastrophic health insurance plan and be eligible for a premium subsidy. The Secretary of Health, Education, and Welfare will enter into agreements with private insurance companies and federally qualified HMOs for them to make available policies which provide catastrophic coverage.

Minimum benefits would include coverage of hospital services after the individual or family unit has been hospitalized for 60 days in a 15 month period (consisting of a calendar year and the last 3 months of the preceding calendar year) and coverage for medical services (identical to those covered under part B of medicare) after $5,000 expenses have been incurred for these services (in such 15 month period). Catastrophic coverage would also begin if the family has out-of-pocket costs for these same services that equal 15 percent of its total income. In no instance could the out-of-pocket expense be less than $200.

REQUIREMENTS FOR APPROVED POLICIES

An approved policy must cover all specified benefits. The policy must provide coverage for an individual, his spouse, and for any of his unmarried dependents under the age of 26 (as defined by IRS), who are not otherwise covered, without regard to any pre-existing medical condition. An approved catastrophic health insurance policy must also offer an annual open enrollment period of at least 30 days, and a 30 day open enrollment period during the calendar month immediately following a change in circumstances including unemployment, death of covered family member, change in marital status, a new dependent, and unemployment of a spouse covered under another employer's group plan.

FINANCING

Insurance companies receive payment for their premium from the individuals and families insured. A subsidy would be provided to those with lower incomes to assist them in purchasing a policy. Eligibility determinations shall consider the amount of the premium, the family income, the family size and coverage provided by the policy

which goes beyond the minimum coverage required of an approved policy. This subsidy would be indexed according to income such that someone without income would have his entire premium paid for by the Federal Government while someone whose income was 120 percent of the national poverty level or greater would pay the entire premium. The index would be phased in such a manner to avoid any notches. These subsidies would be financed out of Federal general revenues.

ADMINISTRATION

Insurance companies would establish premiums which would be community-rated and would be available to all applicants. The premiums might vary from one area to another but they would not vary based on the individual's or his family's health status. There may be different premium rates for individuals and families.

Carriers may enter into contracts with any other carrier or group of carriers for the purpose of participating in an insurance pool to provide catastrophic health insurance coverage for individuals. Company actions carried out for these purposes shall not be subject to otherwise applicable (e.g. antitrust statutes) restrictive laws.

A Federal Actuarial Committee shall be appointed by the President. The Committee shall annually prepare a table of values of catastrophic health insurance coverage for an individual, to be used as a guideline by which to evaluate the actuarial value of catastrophic health insurance coverage, and the costs of premiums for such coverage, offered through private carriers. The table shall be made available to carriers, health maintenance organizations and all other interested parties.

No tax deduction shall be allowed for individuals for the cost of any health insurance policy purchased by the individual for himself or for his family unless such policy meets the requirements of an approved policy.

The Secretary of Health, Education, and Welfare would be responsible for certifying the plans. For premium subsidies, HEW would be responsible for administration including making payment directly to the insurance carrier on behalf of the individual or family and determining who on the local level will make income determinations and notify the insurance company that the 15 percent test has been met.

V. Other Improvements to Medicare

COVERAGE AND BENEFITS

In addition to the catastrophic coverage of inpatient care, skilled nursing care, medical care, and outpatient drugs discussed in section I, this plan would expand benefits under medicare. The length of time after discharge from a hospital during which a medicare beneficiary can transfer to a skilled nursing facility, would be increased. The home health benefits would be expanded. The current 100 visit limitation and 3 day prior hospitalization requirements would be deleted. The home bound requirement would be liberalized. Occupational therapy would be considered a primary home health service. Appropriate training would be required for all home health aides. The plan calls for a modest increase in coverage for outpatient psychiatric benefits from the current limitation of $500 in allowable expenses per year

to $750 and a reduction of the current cost sharing of 50 percent to cost sharing that is consistent with other physician services, 20 percent. In addition, community mental health centers are recognized by medicare as providers. The Secretary of Health, Education, and Welfare is directed to determine the appropriate number of visits which will be covered.

VI. Phase In

All medicare benefit expansions, except the outpatient drug benefit, take effect January 1, 1981. The drug benefit, including allowing expenses for drugs to count towards the deductible, would take effect January 1, 1982.

All employers must comply with offering catastrophic coverage by January 1, 1982. If an employer's health plan under a collective bargaining agreement was in effect on the date of enactment of this program, the employer requirements would not apply until the agreement expired, but not later than January 1, 1984.

S. 760 (Long)

General Concept and Approach

This act would require employers to provide insurance against the costs of catastrophic illness to their employees and the employees' families. It assists other persons, by providing tax credits, to purchase such coverage on their own behalf. The existing medicaid program would be replaced with a Federal medical assistance plan for low-income people. A new program would also be implemented to encourage and facilitate the availability of basic health insurance through private insurance carriers.

I. Catastrophic Health Insurance Program

Every employer would be required to provide his employees, who are not otherwise protected under an approved employer plan, protection through an approved catastrophic health insurance plan. Employers with a payroll of $250,000 or less in a year will be eligible for a refundable 50 percent tax credit, if they choose such a credit in lieu of claiming their premium payments as business expenses. Individuals not covered under an employer-sponsored catastrophic health insurance plan may purchase coverage through an equivalent individual coverage plan and would be eligible for a similar 50 percent credit or rebate with respect to their premium payments.

COVERAGE

Employer plans must cover all full-time employees (more than 25 hours per week and not temporary) and the spouse and dependent family members (including dependent children until age 26) of the employee. Individual plans must similarly cover the individual and the spouse and dependent family members (including dependent children until age 26) of the individual. New coverage must begin no later than the first day of the first calendar month beginning more than 30 days after employment commences. Coverage must be continued for 180 days after the employee separates from his employment, unless the separating employee first obtains coverage under another approved employer plan.

BENEFIT STRUCTURE

An approved plan must include, but shall not be limited to benefits for:

Hospital and related services which are furnished to covered individuals during a period for which the appropriate deductible has been met. Coverage will apply to:

—inpatient hospital services;
—post-hospital extended care services; and
—home health services.

Medical and other health services which are furnished to covered individuals during a period for which the appropriate deductible has been met. Coverage will apply to:

—medical and other health services;
—home health services;
—outpatient physical therapy services; and
—rural health clinic services.

To be eligible for payment of covered benefits, the insured individual must have incurred certain minimum expenses. In the case of expenses incurred for hospital and related services, the insured individual will be covered for such expenses following the 60th day (during a calendar year and the last 3 months of the preceeding calendar year) he received inpatient hospital services. Once the deductible is met, the period of eligibility for covered services (the benefit period) would continue indefinitely until the patient has been out of both a hospital and skilled nursing facility for a consecutive period of 90 days. Once an individual has been out of such facilities for a period exceeding 90 days, catastrophic coverage for hospital and related services would not be reinstated until the 60 day hospital deductible has been met again.

In the case of expenses incurred for medical and other health services, the insured individual will be covered for such expenses after he has incurred $2,000 (in a calendar year and the last 3 months of the preceding calendar year) in medical expenses. For the purposes of this provision, all the expenses incurred by covered members of the family would be counted toward meeting the deductible. Once the medical deductible is met, the period of eligibility for services would continue indefinitely until the family has incurred expenses of less than $500 in a 90 day period. In future years, these deductibles will be adjusted based upon the increase in the physician fee component of the Consumers Price Index (C.P.I.).

Family is defined in this Act as two or more individuals who are related by blood, marriage or adoption. living in the same residence. A child under age 26 who is absent from home for the purpose of attending an educational institution as a full-time student shall be considered to be living in that place of residence and so covered.

Mental health benefits.—Special provisions would apply to coverage of mental conditions. The hospital insurance part of the proposal would include coverage of inpatient hospital care for mental illness provided in general and mental hospitals. To be covered, these services must constitute active care and treatment and must be provided by an accredited medical institution. Partial hospitalization would be covered in an accredited medical institution or a qualified community mental health center.

Mental health care services on an outpatient basis would be covered under the medical part of the program. Under a special provision, the amount of expenses for outpatient mental illness care which could be credited toward meeting the $2,000 deductible could be limited to a maximum of $500. Once the medical deductible is met, outpatient care would be covered with no limit on the number of visits when provided by a qualified community mental health center. Care by a private psychiatrist would be covered, but limited to a maximum of 5 visits during a 12 month period, with additional visits covered only if ap-

proved in advance by a professional review organization as being necessary to avoid institutional care.

ADMINISTRATION

For an employer plan or an individual coverage plan to be approved by the Secretary, it must be offered by a carrier which is approved by the Secretary and include, but not necessarily be limited to, the mandated scope of benefits. An employer plan which an employer wishes to self-insure, must be supported by proof and assurances satisfactory to the Secretary that the employer has the financial ability to discharge his obligations under the plan and has the administrative ability to effectively discharge such obligations. The Secretary might require a self-insured plan to deposit in a specified depository either an indemnity bond or securities of a kind. Coverage could also be implemented through multiemployer plans or plans operated under trust or trade association arrangements.

All plans would need to be approved by DHEW. The Department could include on the applications for approval provisions for recommendations of approval by State insurance departments and could use these recommendations in expediting approval.

If, three years after the date of enactment, one or more approved catastrophic health insurance policies are not actually and generally available to employers or to individuals in a State, the Secretary shall offer a catastrophic health insurance policy, which meets the bill's specifications, in that State. Premiums collected by the Secretary for insurance policies offered by him shall be deposited in an insurance revolving fund. Provisions are also made for this fund to maintain a contingency reserve. The Secretary shall utilize the Medicare payments methodology and administrative mechanism to pay for covered services.

FINANCING

The employer would be required to pay the entire cost of the catastrophic benefits included in a health insurance plan. Employees or individuals covered under an employer plan could not be required or permitted to contribute toward this cost.

The determination of the premium amount for the catastrophic insurance must be based, at least in part, on the pooling of risk among employer plans. The premium could be based entirely on a pooled risk method. Alternatively, this method could be used only to determine the part of the premium which applies to benefits exceeding a specified amount for any one policy. This specified amount could be any amount agreed between the employer and the carrier. The balance of the premium could be based on another rating method. The premium for the required catastrophic coverage must be stated separately to the employer and in a manner that will facilitate comparison with the amount allowable as a tax credit.

Premiums imposed under any catastrophic health insurance policy offered by the Secretary shall be in an amount designed to cover the costs (inclusive of administrative costs and appropriate reserves) which will be incurred in furnishing the benefits provided in the policy.

An employer with a payroll of $250,000 or less who has secured a qualified plan for his employees and an individual taxpayer, who is not an employer, who has secured a qualified plan for himself and his dependents, may, in lieu of any deduction, credit against the taxes otherwise imposed for the taxable year, and amount equal to one-half of the actuarial value of such coverage as determined under the appropriate table of values of catastrophic health insurance coverage. Such credits shall be refundable to the taxpayer to the extent they exceed his tax liability. Total credits allowed, however, may not exceed 100 percent of the premiums against which such credits are allowable.

REQUIREMENTS FOR INSURANCE CARRIERS

Insurance companies would need to be approved by DHEW in order to participate in the catastrophic program. Various types of profit and nonprofit organizations could qualify. In general, an approved carrier must:

Offer catastrophic health insurance on both a group and individual basis in each State in which it does health insurance business. The policies must be non-cancellable and guaranteed renewable.

Establish procedures, approved by DHEW, to assure payment of claims in case it discontinued its catastrophic business or lost its status as an approved carrier.

Establish procedures for the determination of claims which comply with the requirement of the 1974 Employee Retirement Income Security Act, are consistent with the procedures used in its regular health insurance business, and are at least as favorable to claimants as the procedures used in the Federal plan established by the Secretary. To assist carriers in meeting the latter requirement, DHEW would provide them with reasonable access to claims data from the medicare program.

Carriers would be permitted to participate in insurance pools, reinsurance, or other residual market arrangements, and related activities in offering and administering catastrophic insurance. Companies engaged in such activities would be immune from any antitrust laws to the extent such laws now make certain arrangements of these types illegal.

An actuarial committee consisting of five qualified actuaries, of whom no more than two could be persons employed by insurance companies, would be appointed by the Secretary. The committee shall prepare and recommend to the Secretary a table of value of catastrophic health insurance coverage which shall be in effect for the following calendar year. The committee would also review practices of insurance carriers in marketing and premium rating of approved plans to determine whether these practices unduly retrict the availability of approved plans.

Penalty on Uninsured Employers

If an employer fails to insure his employees under an approved employer catastrophic health insurance plan, he will be taxed an amount equal to 150 percent of the premium that it is estimated he would have paid had his employees been so insured.

II. Medical Assistance Plan for Low-Income People

This part of the act would replace the existing medicaid program. It provides low-income individuals and members of low-income families with assistance toward the costs of necessary hospital, skilled nursing facility, medical and other health care services. It is designed to mesh with the catastrophic plan, as well as other public and private health plans. The program would be financed jointly from Federal and State general revenues.

COVERAGE

The benefits of the program would be available to citizens and aliens admitted for permanent residence whose annual family income is below the following amounts:

Individual	$3,000
Family of 2	4,200
Family of 3	4,800
Family of 4	5,400
Family of more than 4	[1] 5,400

[1] $5,400 plus $400 for each additional member.

A family is defined as two or more persons related by blood, marriage, or adoption living in the same home.

The types of income counted for eligibility would include both earned and unearned income—including wages, self-employment income, support and maintenance, annuities, pensions, veterans payments, workmen's compensation, social security, and unemployment insurance. Also included are rents, dividends, alimony and inheritances. Excluded from consideration are small gifts and certain funds received for educational purposes such as scholarships, loans, and fellowships.

By regulation, procedures may be established under which specified gross amounts of income from a trade, business, or farming may be considered sufficiently large to disqualify families even though their income technically falls within the limits. These procedures could be similar to those under the present supplemental security income (SSI) program for the aged, blind, and disabled.

In addition, families who meet all the requirements for eligibility under a State medicaid program at the time the assistance plan started would automatically be eligible under the plan if their income was within 105 percent of the States' income requirements for medicaid.

Spend-down provisions.—Families with income higher than the specified amounts could still qualify for benefits under the "spend-down provision." Under this provision, the family's income for the purpose of eligibility, is considered to be its actual income reduced by the amount of incurred medical expenses the family is legally obligated to pay out-of-pocket; that is, expenses not covered by a private or government plan. These medical expenses could be expenses actually paid or the reasonable charge for the services, if not yet paid. The types of medical expenses considered for computing the spend-down include a broad range of services including all the types of services covered under the proposal, and many not covered such as dental care and prescribed drugs. It would also include expenses for health insurance premiums and one-half of the premiums paid by a self-employed

person under the catastrophic health insurance provisions. Eligibility under the spend-down provision may be determined on a prospective basis if the future income is determinable and a family member can be expected to need institutional care.

DETERMINATION OF ELIGIBILITY

While eligibility is based on the family's annual income as indicated above, the determination of its annual income would be based on its rate of income in the 2-month period before the date of application for benefits and its estimated prospective income for the 2 months after application. Prospective income would be based on current income and other relevant factors.

When an application is approved, eligibility for benefits would usually start the first day of the month in which the application is filed, but eligibility could be extended backward for as many as 3 months before the month of application, if the family was qualified during this earlier period and incurred covered medical costs.

In most cases, an application would be filed to establish eligibility for a coverage year which would be the 12-month period beginning April 1st of each year. Once approved, eligibility would continue throughout the coverage year unless family income increased to an amount more than 20 percent above the income limit for the family size. Also, a change in eligibility resulting from one member leaving the family would be disregarded during the coverage year.

If at the time eligibility for a family terminated, a member of the family was an inpatient in a hospital or a skilled or intermediate nursing facility, eligibility for that member would continue until he was discharged.

Services in an intermediate care facility would be available to patients who do not require services in a hospital or skilled nursing facility, but who have a physical or mental condition which requires care (in addition to room and board) available only through institutional facilities.

The types of mental health services covered under the medical assistance program would include the same services as under the catastrophic program (including inpatient hospital care, partial hospitalization, and outpatient services) subject to the same conditions and limitations, except of course for the deductible requirements. In addition, care for mentally retarded persons in public institutions would be covered if the patient is receiving active treatment; this coverage would be provided under the provisions applicable to intermediate care facilities.

The mental health benefits under medical assistance would also cover prescription drugs provided on an outpatient basis. (Outpatient drugs are otherwise not covered under the proposal.) The drugs must be prescribed by a physician who could be a physician in an approved mental health center or a private psychiatrist. In either case, the drug would be covered only if the physician determines that the patient can be expected to need institutional care unless he receives the prescribed drug. The covered drugs would be limited to those included on a list, established by DHEW, which would indicate the mental condition for which it is effective and the appropriate dosage.

BENEFITS

Benefits of the program include:

Necessary inpatient hospital services,
Medical and other health services,
Skilled nursing facility services,
Home health services,
Intermediate care services,
Mental health services,
Pre-natal and well-baby care,
Family planning counseling, services and supplies,
In the case of eligible children under age 18, early and periodic screening, diagnosis, and treatment,
Payment of any premium imposed under part B of medicare for coverage under that insurance program.
Reimbursement of one-half the actuarial value of catastrophic health insurance coverage for any period the individual and his family paid premiums for an approved self-employed plan.

Copayment requirements.—Covered individuals and their families shall be responsible for the first $3 of the cost for a visit for outpatient physician's services for the first ten visits. The copayment is waived if the visit is for the purpose of securing well-baby care, family planning services or early and periodic screening, diagnosis, and treatment for eligible children. These copayment provisions shall apply to medicare beneficiaries to the extent they are less than the medicare copayment requirements.

A special copayment requirement would also apply to individuals, who are not a member of a family, after the 60th continuous day spent as an inpatient in a hospital, skilled nursing facility or intermediate care facility. The amount of this copayment would be equal to the amount of the patient's monthly income, less $50. (A similar requirement would apply in a situation where all members of a family have a stay exceeding 60 days.)

RELATIONSHIP TO OTHER GOVERNMENT AND PRIVATE PROGRAMS

The present medicaid program would be abolished and replaced by the new program. The medicare program would continue.

The bill states its intent that the proposal not be construed to preclude States from providing protection for its residents against health costs, or individuals from obtaining (through collective bargaining or otherwise) protection against the cost of health services.

Payments under the medical assistance program would be secondary to all other government and private health programs and plans, including the proposed catastrophic program, medicare, and workmen's compensation programs. Thus, where a person has coverage under another public or private plan, the medical assistance plan would pay only for services or any cost sharing not covered by the other plan. However, the medical assistance program would pay for services for its eligible beneficiaries in any State which has established a State medical assistance program designed to supplement the Federal program by providing higher income limits for eligibility.

Under the penalty of law, the bill prohibits employers, who provide group health insurance for their employees, to exclude an employee because he is potentially eligible under the medical assistance proposal.

In the event a person was eligible for enrollment in a health insurance plan (for example, an employment-related group plan) under which the enrollees' contribution was 25 percent or less of the total premium, but did not enroll, benefits payable under the medical assistance plan would be reduced by $250 in a benefit period. A similar reduction would apply to persons who fail to enroll in the supplementary medical insurance (SMI of medicare.)

FINANCING

The program would be financed jointly by the Federal and State governments under an agreement between each State and the DHEW. Unless the State entered into this agreement, persons living in the State would not receive benefits under the proposed medical assistance or catastrophic programs.

The State contribution would be as follows: (1) an amount equal to the State's payments under the medicaid program for those types of services covered under the medical assistance proposal and (2) again, for services under the new medical assistance proposal, one-half the payments it would have made under medicaid if its eligibility requirements were the same as the medical assistance requirements (which of course would be applicable only to States with less liberal requirements). This formula would be based on the State's medicaid spending and eligibility requirements in the year before th enew medical assistance program began (or 1 year earlier, whichever is larger). The State contributions determined under this formula would be a fixed amount payable each year and would not rise in future years. The amount of this fixed payment would be reduced, each year, by one-half the State's expenditures in the year for kinds of health services not covered by medical assistance, if those services had previously been covered under the State Medicaid program and were of a kind eligible for Federal matching grants.

The balance of the cost of the proposed program would be financed from Federal general revenues. All funds would be held in a special coverage trust fund.

ADMINISTRATION

The medical assistance program would be administered in a manner similar to the medicare program and utilizing its administrative mechanisms. Private carriers meeting certan standards would act as fiscal intermediaries responsible for administration of claims and payments to providers of services. There is also a provision authorizing the consolidation of the activities of these carriers in areas with small populations if necessary to improve quality and efficiency.

As under medicare, State agencies would be responsible for determining whether providers of services meet the conditions for participation under the program.

Persons eligible under the proposed medical assistance program could also enroll in a health maintenance organization and receive their services from these organizations, on a basis similar to that authorized for Medicare beneficiaries.

STANDARDS FOR PROVIDERS OF SERVICES

The program would apply the same standards for providers of services as under the medicare program. For intermediate care facili-

ties, which are not covered under medicare, the bill requires the facility to be licensed under State law and meet regulations (to be established) concerning proper provisions of care, and safety and sanitation. It specifically includes qualified Christian Science sanatoria and institutions on Indian reservations.

REIMBURSEMENT OF PROVIDERS OF SERVICES

Providers of services under the medical assistance program would be reimbursed on much the same basis as under the medicare program. Under medicare, hospitals, skilled nursing facilities, and home health agencies are reimbursed on the basis of the reasonable cost of services. Payments to physicians and certain other providers are determined on the basis of reasonable charges. In general, physicians may file and accept the medicare payment as full payment (taking assignment). Alternatively, they may bill the patient, who files and receives the medicare reasonable charge which may be less, but not more, than the physician's charge.

The bill specifies that for the medical assistance program the physician and other providers must accept the reasonable charge as full payment for services. This would also apply where the medical assistance payment is made to supplement a payment under another public or private insurance program. In this case, the reasonable charge for these services, as determined under the medical assistance plan, would be considered the full charge.

III. Private Basic Health Insurance Criteria

The stated purpose of the health insurance certification provisions is to encourage and facilitate the availability of basic health insurance at a reasonable premium charge. These provisions would (1) establish procedures for certification by the DHEW of private basic health insurance meeting specified requirements, (2) permit the marketing of this insurance through insurance pools and reinsurance and similar arrangements, (3) encourage the States to establish facilitation programs to assist in marketing certified insurance, and (4) permit the DHEW to offer directly certified health insurance in States where it is not available.

REQUIREMENTS FOR CERTIFICATION

To qualify as a certified policy, a health insurance policy must meet specified requirements concerning coverage, benefits, premium rates, and other matters.

COVERAGE REQUIREMENTS

Policies based on family status must be made available—for a single individual, a married couple, and a family—each at appropriate premium rates. A family policy must cover dependent unmarried children under age 22 and must automatically cover any newborn and newly adopted children. A policy covering an employment group must meet the following additional requirements:

(1) continue coverage for at least 31 days after the end of employment;

(2) offer employees leaving employment a reasonable opportunity to convert to, or otherwise obtain, certified nongroup coverage; and,

(3) provide an annual enrollment period to permit enrollment of employees who previously failed to elect coverage.

BENEFIT REQUIREMENTS

A certified policy must cover at least the following services, but could include additional services and could reduce the cost sharing requirements.

(1) Hospital inpatient care for at least 60 days,, with a maximum deductible at $100 per person and no other cost sharing.

(2) Physicians services in the home, office, and institutional settings for at least the first $2,000 in physician charges in the year. The maximum deductible could be $50 per person for a year (with credit toward the deductible given for expenses incurred in the last 3 months of the preceding year) and the maximum coinsurance rate would be limited to 20 percent of charges.

The policy could exclude routine physical examinations, cosmetic surgery, and charges for psychiatrists services exceeding $400 in a year.

OTHER PROVISIONS

A group policy could not exclude any pre-existing conditions (conditions or illness in existence at the time the patient was first enrolled under a policy) or require a waiting period before pre-existing conditions are covered. A nongroup policy could not exclude pre-existing conditions except pregnancy and could require a waiting period up to 90 days after enrollment.

A policy could exclude payment for charges to the extent they are not reasonably priced. A charge would always be considered reasonable if not higher than the allowable charge for the same service under the medicare program or the proposed catastrophic program.

A policy could exclude payment for services covered under workmen's compensation programs, medicare, and the proposed catastrophic program. It could also exclude services for which the patient has no legal obligation to pay, such as those provided by the VA.

BENEFIT-PREMIUM RATIOS

As one of the requirements for certification, the DHEW would establish, for each policy, maximum ratio of the amount of benefits and other expenses to the amount of the premium charged (similar to a retention ratio). In determining the ratios, consideration would be given to the nature of the carrier offering the policy, including its profit or nonprofit characteristics, and the number of subscribers in a group. For individual policies, the ratios could not be based on those established for the smallest groups. In determining the ratio for a particular policy, consideration would be given to the average ratio for similar carriers offering certified policies. After its initial determination of the ratio for a policy, the Department would periodically review and evaluate experience under the policy to determine if the policy continues to meet these requirements.

States which have established a qualified facilitation program could, at their option, agree with DHEW to make determinations on behalf of the Department of the qualifications of health insurance policies for certification. These duties would be performed by State insurance departments which would be reimbursed by the DHEW for their reasonable expenses in carrying out these duties.

EMBLEM OF CERTIFICATION

The Department would designate an emblem of certification showing that a policy is certified. Carriers could use this emblem and other indications of certification in advertising the policy to the public.

A carrier which (1) offers certified insurance in all areas in which it does business and (2) uses effective procedures, through means consistent with practices in the insurance industry, to control utilization and costs of services under its policies would be given the status of an approved carrier. Beginning 3 years after the start of the program, only approved carriers could qualify as intermediaries or carriers under the medicare program or the proposed medical assistance program.

ANTITRUST LAWS

The bill would suspend Federal, State, and local antitrust laws to permit carriers to enter into insurance pools, reinsurance arrangements, and similar contracts and combinations (which may now be illegal under some of these antitrust laws) for the specific purpose of offering certified health insurance. These arrangements must be approved in advance by the DHEW.

BASIC HEALTH INSURANCE FACILITATION PROGRAM

States would establish basic health insurance facilitation programs by enacting laws and regulations establishing insurance pools, reinsurance or similar arrangements for use by carriers offering certified health insurance. The premium charged for certified insurance under these pools or arrangements must be between 125 and 150 percent of the average rate in the State for a group of 10 persons. All carriers doing health insurance business in the State must be required to participate in these arrangements and share any losses in proportion to their business in the State. The DHEW would examine the laws and regulations of the States and determine whether they have qualified facilitation programs.

INSURANCE OFFERED BY DHEW

Three years after enactment of the bill, the DHEW would report to the Congress on the extent to which certified insurance is available in each State and the extent of coverage under these certified policies in each State.

Also 3 years after enactment, the DHEW would establish a special program which would offer certified health insurance to residents of those States which have not established qualified facilitation programs and in which no approved certified insurance is available. This special program would be administered by the Department using the same

payment methods and mechanisms used under the medicare program. The premium charge for this insurance would be an amount designed to cover the cost of the insurance, including its benefit and administrative costs and necessary reserves. As needed, Federal revenues could be appropriated to establish a contingency reserve for the program; these funds would be repayable to the Treasury without interest. An insurance revolving fund would be established to handle the funds of the program.

IV. Other Provisions of the Bill

The bill includes additional provisions all of which affect the medicare program and most of which also affect the proposed catastrophic medical assistance, or basic health insurance certification programs.

BENEFIT PROVISIONS

Types of immunizations considered appropriate under DHEW regulations would be covered under the medicare and catastrophic insurance programs. Payment for these immunizations under medicare and the Government-administered catastrophic program would be made on the basis of a scheduled allowance (fee schedule).

Payment under medicare for treatment of mental disorders on an outpatient basis, now limited to 62.5 percent of charges up to a maximum of $312.50 in a year, would be liberalized to 80 percent of charges up to a maximum of $500. This change would make the medicare provision comparable to that under the basic health insurance certification program.

REIMBURSEMENT PROVISIONS

Both the medicare and medicaid laws require that skilled nursing homes be reimbursed on a basis related to costs, but the amount of reimbursement is generally not the same because the method of determining costs used by the medicare program is generally not the same as the methods used by each of the State medicaid programs. The bill would permit the medicare program to pay the same rate to SNF's as are paid by the various State medicaid programs or, to take into account any additional services and requirements under medicare, up to a maximum of 10 percent additional.

The bill expresses the policy of Congress that philanthropic support for health care should be encouraged especially to support innovation efforts to improve health care access and delivery. The provisions for reimbursement of hospitals and other institutions under medicare, the Government-administered catastrophic insurance programs, and the medical assistance program would treat philanthropic contributions as follows:

1. Grants, gifts, and endowment income which are unrestricted by the donor would not be considered operating income to the institution and thus would not be deducted from operating costs for determining reimbursable costs.

2. Grants, gifts, and endowment income designated by the donor for paying operating costs would be considered operating income and would be deducted from operating costs.

3. Investment income from grants and gifts would be considered an offset against the interest expense of the institution and would be deducted from interest expense, but only if the grant or gift is unrestricted and is commingled with other funds and then only up to the maximum of the total interest expense of the institution.

ELIGIBILITY UNDER MEDICARE

Under present law, persons age 65 and over who are not insured for hospital insurance coverage under medicare may voluntarily enroll by paying a premium which is based approximately on the actuarial value of this coverage. Under the bill, the enrollee would pay one-half this premium and the Federal Government would contribute one-half (financed from Federal general revenues).

Under present law, persons must be insured for medicare (or be a dependent of an insured person) to be eligible for benefits under the renal (kidney) disease provisions of the medicare program. This insured status requirement would be removed for persons not meeting it on the date the bill is enacted. The cost of benefits for this group of uninsured persons would be financed from Federal general revenues.

The Administration's Phase I—National Health Plan

GENERAL CONCEPT AND APPROACH

This proposal provides every resident of the United States with the opportunity to obtain health insurance through one of two insurance structures: (1) a Federal insurance program (*HealthCare*) providing comprehensive coverage for the aged, disabled and poor and offering insurance against major medical expenses to other individuals and small employers; or (2) a system of approved private insurance plans through which employers provide coverage to full-time workers and their families.

The program would be national in scope, with uniform policies regarding benefits, provider participation, quality assurance and other standards applied to *HealthCare* and to approved private plans. The HealthCare plan would subsume medicare and the acute care service portion of medicaid. The proposal also incorporates cost containment features and incentives for health system reform, through specific reimbursement provisions and a health system reform section.

I. HealthCare

HealthCare will be a new Federal insurance plan which expands Medicare for the aged and disabled, replaces medicaid as an insurance program to pay for acute care services used by poor families and offers coverage for catastrophic expenses to certain other individuals. The program would be financed through a combination of premium payments, payroll taxes and Federal and State revenues. *HealthCare* would be administered by the Department of Health, Education and Welfare, which would contract with States and private insurance carriers for much of the day-to-day operations of the program.

COVERAGE OF THE POPULATION

HealthCare covers the aged, disabled, poor and near-poor and certain other individuals.

Aged and disabled.—Medicare eligibility standards would continue for all persons over age 65, those under age 65 who meet the Social Security test of total and permanent disability and those who suffer from chronic renal failure.

The poor.—There would be three ways of determining income-related eligibilty for *HealthCare.* First, all persons who qualify for cash assistance under the program from AFDC or SSI would be automatically enrolled, at the time they qualify for cash assistance payments. Second, individuals or families whose incomes are below the Health Care national low-income standards would be eligible; that standard would be equivalent to 55% of the Federal poverty level in Phase I. Third, any individual or family whose health expenses exceed 100% of the difference between their income and the low-income standard can apply to HealthCare for complete coverage of all further expenses for a year. In States where medicaid spend-down standards exceed the HealthCare standard, the higher standard would be used for single parent families with children and for the aged, blind and disabled.

Others.—All other persons would be able to buy insurance from HealthCare by paying a specified premium for individuals and small groups. In addition, any employer can purchase the mandated coverage (with a $2,500 deductible on all services except prenatal delivery and infant care) at a premium equivalent to 5 percent of payroll. (See Section on Subsidies in Employer Plans)

BENEFICIAL STRUCTURE

The HealthCare benefit package would include a comprehensive range of acute care services and complete preventive and acute care benefits for pregnant women and infants. The package includes:

Inpatient hospital services (unlimited);

Physician and other ambulatory services, including laboratory and X-ray, and excluding dental and psychiatric care (unlimited):

Skilled nursing services (100 days per year);

Home health visits (100 visits per year);

Mental health, alcoholism and drug abuse services (20 days of inpatient care; $1,000 in ambulatory services); and

Preventive Care.—Complete prenatal, delivery and total infant care (preventive and acute services) for all mothers and children; a schedule of preventive services for all children up to age 18.

Long-term-care services would continue to be operated under State administration, financed under the current title XIX program grant system.

Cost-sharing.— Different cost-sharing requirements would apply to persons who enter HealthCare through the various eligibility standards. For the aged and disabled, Medicare's current cost-sharing requirements would be extended to HealthCare with several modifications:

There would be an annual hospital deductible rather than a new hospital deductible applicable to each spell-of-illness;

No cost-sharing would be required after an individual had paid $1,250 in out-of-pocket expenses; and

Low-income aged would have no cost-sharing, nor would those aged and disabled persons whose expenses for covered services exceed 100 percent of the difference between their income and the low-income standard.

All persons eligible because they are entitled to cash assistance—or because their income is less than the low-income standard—would face no cost-sharing. Those who enroll in HealthCare through the "spend-down" would have no cost-sharing after they spend-down below the low-income standard.

Individuals who purchase HealthCare coverage by paying a premium face a deductible of $2,500 on all services. However, all pre-natal services, delivery and total preventive and treatment costs for an infant in the first year of life would be covered with no cost sharing.

ADMINISTRATION

The Department of Health, Education, and Welfare would be responsible for overall policy direction and administration of HealthCare. The HealthCare program would closely resemble the Medicare process of claims administration but would allow for determination of eligibility to be done by several different agencies. A HealthCare Trust Fund would be established.

All claims processing would be handled by fiscal agents, including insurance companies, data processing firms or others. Contracts to cover a specified geographic area will be awarded on a competitive fixed-price basis.

Eligibility determination will be handled by the Federal Government (DHEW) for aged and disabled persons. The States will handle eligibility determination for categorically eligible persons (AFDC and AFDC-U). The Federal government will have prime responsibility for determining eligibility for other low-income enrollees in HealthCare, although States may undertake this function for the newly-eligible if they meet performance standards.

Grievance and appeals procedures for providers and for beneficiaries will be similar to those used under medicare.

FINANCING

HealthCare would be financed through a combination of payroll tax revenues, premiums and Federal and State funds.

The medicare payroll tax would continue to finance part of the care for the elderly and disabled; the revenues would be transferred to the new HealthCare Trust Fund. In addition, all aged and disabled enrollees with incomes above the HealthCare low-income standard would pay a premium equivalent to the current Medicare Part B premium. Additional subsidies to cover the full costs of care for the aged and disabled would be provided from Federal general revenues.

State and local governments would continue to share with the Federal government in the costs of financing HealthCare services for the low-income population. The formula used to determine State and local government liabilities would be set to approximate the level of State expenditures that would have occurred under medicaid less any fiscal relief. There will be a 5-year "hold harmless" provision, for any

increased health care costs due to the expansion of HealthCare eligibility, benefits and reimbursement provisions beyond those in the current medicaid program.

Individuals or very small employment groups (those with fewer than 10 employees) would purchase HealthCare coverage by paying a premium, set at a national community rate which could cover most, but not all, of this group's actual costs. Any employer will be able to purchase the mandated coverage from HealthCare by paying a premium equal to 5% of payroll. A similar subsidy will be available for those who purchase privately. Costs not covered by premium payments would be met through Federal general revenue subsidies.

PARTICIPATING PROVIDERS OF SERVICE

Standards for provider participation would be generally similar to those used in medicaid. However, services provided by nurse practitioners, physician assistants or similar trained personnel would be reimbursable under HealthCare, even if State laws were more restrictive. Organized ambulatory care settings would be reimbursable providers as well.

The Department of Health, Education, and Welfare would certify providers meeting the conditions of participation. The Department could enter into contracts or other agreements with private organizations or State agencies to conduct the certification review on its behalf.

PAYMENT TO PROVIDERS

Payment for hospital services would be governed by the Administration's hospital cost containment program.

Physicians and others who provide ambulatory noninstitutional services on a fee-for-service basis would be paid on the basis of a fee schedule. The fee schedule would be established prior to implementation of the program on October 1, 1982. The fee schedule for physicians would be based on Medicare physician payment levels. After the first year of implementation, alterations in the schedule could be developed through a process of negotiation between HealthCare and organizations representing a majority of physicians in the State.

All physicians who accept HealthCare patients would be required to accept assignment of claims—e.g. to accept the HealthCare fee as payment in full for the service rendered.

Organized providers of ambulatory services could be reimbursed in several ways: (1) a prospectively-set, all-inclusive rate per visit; (2) a prospectively set, per capita rate for HealthCare covered services provided to enrolled beneficiaries. Choice among these methods of reimbursement would be based on criteria like the size of the institution and its ability to assume risk for an enrolled population. Health Maintenance Organizations will be reimbursed on the basis of "average adjusted per capita community cost"—they can be paid up to 95% of the per capita amount that would be paid for comparable services, if the provider were other than an HMO.

RELATIONSHIP TO OTHER FEDERAL PROGRAMS

Medicare will be merged administratively into HealthCare. HealthCare would also replace medicaid as a program to pay for acute care services. HealthCare would reimburse Federal delivery programs (e.g.

VA, PHS hospitals) for covered services rendered to eligible HealthCare beneficiaries.

II. Employer-provided Plans (the Employer Guarantee)

All employers would be required to provide full time workers and their dependents with a health insurance plan which meets Federal standards. Insurance companies marketing plans to meet the mandate would be required to obtain Federal approval of these plans, and clearly designate those policies which meet Federal requirements. The requirements of the mandate encompass benefits, cost-sharing liability, extensions of coverage after termination of employment and to spouses and dependents in the event of death of the wage earner or divorce; plus other cosumer protection standards. All employers would have to offer their employees a choice between an insurance plan meeting Federal standards and enrollment in any Federally qualified HMO (or IPA) in the area.

COVERAGE OF THE POPULATION

All full-time employees and their dependents would be covered through employer provided insurance. Full-time employee is defined as one working at least 25 hours per week for 10 consecutive weeks, or working 250 hours in a 13 consecutive week period. Dependents include children through their 22d birthday, or through age 26 if enrolled in school full-time (or otherwise a dependent of their parent). Children disabled before their 22d birthday are continued as dependents as long as they live with their parents. Any employer who fails to meet his obligations under the mandate will be subject to a fine. The self-employed would be treated like any other employer.

BENEFIT STRUCTURE

The benefit package in the employer plans must include the same services as those insured under HealthCare and the plan must limit out-of-pocket payments to a maximum of $2,500 per policy-holder per year.

Within this constraint, employers (and unions) may negotiate for a broader benefit package, if they wish. They may also arrange for any combination of cost-sharing by policyholders—ranging from complete coverage with no cost-sharing at all to a policy with a $2,500 deductible on all services. *However*, there can be no cost-sharing imposed on prenatal and delivery services or on acute and preventive care provided to an infant in the first year of life.

ADMINISTRATION

The proposal establishes national minimum standards for all health insurance plans provided to meet the employer mandate. The standards apply to plans sold by insurance companies and nonprofit plans; to self-insured employer plans; fraternal beneficiary insurance plans and multi-employer/union Trusts. To assure the uniform application of these standards, the certification process will be federally administered. The Federal Government will also offer a voluntary reinsurance program to health maintenance organizations, employers and small insurance companies.

Standards for employer plans.—The purpose of the standards is to assure consumers adequate protection and information about their insurance coverage and to link private average standards with HealthCare standards to achieve a national level of basic protection. To meet the conditions of the employer mandate, a health insurance plan must:

Provide, at a minimum, the HealthCare benefit package with a maximum out of pocket liability of $2,500 per policy. No cost-sharing may be applied to prenatal and delivery services or preventive and acute care services provided to an infant in the first year of life.

Provide the same benefit to all persons. There will be no waiting period for coverage after the 10th week of employment, and coverage must continue for at least 90 days after termination of employment or for the family after death of a worker or divorce of a worker and spouse.

Not limit or exclude coverage due to preexisting conditions; provide care for newborns and have no restrictions on coverage or benefits for those in poor health.

Cover dependents (as specified in section on Coverage), Employees and/or their dependents must be given the right to continue to buy comparable individual coverage from the insurance company after termination of employment, regardless of their health status.

Provide adequate, clear information regarding policy provisions, benefits and costs and conform to any further mandated public disclosure requirements or standards for policies.

Use claims review and quality assurance processes, as specified.

Show a reasonable relationship of premiums charged for qualified plans to benefits paid to policyholders.

Administration and enforcement of standards.—The Department of Health, Education, and Welfare would review and certified all private plans. States will continue most of their insurance regulatory activities. While traditional State roles will be largely preserved, national uniformity would be assured through a provision that, in the event of a conflict between the Federal mandate and State requirements, the Federal standards will be primary.

An insurance company which alters a previously qualified plan—or otherwise misrepresents a plan—will be liable for fines and criminal penalties and will be prohibited from marketing qualified health plans for two years.

Reinsurance programs.—The Department of Health, Education, and Welfare will offer reinsurance to HMOs, employers and small insurance companies. The reinsurance program would cover 80 percent of the costs of a policyholder, when costs exceed $25,000. Insurance plans and firms can purchase this coverage, through payment of a premium or other fee.

FINANCING

Employers will be required to pay at least 75 percent of the premium cost for a plan meeting the Federal mandate standards; the employee pays no more than 25 percent of that cost. Higher employer shares of the premium can be agreed to in collective bargaining. If the employer offers a plan with a broader benefit package, or with lower cost sharing than required by the mandate, the proportion of the additional pre-

mium paid by the employer is also negotiable. Employers are also required to contribute the same dollar amount to an HMO as is paid to a traditional insurance plan premium. If that contribution exceeds the amount of the HMO premium, the employee would be able to get additional fringe benefits. Any collective bargaining agreements in force that call for higher employer shares when the plan is implemented would be protected for the life of the contract.

Subsidies.—In order to protect employers and low-wage workers from undue hardship resulting from mandated premium payments, several subsidies are included:

Employers may purchase the mandated package from HealthCare for a premium equal to 5 percent of the payroll cost. (On average, employers will be able to buy the package from 2.5 percent-3.0 percent of payroll). Alternatively, the employer may apply for an equivalent subsidy to purchase coverage from private insurance firms.

The earned income tax credit will be expanded to largely offset the cost of the employee premium share for low-income workers.

PARTICIPATING PROVIDERS OF SERVICE

Plans conforming to the employer mandate will be required to use the same standards for participating providers as are used by HealthCare.

PAYMENT TO PROVIDERS

Payment for hospital services in approved private plans, as in HealthCare, will be based on implementation of the administration's hospital cost containment program.

In order to stimulate competition among providers and assist beneficiaries in knowing which physicians accept insurance payments as full compensation, the plan provides the following:

The HealthCare fee schedule will be furnished on an advisory basis to all insurance plans (and other health plans meeting the employer mandate). Plans may use—or not use—the schedule in guiding the rates they will pay for a given service. Insurance plans will provide enrollees with lists of physicians in the State who agree to accept the insurance plan's reimbursement as full compensation for their services.

III. Health System Reform

In addition to the insurance portions of the plan, the proposal includes various incentives to encourage health system reform and competition. Some of these are incorporated in reimbursement provisions (e.g. HMOs) and in the standards for qualified private plans. The plan also includes two specific proposals for system reform.

A new process for assessing health needs and determining the adequacy of Federal programs. This program requires development of a 5-year plan for each relevant Federal program, and submission of a coordinated report to the Congress.

A system limiting hospital capital growth. This would establish a limit of $3 billion annually, to be allocated among the States. The limits would be applied using State health planning agencies wherever possible. In addition, a mandatory reimbursement penalty (applied by HealthCare and private plans) would apply to any unauthorized capital expenditure.

SUMMARY AND COMPARISON OF PRINCIPAL FEATURES OF HEALTH INSURANCE PROPOSALS

SUMMARY AND COMPARISON OF PRINCIPAL

S. 350 (Senators Long, Ribicoff, et al.) S. 351 (Senator Long, Talmadge, et al.)	S. 748 (Senators Dole, Domenici, and Danforth)
General Concept and Approach	
Provides a catastrophic illness insurance program for the entire population provided through 1) a federally administered plan for the unemployed, welfare recipients, the aged, and persons who do not opt for private insurance coverage, and 2) a private catastrophic insurance plan allowed as an option for employers and the self-employed, or alternatively under approved private plans. S. 350 also provides for establishment of a uniform national program of basic benefits for low-income persons and families.	Would create a system of catastrophic health insurance protection by 1) amending medicare to provide for catastrophic benefits; 2) establishing employer-based private catastrophic health insurance plans; 3) establishing a residual market catastrophic insurance program for those with no other coverage; and 4) requiring State Medicaid programs to provide catastrophic coverage equal to that or the residual plan or to buy into the residual plan. The type of benefits would be the same as those provided under current State medicaid program.
Coverage of the Population	
Provides coverage for all U.S. residents under the public plan except for employees (and their families) of employers and the self-employed who elect to purchase private plans. Low-income plan coverage would be available to all individuals and families whose incomes were at or below certain specified levels. Families with incomes above these levels would qualify for medical assistance under the plan, if they spent enough on medical care to reduce their incomes to the eligibility levels (S. 350 only).	Medicare could continue to cover current beneficiaries. Employer-based plans would: 1) offer coverage to full-time employees, spouses and dependent children; 2) permit widows, widowers, divorced spouses, or orphaned children to continue coverage for 3 months; 3) offer open enrollment to individuals meeting specified changes in circumstances; 4) permit conversion to individual policies prior to termination of group coverage; and 5) coverage would commence shortly after entering the workforce and continue for up to 3 calendar months following separation from employment. Residual program would be available to those with no other catastrophic insurance.

FEATURES OF HEALTH INSURANCE PROPOSALS

S. 760 (Senator Long)	(Administration)

General Concept and Approach

Requires by Federal mandate that employers provide workers and their families with qualified catastrophic health insurance coverage, assists others, including the self-employed and their dependents, in the purchase of qualified individual catastrophic protection; establishes a new health program for low-income persons and families; and, establishes a voluntary certification program to assure the universal availability of basic health insurance.

Provides for 1) a Federal insurance program (Health Care) providing comprehensive coverage for the aged, disabled, and poor, and offering insurance against major medical expenses to other individuals and small employers; and 2) a system of mandated employer-based coverage for workers and their families through approved private insurance plans. Public Plan incorporates Medicare and acute care portions of Medicaid.

Coverage of the Population

Employment-based plans and plans for the self-employed would cover full-time employees dependent family members. Coverage would commence shortly after entering the workforce and continue for up to six months following separation from employment due to layoff or death.

Low-income plan coverage would be available to all individuals and families whose income were at or below certain specified levels. Families with incomes above these levels would qualify for medical assistance under the plan, if they spent enough on medical care to reduce their incomes to the eligibility levels.

The public plan would cover the aged, disabled, poor, certain near-poor, and certain other individuals and small groups. Employers could also purchase public coverage in lieu of a private plan.

All full-time employees and their dependents would be covered through mandated employer-provided insurance. The self-employed would be treated like any other employer.

S. 350 (Senators Long, Ribicoff, et al.) S. 351 (Senator Long, Talmadge, et al.)	S. 748 (Senators Dole, Domenici, and Danforth)

Benefit Structure

Provides institutional benefits (hospital care, 100 days of post-hospital services, and home health services) after an individual had been hospitalized for a total of 60 days within one year. Medical benefits (similar to those provided under medicare part B with some limits placed on mental health services) would be offered after an individual or family had incurred medical expenses of $2,000 for services similar to those provided under Part B.

Low-income plans benefits (S. 350 only) would be substantially the same as those that are now required or can be provided under the medicaid program. Benefits would be provided generally without limits on the amount of services or cost-sharing requirements.

Medicare—Catastrophic benefits would be provided for Part A-type services through elimination of current copayment requirements for hospital care and skilled nursing facility services and durational limits on hospital services. For part B services, medicare would pay 100% of reasonable costs or charges for covered services (plus drugs listed in a special formulary) once catastrophic coverage has been triggered (when individual incurs expenses of $5,000 in a year or out-of-pocket expenses equal to 20 percent of that amount for covered Part B-type services (plus certain drugs).

Employer based catastrophic plan would cover substantially the same kinds of services that are covered under the medicare program. Institutional benefits would be covered after an individual or family unit has been hospitalized for 60 days. Also covers medicare part B-type physician and medical services without cost-sharing after an individual or family incurs $5,000 in medical expenses for such services.

Residual plan—Same benefits as mandated under employer-based plans. In addition, coverage for medicare part B-type services would be provided once individual has incurred $5,000 in medical expenses or has out-of-pocket costs for such services (not less than $200) equal, to 15 percent of income.

S. 760 (Senator Long)	(Administration)

Benefit Structure

Employment-based catastrophic plans would cover substantially the same kinds of services that are covered under the medicare program. Institutional benefits would be paid after an individual had been hospitalized for a total of 60 days in one year. A $2,000 medical expense deductible (individual or family) would apply in the case of all other covered expenses. The medical expense deductible would be adjusted annually to reflect changes in the price of covered services and other factors.

Low-income plans benefits would be substantially the same as those that are now required or can be provided under the medicaid program. Benefits would be provided generally without limits on the amount of services or cost-sharing requirements.

The public plan includes the following: unlimited inpatient hospital services; unlimited physician and other ambulatory service, including laboratory and x-ray (but excluding dental and psychiatric care); 100 days per year of skilled nursing services; 100 home health visits per year; mental health, alcoholism and drug abuse services (20 days of inpatient care and $1,000 in ambulatory services); for all mothers and children—complete prenatal, delivery and total infant care; scheduled preventive services for children to age 18.

Cost sharing for the aged and disabled—medicare's current cost-sharing requirement with following changes: substitution of annual hospital deductible rather than spell-of-illness deductible; no cost-sharing after individual pays $1,250 in out-of-pocket expenses; no cost-sharing for low-income aged or for aged and disabled with expenses exceeding 100 percent of difference between their income, and a national low-income standard. No cost—no cost-sharing required for persons eligible through entitlement to welfare assistance or because their income is less than low-income standard.

Individuals who purchase private plan coverage through premiums would be subject to $2,500 deductible for all services; except no cost-sharing imposed for prenatal services, delivery and total preventive and treatment costs for infants to age one.

Private plans would cover the same services as under the public plan, subject to a $2,500 limit on annual out-of-pocket payments. No cost-sharing on prenatal and infant care would be imposed.

S. 350 (Senators Long, Ribicoff, et al.) S. 351 (Senator Long, Talmadge, et al.)	S. 748 (Senators Dole, Domenici, and Danforth)

Administration

Provides that HEW would administer the public plan; and qualified private insurance companies of the employer's choice would administer the private plan. HEW would approve employer plans and the self-employed plans which would be required to comply with Federal standards. Exemptions from antitrust laws would be provided to permit carriers to enter a pool, reinsurance, or residual market arrangement.

For employer-based program, provides for civil penalty for employers who fail to comply with catastrophic coverage provisions. Also provides for employee private right of action against employer who fails to make available required coverage for amounts that would have been payable. For residual program, plans would be certified by the Secretary. HEW would administer premium subsidies for low-income persons and families, and would make income determinations and direct payments to insurance carriers. Insurance carriers would establish community rated premiums. Carriers would be permitted to establish insurance pools.

Financing

Provides for financing through a one percent tax on the payroll of employers and the income of the self-employed subject to the Social Security tax with 50 percent of the amount paid allowed as a tax credit. No employee contribution would be allowed. Private-insured employers and self-employed persons would also be eligible for a 50 percent tax credit on the amount paid for premiums and any additional amount paid to meet the payroll tax liability.

Low-income plan protection (S. 350 only) would be financed from general revenues and also with State medical assistance funds.

For employer-based plans, financing through employer and employee premium contributions, with employee share limited to 25 percent of catastrophic insurance costs.

For residual program, financing through premium payments from individuals and families. General revenues would be used to finance premium subsidies for the low-income population..

Provides initial Federal subsidy for employers whose payroll costs increase more than two percent as a result of compliance with the program.

S. 760 (Senator Long)	(Administration)

Administration

Employment-based plans would be subject to approval by the Secretary of HEW. Insurers offering qualified plans would also be subject to certain requirements regarding policies, claims procedures, etc.

Low-income benefits would be administered in a manner similar to the present medicare program, including the use of carriers as fiscal agents for the processing of claims and making payments to providers of services.

Public plan—Similar to Medicare's process of claims administration with use of fiscal agents, including insurance companies, data processing firms and others. Federal government would determine eligibility for aged and disabled. States would determine eligibility of categorically needy persons. Federal government (or States meeting performance standards) would determine eligibility for other low-income enrollees.

Establishes national minimum standards for all health insurance plans offered under the employer mandated program. Plans would be Federally-certified to assure adequacy and uniformity. Federal government would also offer a voluntary reinsurance program to HMOs, employers, and small insurance companies, covering 30 percent of costs of a policyholder when costs exceed $25,000.

Financing

Employment-based plans would be premiums financed, with employers paying the full costs of private catastrophic insurance coverage. Small employers and public and non-profit employers would be entitled to tax credits for up to 50 percent of premium costs.

Low-income plan protection would be financed from general revenues and also with State medical assistance funds.

The public plan would be financed through a combination of current medicare payroll taxes, premiums equal to current medicare part B premiums paid by the aged and disabled above the public plan low-income standards, premiums set at a national community rate for individuals and employer-groups with fewer than 10 employees, and additional subsidies from Federal general revenues. Any employer could purchase public coverage at premiums equal to 5 percent of payroll. State and local governments would share in costs for the low-income enrollees.

Private plan — employer-employee premium payments with employer paying at least 75 percent of cost of plan meeting Federal standards. Includes Federal subsidies to protect employers and low-wage workers from undue hardship.

S. 350 (Senators Long, Ribicoff, et al.) S. 351 (Senator Long, Talmadge, et al.)	S. 748 (Senators Dole, Domenici, and Danforth)

Standards for Reimbursement of Providers of Services

Requires that payments to and standards for providers would be the same under the public plan as that for medicare. Payments to skilled nursing and intermediate care facilities would be on a cost-related basis. Medicare reimbursement and other standards would not be applicable to employer plans.	No explicit provisions.

Other Major Provisions

Private insurers could obtain Federal certification that their basic health insurance policies that meet certain minimum standards of adequacy of coverage, eligibility and reasonableness of premiums. Health insurance facilitation programs would be established to assure that such basic coverage would be available to the general public.	Expands medicare benefits by deleting prior hospitalization requirement and numerical limits on home health services, adding occupational therapy as a primary home health service, increasing coverage of out-patient psychiatric benefits to $750 a year; and recognizing community mental health centers as providers.

S. 760 (Senator Long)	(Administration)

Standards for Reimbursement of Providers of Services

No explicit provisions.	Provider participation standards would generally be similar to medicare's. Permits reimbursement of services provided by nurse practitioners, physicians assistants or similar trained personnel, even if State law are more restrictive. Organized ambulatory care settings would also be considered reimbursable providers. HEW would certify providers, although HEW could enter contracts or agreements with private organizations or States to conduct certification review. Payment for hospital services would be governed by Administration's hospital cost containment program. Fee-for-service physicians would be paid on basis of a fee schedule, based initially on medicare physician payment levels. Insurance carriers may at their option, use health fee schedule in paying physicians. All physicians accepting public plan patients would be required to accept assignment of claims. Organized providers of ambulatory services could be reimbursed on basis of prospectively-set, all-inclusive rate per visit or a per capita rate for covered services provided to enrolled beneficiaries. HMOs would be reimbursed on basis of "average adjusted per capita community cost."

Other Major Provisions

Private insurers could obtain Federal certification that their basic health insurance policies that meet certain minimum standards of adequacy of coverage, eligibility and reasonableness of premiums. Health insurance facilitation programs would be established to assure that such basic coverage would be available to the general public.	Also includes various incentives designed to encourage health system reform and competition, including among other things, a new process for accessing health needs and determining adequacy of Federal programs, and a system for limiting hospital capital growth.