CATASTROPHIC HEALTH INSURANCE - HIAA & AMA POSITIONS

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HIAA and AMA both agree that there are some significant gaps in current health insurance coverage. While no one has any exact figures nor any way to obtain them, there is general agreement on the following estimates:

1. HIAA figures, as of December 31, 1977, indicate that 165 milllion people under age 65 have hospital expense insurance, about 150 million of these have medical and surgical expense, and about 150 million have major medical expense.
2. While the aggregate benefit in major medical has been increasing steadily in recent years and the majority of policies go to $50,000 or above, there are still a significant number at the $10,000 or $15,000 level. This means that there are then perhaps 70 million people under age 65 who probably do not have completely adequate "catastrophic" coverage.
3. It is estimated that about 20-22 million people are uninsured. This includes the poor (not eligible for Medicaid or direct welfare - 3.5 million), near-poor (just above poverty income limit such as marginal employers, seasonal and migrant workers - perhaps 10 million), high risk (uninsurable because of health), and others which include the voluntarily uninsured, short-term unemployed and dependents, strikes, loss of dependent coverage because of death of or divorce from employee, and dependent children attaining maximum age.

It is generally agreed then that there are some significant gaps in current health care coverage. The uninsured and underinsured people that almost everyone is talking about and writing about are principally the 20 million people noted above. Even governmental authorities agree that this is the group that needs attention promptly on a national basis. When it is pointed out to them that 90 percent of the people are probably taken care of quite adequately by current methods and they are asked why it is necessary to subject 100 percent of the people to a federal, all-inclusive plan such as the Kennedy-Corman Plan in order to get at the 10 percent, they have no answer. They reply only that the federal government cannot do something for 10 percent of the people without also doing the same thing for the other 90 percent.

On April 29, 1979, the HIAA Board of Directors approved the following resolution:

> "That the HIAA aggressively support the development of Federal catastrophic health insurance legislation which (1) encourages, through strong tax incentives and disincentives, employers to provide through the private sector a minimum catastrophic benefit to all employees and their dependents, (2) provides increased tax incentives for individuals to purchase such coverage, (3) provides for a pooling mechanism to guarantee the availability of that coverage to all Americans, (4) except for surveillance of compliance, avoids other intrusion of the Federal government in the regulation of insurance, and (5) uses any government revenues only for the purchase of improved benefits for the poor and Medicare recipients."

Further, the HIAA Board expressed the view that catastrophic benefits could be one phase of a plan to fill all existing gaps in coverage.

Under the HIAA plan, the employed underinsureds could rather easily be brought up to the "catastrophic coverage" standard by using current marketing and administrative mechanisms and this would require almost no outlay of federal tax monies.

The other and the uninsureds, as noted above, could be insured through a pooling mechanism with governmental agencies supplying sufficient money to cover an adequate premium for the poor, the near-poor, the uninsurables, and those temporarily unable to buy their own insurance. Those not presently insured on a voluntary basis could either obtain their insurance privately with appropriate tax credits or through the pool mechanism.

It is generally agreed by all concerned that the Medicaid situation is in very bad disarray and needs complete overhauling and probably a complete federal take-over.

Medicare coverage needs improvement. This could be handled directly through the present federal bureaucracy or the private insurance industry could handle the gap defect, again through either pooling or through tax credit mechanisms.

At the July 1979 annual meeting of the House of Delegates of AMA, the House gave the AMA leadership a solid vote of confidence for its conduct of AMA policy on National Health Insurance. That policy, briefly stated, is to maintain the high quality of medical care within the framework of private insurance. The House reaffirmed the four "Resolution 62" principles passed at the last meeting of the House in December of 1978. Those principles require minimum standards of adequate benefits in all policies sold with appropriate deductible and coinsurance features, a simple system of uniform benefits provided by governmental sources for those who ae not able to provide for their own

insurance or health care costs, a nationwide program by the private insurance industry to make available catastrophic insurance for everyone, again with an appropriate deductible and coinsurance feature, and finally that this program should be administered at the state level with national standardization through federal guidelines.

It must be immediately apparent that the official AMA position is almost exactly the same as the HIAA position. Both call for adequate benefits to be available for everyone by one means or another, the use of a pooling mechanism, federal guidelines and surveillance but state administration of any plan and using government revenues only for the purchase of benefits for the poor and Medicare and Medicaid recipients.

The House again left the matter of judgment as to the next move to be made in the hands of the Board of Trustees, recognizing that they must have a certain amount of flexibility and that social, economic, and legislative changes occur very rapidly and that the Board of Trustees had to be able to react to those changes in a prompt and effective manner.

A resolution opposing any and all federally controlled compulsory health insurance programs, which presumably would include catastrophic programs, was soundly defeated by a vote of 164 to 78. This is really in direct support for a federal program, IF THAT APPEARS TO BE NECESSARY, or at least support for federal guidelines and surveillance although the House still insists upon the principle noted above with respect to administration at the state level.

In related actions on NHI, the Delegates directed the AMA to continue to publicize the broad extent of existing health insurance coverage, to work for coverage of medical uninsurables, and to study the use of income tax credits and deductions to accomplish the goal of fair tax treatment for all for payment of health insurance premiums.

In public statements and discussions and particularly in the presence of grass-roots delegates and representatives, all of the conversation and statements keep the insurance plans on a voluntary level. Privately, however, the leadership of both the HIAA and the AMA recognize that the voluntary method will not work by itself.

There must be tax credits available or incentives of some kind to get those who can afford it to get their coverage up to standard. It must be mandatory for the 20 million or so presently uninsured persons to become insured adequately by one mechanism or another. No one believes it will be possible for the private insurance companies to get all of this done on a voluntary basis no matter how they go about it.

At the present time, it is premature to predict the shape of any legislation that Senate or House Committees will draft. It does appear that Senator Long has reacted very favorably to the HIAA presentation and it does appear that the Long-Ribiccoff Bill stands the best chance of passage of any current NHI legislation in the national Congress.

One of the big hurdles, of course, will be to obtain federal legislation permitting the formation of insurance pools, which at the present time are in conflict with the federal anti-trust laws.

Report From The Director of Continuing Medical Education

by Dr. Ferris J. Siber, M.D.

The following constitutes an analysis of the Questionnaires submitted for my review by the Registrants attending the "CONTINUING EDUCATION IN LIFE AND HEALTH INSURANCE MEDICINE SEMINAR" presented by THE BOARD OF LIFE INSURANCE MEDICINE and co-sponsored by THE ASSOCIATION OF LIFE INSURANCE MEDICAL DIRECTORS OF AMERICA, April 22-28, 1979.

I. Subjects and Lectures:

The responses included the following: Inclusion of Medical Directors' role in group consultation work. The subjects and lectures were uniformly excellent. The lectures were very good. All the subjects chosen were "just right". A discussion of the conduction defects and hemi-blocks on electrocardiography would be most appropriate. Subjects dealing with actuarial aspects of impaired risk insurance - pricing mechanisms, mortality experience. Excellent topics and well organized. Very high caliber presentations. A panel or lecture on employee health programs. All the important subject areas were addressed and almost always with excellence. Most practical conference I've ever attended. Superb. High quality and excellent. Include a section on immunology - autoimmune diseases. The lectures were excellent. The lectures were well prepared with adequate coverage for the time allowed. All very informative. Excellent. Very well prepared, and very good presentations. Very high standing. Most of the important subjects were covered. Cases in the workbook were fairly representative of problems we encounter. Dr. Siber's lectures were outstanding. Overall - probably the best Continuing Education Course I have attended inside or outside of the *Insurance Medicine* Group. I felt that the contents of the lectures was very adequate, but particularly those of Dr. Singer and Dr. Siber. Discussion regarding the morbidity and mortality of coronary aortic by-pass graft surgery. Work-

shop on reading chest x-rays would be helpful, including primarily the questionable findings we deal with daily. They were well done with excellent speakers and subject material. More on disability insurance coverage. More legal aspects.

In summary then, there was almost an unanimous response that the subjects indeed met the needs and desires of the membership and that the lectures were very good, excellent, superb. The guest speakers were considered excellent and most knowledgeable in their field of expertise.

II. Panels -

III. Workshops.

Most of the respondents felt that the format worked very well and that the questions addressed to the faculty members of the workshop (panel) were timely, interesting, and answered most satisfactorily. The increased dialogue between the faculty members and the Registrants was well received and appreciated.

The compactness of the group made it very pleasant and allowed a great deal of interchange of thoughts and ideas amongst the various members. Size of the workshops was "just right" and indeed the workshop was "manageable".

IV. Overall evaluation of the entire course.

Almost unanimously, the respondents felt that this Seminar met their educational needs and desires most adequately. There was almost a unanimous response "this Seminar was an excellent one, well organized, and indeed addressed itself to the problems like no other course has ever been presented either 'inside or outside' the insurance industry."

The overall response was almost unanimous in that this Seminar was a most informative and productive meeting.

Again and again, the comments of the Registrants would be characterized as excellent, superb, outstanding.

Those of us who were privileged to be involved in the planning, organization, administration, and evaluation of this Seminar may well feel very proud of our accomplishments.

Professional Activities

James C. Harris, M.D., has joined American United Life Insurance Company in Indianapolis as Assistant Medical Director. Dr. Harris was graduated from the Indiana University School of Medicine and maintained a private practice in internal medicine in Indianapolis since 1964. A veteran of the United States Army, he is past president of the Hamilton County Heart Association.

The Insurance Medical Scientist Scholarship Fund

by C. Paul Nay, M.D.
V.P. and Chief Medical Director
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In my last article, I indicated that the best way to promote the IMSSF would be for you to meet the scholarship recipients and hear fromm them what our Fund has and will accomplish in the fields of medical research and teaching.

Thanks to our President, Don Haskins, you will have an opportunity to do just that at our ALIMDA meeting in Atlanta this fall. Two of the speakers on the program, Drs. R. Michael Williams and Richard J. Cohen, are former IMSSF scholars who were supported at a key period of their training by the Massachusetts Mutual Life Insurance Company.

Mike Williams, at age 32, has recently been appointed Professor of Medicine and Chief of the Medical Oncology Section at Northwestern University Medical School. He was born in Little Rock, Arkansas and received his M.D. degree (magna cum laude) from Harvard Medical School in 1974. In the same year, he was granted a Ph.D. also from Harvard. In 1976, Mike became Assistant Professor of Medicine at Harvard Medical School and at the same time Associate in Medicine at Peter Bent Brigham Hospital and on the Professional Staff of the Sidney Farber Cancer Institute. A Phi Beta Kappa, Mike received the prestigious Frances Stone Burns award for research from the American Cancer Society in 1977. He is the author of some 40 publications in fields of oncology, pathology and immunology.

Mike is married and the father of two sons of whom he is quite proud. In a recent conversation with him, he expressed to me his deep gratitude to the IMSSF for making his illustrious career possible. In 1972, when he applied for our scholarship, Mike was at the end of his financial resources. Without the scholarship and with a family to support, Mike intended to leave school for an Army career. As we can now see, to have lost this fine young man's current and future contribution to research and teaching would be a tragedy for American medicine.

I know all of you attending this year's ALIMDA meeting will enjoy hearing these two fine young people. I intend to devote my next article to Richard Cohen and some of the fascinating research he is doing on ventricular irritability and the non-invasive identification of persons susceptible to ventricular fibrillation.