EXECUTIVE COMMITTEE MEETING

WEDNESDAY, SEPTEMBER 27, 1995

U.S. Senate

Committee on Finance

Washington, DC.

The meeting was convened, pursuant to recess, at 7:27 p.m., in room SH-216, Hart Senate Office Building, Hon. William V. Roth, Jr., Chairman of the Committee, presiding.

Also present: Senators Dole, Chafee, Grassley, Hatch, Simpson, Pressler, D'Amato, Murkowski, Nickles, Moynihan, Baucus, Bradley, Rockefeller, Breaux, Conrad, Graham, and Moseley-Braun.

Also present: Lindy L. Paull, Staff Director and Chief Counsel; Joseph H. Gale, Minority Staff Director and Chief Counsel; Julia James, Chief Health Analyst; Roy Ramthun, Health Analyst; and Susan Nestor, Health Analyst.

The Chairman. The Committee will please be in order.

I have to tell you, we are starting a little later than I had earlier planned on, Senator Moynihan. But, as you know, we did have an objection earlier today from a member on the Democratic side of the aisle. So I plan to meet for a couple of hours or so tonight, and then we will reconvene tomorrow morning at 9:00 a.m.

I would like to point out that, after our staff describes the further modification to the Chairman's Mark, Senator Moynihan and I have agreed that the first amendment will be the Moynihan-Rockefeller substitute on Medicare. This is the only substitute that will be offered. I think we have been discussing, Pat, that 20 minutes on each side ----

Senator Moynihan. Yes, sir.

The Chairman. ---- will be sufficient for the substitute.

I might point out, Pat, that we have something like 100 amendments pending, so that is going to keep us busy. I would like to hold the rest of the amendments to no more than 10 minutes, equally divided.

Senator Breaux. Mr. Chairman?

The Chairman. Senator Breaux?

Senator Breaux. Can we do them en bloc?

The Chairman. I would hope so. We are looking forward to that approach.

Senator Breaux. Just checking.

Senator Moynihan. That is very sensible, Mr. Chairman.

The Chairman. I would now like to call on Roy Ramthun to go over the modifications. Let me just say, with respect to the modifications, that some Members may wish to amend them. I would ask that you file such amendments with Lindy Paull by 9:00 a.m. tomorrow, Thursday morning.

Roy, do you want to proceed now to discuss the amendments?

Mr. Ramthun. Actually, I want Julie James to start, and I will quickly follow.

Ms. James. I just have an easy beginning. The first modification is to add language that would prohibit the Medicare payment for assisted suicide, and would say that the providers are not required to inform patients of the availability of such services.

Mr. Ramthun. Mr. Chairman, there is a very similar provision on page 3 of the modification to the Chairman's Mark, relating to Medicaid. In addition to the provision that would prohibit the use of Federal Medicaid funds for assisted suicide, it would also add a provision stating

that Federal Medicaid funds cannot be used to pay for abortions, except in the cases of rape, incest, or to save the life of the mother.

Senator Chafee. Mr. Chairman?

The Chairman. Senator Chafee?

Senator Chafee. Can we make comments on the Chairman's Mark?

The Chairman. How do you want to proceed on this?

Senator Chafee. Well, why do we not let him go through the modification, and then we will give you the opportunity to comment.

Senator Chafee. Thank you.

Mr. Ramthun. Mr. Chairman, the remainder of the modification to the Chairman's Mark deals primarily with the Medicaid funding formula. And I would call your attention to five handouts that should be on your desk. The first one that I will be starting with says, "FY 1994 Medicaid Federal Grants Per Person in Poverty."

Mr. Chairman, what this table shows is the current rank ordering of the amount of Federal funds that each State receives, per person in poverty, under the Medicaid program. You might be able to tell, looking at this table, that the amount of Federal funds that States receive today is primarily on the basis of the level of effort that States put up of their own resources.

Many of the States that are at the top of the rank ordering list also have the lowest Federal matching rates. Generally, those States have more ability to raise State funds to draw down the Federal matching funds. And you can see the level of disparities on the Federal funding across the various different States.

What we are proposing is a new Medicaid formula that would distribute funds across States on a need basis. If you will turn to the chart that says "Proposed Medicaid Formula." As this chart shows, and the board behind me shows, the amount of Federal funds that States would receive under the proposed formula change would be based on four basic factors: One, the number of people in poverty in the State; two, the national average spending per person in poverty; and two adjustment factors, one for case mix--that being the relative mix of elderly and disabled individuals, generally more costly, as well as low income families and individuals--and a health care cost index, which tries to give some accounting for the variation in the cost of providing health care services across the country.

Essentially, we are starting from a position where we are trying to reduce the disparities in spending across States, and we start with a national average benefits spending amount per person in poverty. That is

where we would like to get States to end up.

We are trying to make sure that every State will eventually receive enough money to cover every person in poverty in the State, all things being equal. So we have two adjustments for the case mix. Again, the relative share of elderly and disabled persons covered under the State's program generally being more costly to cover, versus low-income families and children, and the health care cost index.

The case mix index specifically is represented in the equation with the arrow above on the chart in front of you. The formula which multiplies the States' relative shares of elderly, disabled and low-income families, times the national average spending amount per individual in each of those categories, produces a weighted average case mix index.

The health care cost index is a blended index, 15 percent of which is a constant, and 85 percent of which is a wage index, which is the Medicare wage index used under the Medicare prospective payment system.

The next chart, has a series of columns. At the top, it says, "Expenditure Needs - Medicaid Formula," and we have poverty count, Medicaid case mix, cost index, the health care cost index and the average spending per person in poverty. It shows you the data for each State,

for each of these indices. The data is based on the most recently available data. The data would continue to be updated, so every time these calculations are done, there would be the most recent data used to calculate the equation.

We essentially multiply these four variables together, and come up with an aggregate expenditure need. We compare the State's expenditure need to its current Medicaid spending per person in poverty. Those States who are currently spending more per person in poverty would have restrained rates of growth in the future. States who are currently spending less than their expenditure needs would be allowed to grow at a faster rate.

I would turn your attention to the chart which says "Annual Growth Rates Under the Finance Committee Medicaid Formula." This shows you the growth rates that each of the States would receive under the Medicaid distribution formula in the Chairman's Mark. At the very bottom, you notice that the national rates of growth that are necessary to produce the necessary Medicaid savings to meet our budget target are 7.25 percent for 1996, 6.7 percent for 1997, and then 4.42 percent for years 1998 through 2002.

Every State would start with its 1995 actual

spending as its base. However, some of the excess disproportionate share payments would not be included in every State's base. States would be allowed to keep up to the amount of disproportionate share payments that equal 9 percent of the State's total Medicaid spending. That means that States which currently have a percentage of disproportionate share spending, less than 9 percent, get to keep all of their disproportionate share spending in their base. States who are currently above the 9 percent disproportionate share threshold can only keep the amount that equals 9 percent of their base. That is basically how we determine the State's initial base year, from which the rest of the calculations depend.

All States would receive the national growth rate of 7.25 percent from 1995 to 1996. We believe that States need a year of transition and some predictability in their funding. That is why we gave every State that rate of growth. I believe it is one of the first times we have given States some transition time. Starting in 1997, the growth rates would begin to vary, to start to reduce some of the disparities in spending per person in poverty across each State.

In 1997, the national growth rate is 6.75. Every State would be able to grow at least 2 percent, and other States would be allowed to grow at a faster rate, but no

more than 25 percent above the national growth rate of 6.75 percent. Twenty-five percent above the national growth rate of 6.75 equals 8.44 percent. So in the 1997 column, you will see a large number of States--I believe 40 in all--at the maximum growth rate of 8.44 percent. There are several States that are at the minimum growth rate of 2 percent, and there are a few States that are in between.

In 1998, again, the minimum growth rate is 2 percent. The national growth rate is 4.42 percent and, again, 25 percent above the national growth rate would determine the maximum growth rate for the remaining States, which turns out to be 5.53 percent.

I do want to point out two maybe strange-looking sets of numbers for the States of Louisiana and New Hampshire. You will see a couple of years of zero growth rate. The two States mentioned have approached us. They are States that have very large disproportionate share payments currently in their base, which they can no longer maintain, based on changes in the Federal law from 1991 and 1993 out of this Committee. They have agreed to reduce their Federal allocation amount, and hold it constant until such time as the State can raise a sufficient State share to begin to exceed the threshold that they have agreed to.

Last, I would draw your attention to the chart that says, "Finance Committee Medicaid Formula Simulation." This chart shows a simulation of States' Federal spending allotments for each of the fiscal years through 2002, with a 7-year total at the end. I want to emphasize very strongly that this is a simulation; this does not represent the actual amounts that States will be locked into.

We do not have the ability to forecast the actual amounts that every State will receive, for a variety of reasons. Number one, States have to put up State dollars, like they do under the existing program, in order to receive Federal matching dollars. This chart gives an illustration of the maximum amount under the current data that we have, that States might be able to receive, and gives you the corresponding growth rates from year to year, which do correspond to the growth rates on the previous table.

The one remaining change that is related to the Medicaid distribution formula is the treatment of disproportionate share hospital funding. As I described earlier, States would be allowed to keep up to the amount that equals 9 percent of total program funding as disproportionate share in their base.

This would require a modification of the Chairman's

Mark, which is listed in the modification, which would eliminate the original proposal where we had a $5 billion targeted Federal disproportionate share funding program. In its place, since disproportionate share funds are in each State's base now--they were previously taken out of each State's base--States would be required to include a description in their State plan of the manner in which it has addressed the special needs of the disproportionate share hospitals in their State.

The Federal criteria as to who is a disproportionate share hospital would remain the Federal criteria that were described previously in the Chairman's Mark.

Senator Moynihan. Mr Chairman?

The Chairman. Yes, Senator Moynihan.

Senator Moynihan. I wonder if it would be possible for there to be a staff briefing of the higher mathematics involved here. Mr. Ramthun has done a fine job, but ----

Mr. Ramthun. Certainly, Senator Moynihan.

Senator Moynihan. ---- I think at one point, when the Committee is not in session, it would be helpful.

In the proposed Medicaid formula, the Federal medical assistance percentage is 1 minus 0.45, times the square of the ratio of State per-capita income to U.S. per-capita income. So we are putting algebra into the

formula.

Mr. Ramthun. Higher mathematics, yes.

Senator Moynihan. Higher mathematics. We are now up to square. Would you consider square root?

Mr. Ramthun. Mr. Chairman, I am afraid you will have to answer that one. [Laughter.]

Senator Moynihan. I proposed it 17 years ago, to no consequence yet.

I see that New Hampshire has the highest per-capita Medicaid Federal grants. And they are obviously going to have a very hard winter when they see these proposals.

If we could have a staff briefing, sir, we would appreciate it.

Mr. Ramthun. Certainly.

The Chairman. I will make certain that happens, Senator Moynihan.

Senator Breaux. Mr. Chairman?

The Chairman. Yes, Senator Breaux.

Senator Breaux. I want to ask just a real general question. Can we get a comparison of how much money we are spending now under the current Medicaid formula, as opposed to how much we would be spending with these changes? I imagine this is a reduction in what it would be without these changes that are being proposed. My question is, how much of a total reduction in Medicaid

Federal contribution does this proposal envision?

Mr. Ramthun. This proposal is envisioned to produce the $182 billion to achieve our target. I believe you do have a CBO estimate in front of you--correct me if I am wrong--that illustrates the $182 billion savings figure.

Senator Breaux. I just do not see it right now. But can you tell me what we were spending under the current plan, what we would be spending, and what percentage reduction that would be?

It would probably be an increase in the actual amount, I guess. There is this big argument about we are going to spend more, and it is not a cut. You are probably spending more under this, but it would be less than it would be if we did not make the change.

Mr. Ramthun. No. This proposal is designed to fit within a fixed amount of Federal money each year. The distribution that goes on between the States happens within the parameters of the fixed Federal funding.

Senator Breaux. All right. But I mean ----

Mr. Ramthun. The amount of Federal funds available in each year produces reductions off of the baseline, which would total to $182 billion.

Senator Breaux. So, over 7 years, it is $182 billion less than it would have been?

Mr. Ramthun. Under current law.

Senator Breaux. Under current law.

Mr. Ramthun. That is correct.

Senator Breaux. And that $182 billion is 10 percent less than it would have been? Twenty percent less? Can you give me just a ball park figure there?

Mr. Ramthun. I do have the numbers here. One moment.

[Pause]

The Chairman. I might say to Senator Breaux that I understand Medicaid is growing over 10 percent, roughly 10.5 percent. Again roughly, under this proposal it would continue to grow at 5 percent, roughly half of what it was growing.

Mr. Ramthun. Senator Breaux, I thought I had it with me, but I do not. I will certainly get those immediately so I can give them to you.

Senator Breaux. Maybe somebody on the staff, I am just asking. If somebody says, how much are we cutting Medicaid, should I say 10 percent, 15 percent.

Senator Moynihan. Half.

Senator Breaux. Twenty percent?

Senator Moynihan. Half. You are cutting Medicaid in half.

Mr. Ramthun. We are cutting the growth rate in

half.

Senator Breaux. Cutting the growth rate in half.

Mr. Ramthun. Over the 7-year period, it is approximately a 20 percent reduction from the current law baseline. That is comparing the total amount of spending over the next 7 years under current law, and the total amount of Federal spending under the Chairman's Mark over the next 7 years. There is a reduction of 20 percent.

Senator Breaux. All right. That is what I wanted to know.

Senator Graham. Mr. Chairman?

The Chairman. Senator Graham?

Senator Graham. Mr. Chairman?

The Chairman. Yes.

Senator Graham. Mr. Chairman, first I have a question of the Chairman. As I understood, the request was that amendments that relate to the modification be filed by 9:00 a.m. in the morning. I wonder if we could ask for an extension of that. Many of us are going to want to have the benefit of the staff briefing to go into further detail on this, as well as review this with the people in our States who are technically competent to evaluate this formula. I doubt that we will be able to do that before 9:00 a.m. in the morning.

The Chairman. Yes. Why do we not make it 12 noon

tomorrow?

Senator Graham. Fine. Thank you, Mr. Chairman.

If I could ask a question. In terms of the growth that Medicaid has sustained in recent years, what proportion of that growth has been a function of additional people being added to the Medicaid rolls, and what proportion has been a result of increase in per-unit, or per-beneficiary costs?

[Pause]

Mr. Ramthun. I do have those figures.

[Pause]

Mr. Ramthun. Senator Graham, roughly one-third of the increase is due to enrollment growth. The other two-third are accounted for by health care inflation and increased utilization.

Senator Graham. So roughly 3.3 percent of the growth has been a function of increased enrollment, and 6.7 percent of inflation in medical costs?

Mr. Ramthun. Well, up until 1990, enrollment growth was very stable, was fairly flat. It did not increase more than 1 percent on an average annual basis until the period 1985 to 1990. But during that period, the growth rates were 9 and 10 percent per year, even though beneficiary growth was relatively flat.

By 1990, growth rates were starting to pick up a

little bit. Between 1990 and the projected amounts for 1995, beneficiary growth was growing almost 7.8 percent. But the per-capita spending is still growing 8 to 9 percent. And CBO projects that per-capita spending will continue to increase by 7 percent over the next 10 years.

Senator Graham. And what does your plan provide, in terms of per-capita increase in medical expenditures under Medicaid?

Mr. Ramthun. There is no direct linkage between the funding and per-capita enrollment growth, or anything like that.

Senator Graham. No. In per-capita medical increase?

Mr. Ramthun. It is virtually impossible to calculate on a per-capita basis because we do not know the exact number of beneficiaries that States would provide coverage to under their plans. The best we could possible do would be to try to make some calculation and some estimates of what States would do in their behavior. But I specifically asked the Congressional Budget Office what they would assume, and they said they could not estimate that.

Senator Moseley-Braun. Mr. Chairman?

The Chairman. Carol?

Senator Moseley-Braun. Thank you very much, Mr.

Chairman.

I would like to echo Senator Breaux's request, if we could have a formulation based on CBO baseline numbers. I have numbers here from the House bill, and, frankly, their formula seems to be a little less generous than this one is. And I do not want to compare apples and oranges, but the House calculation showed that my State of Illinois would have about a $6.8 billion cut, reduction, savings, whatever you want to call it, over the 7 years, or a 33 percent reduction, using their formula, which was 80, 55, 40, 40, 40, 40, 19. This formula for my State is 84, 55, 55, 55, 55, 40, 40. So it is a slightly different number run.

My question to you is, since we were just given these numbers when we walked in the door, what is the total dollar reduction over the 7 years for Illinois? What is the percentage reduction over the 7 years for Illinois?

Mr. Ramthun. Senator, there is no way for me to estimate that because we have no idea of what Illinois' spending would be over the next 7 years.

Senator Moseley-Braun. Well, based on the baseline numbers, you could run them. This projection here shows Medicaid estimated grant on this chart, again based on the calculus or calculation that you come up with, and

you are able to run the numbers here. You do not have comparable chart of what it would have been?

Mr. Ramthun. Senator, CBO does not provide estimates on a State-by-State basis for Medicaid. They only provide estimates on an aggregate Federal spending basis. So I have no way of giving you such a chart.

Senator Baucus. Will the Senator yield on that point?

I have the same chart. The House did it. I have a table here where the House broke it down on a State-by-State basis, indicating the reduction. For example, the State of Montana would get 37 percent reduction under the House formula by the year 2002.

Mr. Ramthun. I do not believe the House put those numbers out.

Senator Moseley-Braun. They are right here.

Senator Baucus. These are HHS numbers then.

Mr. Ramthun. I am sorry. I do not have a copy of those, so I cannot comment on them.

Senator Baucus. Well, do you not think it would be helpful if those of us who are very concerned about our States could have a sense of what the State breakdown is?

Mr. Ramthun. Well, anybody can make up projected growth rates for any State as they wish.

Senator Baucus. So you do not have any?

Mr. Ramthun. I could do it as easily as you could do it. To compare them to these numbers is clearly apples and oranges. There is no way to know what States would actually spend over the next 7 years. States' growth rates are not an even pattern that is very easy to follow.

Many different economic factors are important considerations when States look at their budgets. They are comparing Medicaid spending to welfare spending, to education spending, to transportation spending. For them, with some balanced budget requirement, it does force some difficult decisions at the State level.

So to say that States will continue to grow at their present rates, we are currently seeing State estimates come down already, and the States' own estimates for 1996 are under 5 percent growth. This would provide every State with 7.25 percent from 1995 to 1997.

Senator Moseley-Braun. Can I ask a question in just kind of plain English? What would be the dollar figure for Illinois if we did not do this?

Mr. Ramthun. I have no idea. I have no way of calculating that.

The Chairman. Could I suggest that we have a staff briefing on this matter in the morning, which I think will help clarify this for many of you?

Senator Baucus. Mr. Chairman, I think that is a good idea, but I am having trouble understanding how you can calculate national growth rates, but you cannot calculate State growth rates.

Mr. Ramthun. The Congressional Budget Office takes the States as a collection, makes assumptions looking at the history of the program, and makes estimates on a total-program basis for the Federal levels of spending. It does not calculate estimates, or make estimates or projections for individual States; it takes them as a collection. Every State is so different, and their historical spending patterns have been so different, that it would be very imprecise to even try to project the States' growth.

I am sure, if you asked your State, they would produce something for you, but whether we will actually hit that number, we do not know.

Senator Baucus. Just for my clarification then, if that is the case, then how can you come up with different growth rates for different States in putting together the Chairman's Mark formula?

Mr. Ramthun. Senator, I am starting with a fixed pot of Federal money for each year. And I am looking at how that is distributed, starting with a fixed base amount for every State. Then we distribute the increase

in the Federal spending from one year to the next on an allocation basis that allows some States to grow faster, some States to grow slower. But, in aggregate, the total increase in Federal spending would not increase more than 7.25 percent for 1996, 6.75 percent in 1997, and 4.42 percent per year from 1998 through 2002.

Senator Rockefeller. Mr. Chairman?

The Chairman. Yes, Jay Rockefeller.

Senator Rockefeller. Roy, maybe you could help on this. I am trying to deal with this chart here. In April, 1995, GAO came out with a report which talked about 8 or the 10 largest State. My State is not one of those. For every 1 percent in the increase in unemployment, should that occur, the Medicaid spending rises by about 6 percent.

More specifically, in 1991, in Massachusetts--again, this is GAO--there was a 2.8 percent jump in unemployment. And that led to a 17.6 percent increase in spending under Medicaid.

Now my question is, does this formula allow for outlays, readjustments, at times of disasters or enormous economic dislocations which, frankly, are known to smaller States as well as larger States?

Mr. Ramthun. Senator Rockefeller, States would be able to carry over unused Federal funds from one year to

the next. States could build up a credit balance that they could carry over into future years, if they needed to use them if their unemployment or other economic circumstances change.

Senator Rockefeller. Roy, in the case of my State, all the State legislature ever talks about, and has special sessions about, and the Governor worries about, is how to get more money to try to pay what they owe on Medicaid. So it is never a question of a reserve or a carry-over. It is a question of how you get to the end of the year, which is why this question of flexibility, as one cuts back 20 percent of Medicaid, not talking about the human cost of that, but simply what does a State do? And can this formula, which I can barely read--not because it is not done properly--because it is very small and hard for me to see.

Mr. Ramthun. We tried to keep it all on one page.

Senator Rockefeller. I eat lots of carrots and everything. But does this allow for the kind of adjustments that States have? And they are from Florida to California. We have them constantly. And all of this is during a time at which, because of cuts in Medicare and Medicaid, which I assume are going to go through, and because private employers are reducing health insurance, either to employees and their dependents or just the

employees and cutting out the dependents, there will be more people coming onto Medicaid. So the growth factor for people may in fact be larger than it has in the past, and probably will be.

Mr. Ramthun. I do not think you will find the specific provision you are looking for. We believe that there are sufficient funds in here, and sufficient flexibility to the States to make the necessary decisions to deal with those economic situations when they arise.

Senator Moseley-Braun. Will the Senator yield?

Senator Moynihan. Mr. Chairman, if I could just say, we were going to commence voting. And we have the possibility of a substitute measure which would resolve all these question, and quite readily. And I do not doubt that we have enough votes to do it.

The Chairman. I think the time has come when we can move on.

Senator Moynihan. There is plenty of time to talk. The briefing will help a lot.

Senator Chafee. Mr. Chairman?

The Chairman. Yes.

Senator Chafee. I just want to make a couple of comments on one matter, if I might.

The Chairman. Senator Chafee?

Senator Chafee. Mr. Chairman, You added in the

language--if we want to call it the Nickles proposal language--as part of your Mark. That language says, "In addition, Federal Medicaid funds could not be used to pay for abortions, except in cases of rape, incest, or to save the life of the mother."

I think it is very unfortunate, Mr. Chairman, that you put that language in there. As you know, that is language that comes along on appropriations bills every year. We dutifully vote on it. Sometimes it is modified, and indeed it has been modified over the years.

With this in the Chairman's Mark, and if this becomes part of the bill, that means that this so-called hard language is part of Medicaid language in perpetuity. And I think that is very unfortunate. It does not give us a chance to revisit it every year, as we can currently do under the appropriations process.

And I might say, Mr. Chairman, there is nothing in this bill dealing with Medicaid that provides monies for family planning. So what we have done, if this succeeds, is to deny women Federal money for abortions. You can say, well, you can always use the State money. Well, they can use the State money for anything, but here we are dealing with the Federal monies. At the same time, we are denying them, or not providing any money for family planning services.

So I think that is an unfortunate combination, Mr. Chairman, for poor women in this country. And I am distressed that that was included.

Now let me ask you a question, Mr. Chairman. Of course, I thought there were no more entries into the Chairman's Mark, but apparently this is. If this was the ground rule, it is all right. But we were not aware that this was going to come up in this fashion. Should we choose to strike, or do something else, amend it, is that still open to us?

The Chairman. Yes. I would say, John, as I indicated earlier, there will be the opportunity to offer amendments to these changes until 12:00 o'clock noon tomorrow. So there will be the opportunity to make a motion to strike, or whatever you think is appropriate.

Senator Chafee. Thank you, Mr. Chairman.

The Chairman. I would now like to call on Senator Moynihan and Senator Rockefeller to present their substitute to the Chairman's Mark.

Senator Moynihan. Thank you, Mr. Chairman. We have had a good discussion all yesterday, and we have done so again tonight. And we realize what an extraordinary change is being suddenly presented to the nation. It may not have full awareness of this yet. It may take a great deal of time for it to actually sink in.

But it can be avoided by a simple set of measures which we are hereby offering.

We have an amendment which replaces the $270 billion in Medicare reductions in the Chairman's Mark with a total of $275 billion. That is made up of $89 billion in Part A savings, $16 billion in Part B, and the $170 billion fiscal dividend, which we will get when we reach a balanced budget by the year 2002, which CBO has said will be scored, and will be available for our purposes.

What we do, sir, in the first place, we have $89 billion in Medicare Part A savings, which is basically your amendment, but there is no reduction in indirect medical education payments, disproportionate share payments or hospice payments. Other provisions have been shaved by CBO to get to $79 billion. We pick up $10 billion from depositing secondary payer and fraud and abuse savings into the Part A trust fund, which you also approved.

And then, sir, we have a $16 billion savings by extending the Medicare Part B premium at 25 percent. It is scheduled to go down to 21 percent later on.

I want to share this time with colleagues on either side. I simply want to say that it makes no sense, it defies reason, to cut taxes at the same time we are slashing medical care to the retired persons and, of

course, to poor persons as well, as Senator Chafee has said. If there is a fiscal dividend coming, we should have that dividend because we should balance our budget, but we should not use it for a tax cut; we should use it to make the minimum necessary reductions in provision of health care for retired persons, poor persons, and for poor children.

We have 20 minutes on our side. I yield 5 minutes to my colleague and friend from West Virginia, Mr. Rockefeller, my cosponsor.

Senator Rockefeller. Thank you, Senator Moynihan.

The amendment, as Senator Moynihan said, explicitly recognizes that $270 billion in cuts is absolutely and totally unnecessary for the purpose of dealing with the HI trust fund. Eighty-nine billion is all that is necessary to do that. We have a letter from the Chief Actuary of HCFA, which indicates that $89 billion in Part A over the period of 1996 to fiscal 2002 would extend the life.

What is interesting is that the Republican plan which, according to CBO, would extend life to the year 2007, only extends it 1 year more at $270 billion in cuts than does our amendment at $89 billion in cuts.

Senator Moynihan. We go to 2006--10 solid years.

Senator Rockefeller. Right. The amendment also,

if you want to do this part now, Part B ----

Senator Moynihan. It is all part of the amendment.

Senator Rockefeller. Yes. The amendment also includes a provision we think is part of the Congressional intent. It keeps the Part B premium at 25 percent. The rhetoric on the Senate floor was to continue it at 31.5 percent. Well, of course, it does not continue; it goes back to 25 percent unless we make a specific act to change it. We think that specific act should not be made, and this Committee wrote the actual Part B premium dollar amounts into law. So we would leave it at that.

And it is interesting because Part B spending ended up being slower in fact than CBO had originally estimated. So Part B premiums sort of drifted up, have now arrived at that 31.5 percent of Part B costs. That was not Congressional intent.

This means that, if the Republican plan is accepted, seniors would pay $19.90 per month, $240 more per year. In West Virginia, the average senior makes $10,700 a year, therefore that is not an insignificant increase.

I hope the Committee adopts this amendment. We do not even get into the Republican plan would do in terms of rural hospitals. The genuine fear of people in hospitals is spread by Democrats, not spread by rhetoric,

but spread by hospital administrators who are looking at their balance sheets, and they are terrified of what is going to happen. They do not seem to know. I am not sure, in this Committee, with a staff briefing and a 12:00 o'clock deadline tomorrow afternoon, that we know exactly what we are doing on Medicaid, which I think is extraordinary.

And I will report that the Republican plan to cut Medicare was first crafted before the release--I repeat, before the release--of the Medicare trustees report projecting insolvency for the year 2002, which says explicitly what the purpose of it was, which was for the tax cut. Coming from a State that Senator Moynihan knows very well, I am profoundly offended by the prospect of a tax cut, and its effect on pregnant women, children and others. Although the Chairman said they were guaranteed care, they are not. And that will be the subject of an amendment.

I think what this does is restore Medicaid to what we intended it to be, and yet addresses the HI trust fund, the health insurance trust fund, in a responsible manner, and then looks forward to a longer-term solution, based upon the Greenspan Commission, on which both Senator Moynihan and Senator Dole performed brilliantly. And I never received any mail as a result of that

commission because everybody agreed, people know what they were talking about, everybody agreed they were going to vote for it; it was passed by the House, the Senate, signed by the President, became law, and that was that.

And I hope that this amendment is accepted.

Senator Moynihan. I thank the Senator, my cosponsor, very much.

Senator Breaux, 3 minutes.

Senator Breaux. Thank you, Mr. Chairman.

Mr. Chairman, my colleagues, the problem we have tonight is before us because we have a budget that was conceived in the other body, and it was given birth on the steps of the House of Representatives. They made the decision that this Committee was going to have to cut Medicare by $270 billion. That was a number they picked out of the hat.

The facts are that the people who look at these numbers tell us very clearly that we need $89 billion to fix Medicare; we do not need $270 billion, we need $89 billion, and that will fix it until the year 2006.

That takes care of the short-term problem. That will not be easy to do. That will call for cuts, it will call for sacrifices. It will be very difficult to achieve, but it is something that I think this Committee should and must do. That would fix Medicare until the

year 2006.

The proposal of the Committee Chairman gets credit for $50 billion for going to managed care. I like managed care. We tried it 2 years ago. Some people said it was terrible 2 years ago. Today, some of the same people say it is a great idea because it saves us $50 billion.

So, all right, let us accept the $50 billion in savings from managed care. That means we only have $39 billion more in cuts. And I think this Committee could do that, not without some pain, but we could certainly achieve it, and say we have fixed this system until year 2006.

Then I would suggest that we are not through when we do that. I would suggest that a bipartisan commission needs to look at some long-term changes to really fix what is basically a very archaic system, which I think, and we almost all agree, is not working as best it should as we move into the 21st century.

But we should not try to do it tonight. We should not try to do it in the next 10 days. We should look at it in a bipartisan fashion, fix the short-term problem. It is an $89 billion problem, not a $270 billion problem. And none of this is our idea. This came over from the other body, conceived and born on the steps of the House

of Representatives. And we are having to agonize over it. I do not think we should do that.

Senator Moynihan. Thank you, Senator Breaux.

Senator Bradley, 3 minutes, sir, if you could.

Senator Bradley. Mr. Chairman, I would just like to make a couple of points. A number of them have already been made; I think they need to be reiterated.

We have heard the rhetoric that the reason we need $270 billion in Medicare cuts is because the trust fund is about to go bankrupt. Of the $270 billion of Medicare cuts embodied in the proposal that is before us on the other side, only $85 billion in cuts go to saving the trust fund, bolstering it up. That is all we need.

But, in addition to that, the proposal cuts $126 billion in Part B, which goes for general deficit reduction. And it is done that way to make room for the tax cuts that the other side has proposed.

But the effect of the Part B is essentially to deny a tax cut to senior citizens, who were scheduled to have what they pay the doctors drop from 31 percent to 25 percent. But, instead of that, we are going to keep it at 31 percent, which is to say no tax cut for senior citizens, and instead have a tax increase. Mr. Chairman, it makes no sense to me to do this.

Another $50 billion of this $270 billion comes from

the assumption that we are going to push senior citizens into managed care programs. They are going to choose managed care programs. Of course, if they have to pay more, that is out of their own pockets. So they will pay more out of their own pockets for various programs for health care. They will pay more out of their pockets when they go to the doctor, if they choose fee-for-service. And there will be an excess of about $180 billion more than we need to save the trust fund. One hundred billion dollars more is embodied in the Republican proposal than we need to save the trust fund. That should be clear to everyone, that this is a decision to reduce the budget deficit by asking seniors to contribute $180 billion more than is needed to save the trust fund.

What we have done in this proposal is say, let us save the trust fund. Let us save $89 billion out of Part A, and that is it. From my perspective, that is far superior to the proposal that is before the Committee.

Senator Moynihan. Thank you, Senator Bradley.

Senator Baucus?

Senator Baucus. Thank you, Mr. Chairman--Democratic Chairman.

Mr. Chairman, all of us on this side feel constrained to make the very basic points which just cry

out against this proposal in the Chairman's Mark.

We are in a very difficult artificial situation here. Under the budget resolution which, in effect, says that if the authorizing committees, including this Committee, do not come up with their "cuts," in the aggregate, there will be no tax bill whatsoever. It is an on and off switch; it is not a proportionate matter.

That is, if the authorizing committees, or if this Committee is about, say, $30 billion short, we cannot reduce the tax bill by $30 billion. We just cannot go to the tax bill, assuming other committees do not make up the difference. It is an on and off switch. It is not a proportionate matter, which forces a very, very artificial constraint upon this Committee to come up with this artificial, incorrect cut in Medicare.

It is just wrong. But that is the situation the Budget Committee has forced us into, and I suspect that is one of the main reasons why Senators on the Minority side voted against the budget resolution.

Now it has been said many times, it is worth repeating, there is no crisis in the hospital insurance trust fund. There is no crisis. It is a fabrication, it is a myth for people to say that Medicare is in crisis. It is not in crisis. The Medicare trust fund will only go belly up under our proposal in 10 years. That is more

than the usual number of years of solvency for Medicare.

Nine or ten times, in the 30 years of Medicare, the trustees have said that the trust fund is going to be insolvent. One time, 2 years, another time 4 years. We are saying 10 years. That is more than the average number of years of solvency under the proposal offered by the Senator from New York, which is only an $89 billion cut in Medicare over 7 years, not $270 billion, as proposed by the Majority.

In addition, the right way to deal with the minor problem facing Medicare is obviously to deal with it in the same way dealt with Social Security in 1982, when the Senator from Kansas, the Senator from New York, other Senators, on a bipartisan basis, Republicans, Democrats, private sector, public sector, came up with some good, honest solutions to Social Security. The Social Security trust fund is now in very good shape.

That is obviously the way to do it here. Take the politics out of the little problem facing Medicare, come up with some solid solutions, instead of just slashing, bleeding for the sake of tax cuts for the most wealthy.

So, Mr. Chairman, I am frankly appalled at the Mark. And I think the Senator from New York is correct when he says that this is a major consequence. It may not be fully understood today, but it will be more understood in

the next weeks, the next months.

And I just say to Americans listening, this is a major decision before us. Unfortunately, it is being foisted upon us very quickly, and it is very unfortunate that we are not dealing with this in a more deliberate, nonpartisan way, as we could if we had a commission, as opposed to cutting Medicare in this fashion.

Senator Moynihan. Exactly so.

Senator Moseley-Braun, would you like to speak to this matter?

Senator Moseley-Braun. Just very briefly, Mr. Chairman. I support your substitute amendment. I just think it is an outrage that senior citizens and people who run hospitals are being called upon to pay more money so we can have a tax cut. I just do not understand that. It is not logical to me. The responses in terms of what States will do in these situations has not been a rational one. You know, how will a State that loses 33 percent of its funding deal in times of hardship?

I know this is going to pass because this is partisan political thing. I am the newest Member of this Committee.

Senator Moynihan. Hope springs.

Senator Moseley-Braun. Eternal. All right. Yes. Well, I do hope it passes. I hope your substitute

passes. And I hope we can come up with something that is not so partisan. It seems to me that the American people really do not want to see us scrapping on political grounds.

These issues are not Republican or Democrat issues; they are people issues in the final analysis. I just hope that we find our way, instead of railroading this thing, to do the right thing, to do the right thing, to take a sensible, considered, judicious approach to trying to solve what is a national issue.

Senator Moynihan. Thank you, Senator.

Senator Graham?

Senator Graham. Thank you, Senator.

My colleagues, we have been proceeding under the myth that the only way to achieve a balanced budget is to take these Draconian cuts in the health care programs for our most vulnerable citizens.

These two programs, Medicare, which is the subject of the amendment, and Medicaid, which we will be discussing shortly, represent 17 percent of the Federal budget. We are asking these two programs to take 45 percent of all the cuts--45 percent of all the cuts--to achieve a balanced budget. I just ask you and the American people, does that on its face sound fair? Clearly, the answer is no.

My colleague and Ranking Member, we also need to be very careful about what we are doing. We are dealing with highly vulnerable Americans. We owe it to them, and we owe it to our own sense of professionalism as legislators to carefully evaluate the implications of what we are about to do.

I would suggest some of the possible, even likely, implications of what we are going to do. One is that we will not achieve the budget numbers which are projected. A very respect health economist has suggested that, rather than the medical savings account costing us in lost revenue, the $2.3 billion upon which this plan is predicated, in fact the medical savings account could lose us up to $15 billion over the next 7 years.

Instead of seeing an increase in the number of persons enrolled in managed care, which is a foundation stone of the savings, we could in fact see people disenrolling from managed care programs.

The plan before us, as the amendment offered by the Majority, would, for instance, result in the managed care plan in the largest county in this country, Los Angeles County, with 306,000 members seeing a $777. per year cut in what is paid to managed care plans. That kind of sharp reduction is going to result in a reduction of benefits to managed care beneficiaries, and probably a

reduction, not an increase, in the number of people covered. Who will pay the consequences if our numbers are in error? Under the so-called Belt plan ----

Senator Moynihan. Belt indeed. Belt in the belly.

Senator Graham. ---- which is the 1990's version of the plan that worked so well to control our deficit in the 1980's, Gramm-Rudman-Hollings, we will see the fee-for-service component of Medicare pay 100 percent of the consequences of the failures in managed care and medical savings accounts. That does not sound like a proposal the American people would like to support.

Finally, there are tremendous impacts on State and local governments. This is the grandmother of all unfunded mandates that we are about to impose upon our State and local governments, at 8:36 in the evening, without much of an opportunity for us to know or them to understand what is about to explode upon them.

I would suggest that prudence calls for doing what we need to do, but holding for another day the serious consideration of fundamental change in our Medicare program.

Senator Moynihan. I thank the Senator from Florida. We have 2 minutes remaining for the Senator from North Dakota.

Senator Conrad. I thank Senator Moynihan. I must

say that this reminds me of a plan that the Republicans often decry by accusing those on our side of the aisle. Whenever we raise questions about fairness, and whether or not the burden is being distributed equally, they say, well, that is class warfare. Really, this is a case of the pot calling the kettle black because what we have, in effect, got here is a plan in which you go around to all the people in the country, at least the lower-income people, the lower-income working families, and middle-class families with a sack. And you say to them that they have to put money into the sack in order for us to take care of the family problems. We have a big budget problem, and you have got to put money into the sack so we can make the books add up. Then we find out that they are taking half the sack and going to the wealthiest among us, and saying, here, you get the sack.

It is not going to solve the problem that exists in the budget of the United States, the family budget at large. This is money we are bringing to you by way of a burnt offering, I guess. I do not understand it. We are going to give a $20,000 a year tax cut to people earning $350,000 a year. And we are financing it in part by saying to people who earn $28,000 a year, who qualify for the earned income tax credit, we are going to take $1,500 from you over the 7-year period.

You go to the senior citizens and say, we are going to take $2,500 from you over the 7 years to put into the sack, so we can go and deliver it to the wealthiest among us, those earning $350,000 a year, to give them a $20,000 tax break. If that is fair, it eludes me.

Senator Moynihan. Mr. Chairman, you have heard very eloquent statements. I thank the Senator from North Dakota.

I would make a final remark. We all here know--we are not required to say, but we all here know--that the idea of cutting health care in order to cut taxes was a notion that arose on the steps of the House of Representatives. At no time, until this last week, has it had any support in this Committee. But we are ready to vote, sir, after, of course, you have your time.

The Chairman. Well, let me start out by saying that the idea that the steps we are taking to preserve and strengthen the health programs are really to make possible a tax cut is pure demagoguery. Make no mistake about it.

I notice that the Washington Post has had a series of editorials where they express their concern and unhappiness with what they call Mediscare, the effort to try to scare the senior citizens because of the steps that we are taking, the purpose of which is to preserve

and strengthen health care for the senior citizens, as well as Medicaid.

We are not the ones who said there was a problem. It is the board of trustees for Part A of Medicare that has said that the program is going into bankruptcy if we do not do anything about it. They said that there will be no money in the trust fund in Part A by 2002.

Just let me quote what the Washington Post had to say about this claim that this action on our part is to make possible a tax cut. It says, "The Democrats have fabricated the Medicare tax cut connection because it is useful publicity. It allows them to attack, and to duck responsibility, both at the same time. We think it is wrong." And I think it is wrong as well.

What we are trying to do, as I said, is to preserve and strengthen these programs. In the case of Medicare, the problem is that it is out of date. We want to give the senior citizens choice, the opportunity to have different kinds of programs that are best suited to its needs. Unfortunately, the Democratic plan does not address that.

There are three specific weaknesses in the Moynihan-Rockefeller amendment. First, the Moynihan-Rockefeller amendment does nothing to help with Medicare part B spending. According to the Medicare trustees, the SMI

trust fund, or Part B, shows a rate of growth of cost which is clearly unsustainable. Our actions on this Committee must address this pressing concern. At the moment, Part B is growing, Pay Moynihan, something like 19 percent faster than the economy. To put it off only delays what needs to be done to preserve and strengthen the system.

Second, the Moynihan-Rockefeller amendment does not go far enough to help with the Medicare Part A trust fund. As I said a few minutes ago, Part A will run out of money by 2002, which means that Medicare will not be able to pay its bills. Eighty-nine billion dollars in savings does not take care of the problem in any substantive way. It only delays the inevitable.

On the other hand, the Finance Committee proposal, boldly reforms the program, gives us the time to get ready for the baby boomers.

And third, as I said, the Moynihan-Rockefeller does nothing new for seniors. There is no opportunity for seniors to choose health plans that best meet their needs. There is no effort to integrate private market incentives into the Medicare program. This is simply more of the same. And, frankly, we do not think that is good enough.

We believe that the Medicare program must be moved

into the future, not mired in the policies of the past. What worked in the 1960's will not work in the 1990's. It is not working now, and it certainly will not carry us into the new millennium.

Senator Dole. I will just take a minute. I cannot remember the precise date, but several weeks ago, months ago now, I suggested to President Clinton, along with Speaker Gingrich, that we do in Medicare what we have done successfully in Social Security with a commission where we had Democrats and Republicans. As pointed out by Senator Baucus, Senator Moynihan and I were fortunate to be on that commission.

The President called it a gimmick. It was not a gimmick; it worked. So we dismissed that idea. Probably, if we had done that several months ago, we might have had a report now from a commission made up of Democrats, Republicans and people from all works of life. And we might not have the partisan dispute we are having now.

But that did not happen. I do not know if the President has changed his mind or not. But I think the record should reflect his view, how he viewed a bipartisan, nonpartisan commission approach to strengthening and preserving Medicare.

I am also reminded that the 1993 tax bill, the

largest tax increase in the history of America, $265 billion, takes $54 billion away from senior citizens over a 7-year period by taxing benefits. And not a single Republican voted for that tax increase that affected seniors, everybody who drives a car, and a lot of people who are not rich, even though that was the story then. Now we are told that we are cutting programs for the rich.

The Senator from Oklahoma is going to have an amendment, which he will describe, which will do pretty much what I think was done in 1993, to set aside and lock up these funds. I do not know how you lock them up, but the President thought it was a good idea. We did it. And I think Senator Nickles will comment on that.

It just seems to me that we have a tremendous job to do. I am just looking over the Moynihan-Rockefeller substitute, and I notice they use many of the savings we use. So at least we are in agreement, if we are going to make savings as far as part A is concerned.

We make pretty much the same Part B. We keep it at 31.5 percent; you go back to 25 percent. The original law was supposed to be 50 percent. We have never reached 50 percent, and we are afraid to keep it at 31.5 percent. And that is a voluntary program; you do not have to be in Part B Medicare. It is paid out of general revenues, not

payroll. So somebody working in a kitchen somewhere, or somebody changing tires, or somebody working anywhere in America is paying 68.5 percent of somebody's premium, whether they are billionaires or paupers.

Now we address that by increasing the premium if you are single and make $100,000 or more, or if you are a couple of $150,000 or more in income. We tried to address that. Maybe it should be lower, whatever. So I would hope that people understand that Part B is voluntary, that it comes out of general revenues. The program is growing and growing. The original intent of the law was to be 50 percent paid for, and I think we have been fairly consistent by keeping it at 31.5 percent. As I recall, you raised it by some $50 billion, $53 billion or $54 billion.

Senator Bradley. One hundred twenty-six billion.

Senator Dole. But, in any event, for all the reasons I can think of, I cannot vote for the substitute. But I think we do have a duty to make the case on our proposal, which we hope to do tomorrow or Friday, or sometime next week.

Senator Nickles. Mr. Chairman?

The Chairman. Senator Nickles?

Senator Nickles. Mr. Chairman, first let me make a couple of comments concerning the Democratic proposal,

because it does have many of the things we have for Part A. That is the reason why I think you are able to say that you are keeping Part A solvent until the year 2006 or something. But you did not make any changes in Part B. And I think some changes are called for.

Also, I want to mention that I have heard so many of our colleagues say that we are cutting $270 billion out of Medicare. Just a couple of facts--we are spending $177 billion in Medicare in 1995, and we will be spending $286 billion in the year 2002. That is $110 billion more. And it increases every year. I think the average increase is about 6.6 percent.

Also, this is very interesting. Looking at President Clinton's budget that he submitted on July 14, I was looking at his outlays, total outlays under Medicare, compared to the total outlays that we are proposing. The differences are not all that great. But we will come back to that.

The President uses OMB; we use CBO. The President said he was going to use CBO, but he has a growth rate in Medicare of about 7.1 percent gross outlays. We have gross outlays increasing in Medicare about 6.4 percent. There is not that much difference. I just did a quick summation. It is about $41 billion difference.

Now we do make some changes in Part B. We do keep

Part B at 31 percent. That is what it is right now. We do say that we should stop subsidizing wealthier people, people who make as individuals over $100,000 or couples over $150,000. We should stop subsidizing those individuals as far as Part B. And I recognize that you did not do that in your substitute. But I also know, in talking to many colleagues on both sides of the aisle, that people have said maybe we should be doing that. That is in ours.

Then I will say, under our proposal, we do have options. CBO said we can save maybe about as much as $50 billion by offering seniors lots of options. They should be entitled to have options. They should be able to choose among different types of health care, including the same Medicare system they have right now. They should have the option to choose different types of health care. And we think we can have some real savings by that.

So I would hope that we would not adopt the substitute offered by our colleagues on the other side, but recognize that they did step forward at least on Part A.

And I would follow up with the Leader's comment that we will try to see if we can do something to make sure that whatever savings we have in Part B, or whatever

revenues, the difference between the 25 and 31 percent and the elimination of the subsidy, we will try to make sure that those revenues stay in Part B. Because Part B has problems. In 1970, Part B cost $2 billion. In 1995, part B cost $66 billion. It has really exploded in costs, and reforms are certainly long overdue.

Senator Chafee. Mr. Chairman?

The Chairman. Senator Chafee.

Senator Chafee. Thank you, Mr. Chairman.

I heard one of the Democratic Members refer to the trustees' report with the suggestion that they are just crying wolf, do not worry. There is no crisis out there. Well, these were appointees of the Democratic President of the United States. And in this report, which everybody has a summary of here, they use language such as--and these are the public trustees--"We strongly recommend that the crisis presented by the financial condition of the Medicare trust funds be urgently addressed." Now, I do not know what stronger language you can have than that, "the crisis be urgently addressed."

And who are these people? Are they a bunch of fly-by-nighters? Well, the include Secretary Rubin of the Treasury, Secretary Reich of the Labor Department, Donna Shalala, Secretary of HHS, and Shirley Chater,

Commissioner of Social Security. What do they talk about? The trustees believe that prompt, effective and decisive action is necessary. These are not some words of, just give it a passing glance, will you fellows? But do not really worry about it. These are words to get going.

Now, Mr. Chairman, we have got a real problem in this country of ours. Thirteen cents of every dollar that the Federal Government spends is borrowed. And this is during a peaceful time, relatively good conditions, low interest rates, not too high unemployment, and we are still borrowing and passing the bill on to our children. I think that is just plain wrong.

So we are making cuts in a whole series of programs, reducing rates of growth in Medicare and Medicaid, which is the subject before us, Medicare.

Now there has been some discussion of Part B. Just look at these figures.

Senator Breaux. Would the Senator yield for a question? He is making a good point.

Senator Chafee. Yes. If I could just finish, and then I will be glad to answer questions.

Senator Breaux. All right.

Senator Chafee. Part B is currently costing $36 billion of Federal dollars, dollars from the Federal

Treasury, exclusive of what people have paid for insurance, but out of the general Treasury which we are all paying for taxes. The street sweeper and the person working in a jewelry shop and a person working on a punch press, his or her taxes are going in to help pay very wealthy people's doctor bills under Part B. That is just plain wrong. And we have addressed that here. And I think it is high time we did that.

So I do not think we should get bogged down and talk about tax cuts, or this or that. As you all know, I have never been for these tax cuts. But that has nothing to do with doing something about trying to recover some money that we believe should be recovered to help reduce the deficit of this country and put this program on a sound basis.

I would be glad to answer a question. I do not know how much time we have.

The Chairman. We are almost out of time, so I will have to yield to Senator D'Amato.

Senator D'Amato. Well, Mr. Chairman, I am going to make it brief because I believe Senator Chafee went right to the nub of this.

How can we in good conscience permit this system, as it relates to Medicare Part B, to continue? To have wealthy people, people with incomes of $100,000 a year,

an individual, pay 31 point some odd percent of his or her premiums, and to have that deficit being made up by working people, taxpayers, young couples. That is ridiculous. I do not even think we go far enough. But I commend the Chairman in at least saying that, if you make $100,000, you ought to buy your own insurance, pay for your own part, which comes to about $145 a month. And for a couple that makes $150,000, they have to pay for this. This is a savings. This is the kind of thing we have got to begin to do.

It is so easy to sloganeer, and that is what we have got, a log of sloganeering. If you are going to put this system on a sound basis, there is going to have to be some sacrifice. If we do not have the courage to match up to this, we are really running out on the American people.

So I would hope that we would get to the business of making meaningful reform. I commend my senior Senator and colleague for some of the suggestions he has made--fixing up Part A, recognizing that--and also for his call to look at the CPI and some of the adjustments that have to be made.

So I would have to vote against this amendment. But I do say that at least there is a recognition that we do have a problem here, and I think we are going to have to

face up to our task. It is too easy to go home and say, oh no, they are raising all your premiums. By gosh, some of these premiums should be raised. If you are wealthy, you should not have working middle-class families subsidizing you. That is just wrong.

Senator Rockefeller. Mr. Chairman, out of the $270 billion, I see $9 billion relates to the means-tested program. So we could do what Senator D'Amato said, and we would still be cutting Medicare.

Senator Moynihan. Do we have an agreement here?

The Chairman. The time has expired on the substitute. So the clerk will please call the roll.

The Clerk. Mr. Dole.

Senator Dole. No.

The Clerk. Mr. Packwood.

Senator Packwood. No, by proxy.

The Clerk. Mr. Chafee.

Senator Chafee. No.

The Clerk. Mr. Grassley.

Senator Grassley. No.

The Clerk. Mr. Hatch.

Senator Hatch. No, by proxy.

The Clerk. Mr. Simpson.

Senator Simpson. No, by proxy.

The Clerk. Mr. Pressler.

Senator Pressler. No.

The Clerk. Mr. D'Amato.

Senator D'Amato. No.

The Clerk. Mr. Murkowski.

Senator Murkowski. No.

The Clerk. Mr. Nickles.

Senator Nickles. No.

The Clerk. Mr. Moynihan.

Senator Moynihan. Aye.

The Clerk. Mr. Baucus.

Senator Baucus. Aye.

The Clerk. Mr. Bradley.

Senator Bradley. Aye.

The Clerk. Mr. Pryor.

Senator Pryor. Aye, by proxy.

The Clerk. Mr. Rockefeller.

Senator Rockefeller. Aye.

The Clerk. Mr. Breaux.

Senator Breaux. Aye.

The Clerk. Mr. Conrad.

Senator Conrad. Aye.

The Clerk. Mr. Graham.

Senator Graham. Aye.

The Clerk. Ms. Moseley-Braun.

Senator Moseley-Braun. Aye.

The Clerk. Mr. Chairman.

The Chairman. No.

And Mr. Hatch votes no, by proxy.

The Clerk. All right. The nays are 11, the ayes are 10.

The Chairman. The substitute does not carry.

Senator Moynihan. Did I hear 10? Good. Let us hold it right there. [Laughter.]

Senator Breaux. We have another Democrat.

The Chairman. I would now like to turn to the rest of the amendments. As I mentioned in my mark-up letter, I am ruling out of order en bloc the nongermane amendments under Committee rule 2-A. A list of the nongermane amendments is at your desk.

I would point out that this has been a practice of past chairmen. Most recently, Senator Packwood enforced this rule at both of our mark-ups earlier this year.

In addition, as I stated in my mark-up letter, I am ruling out of order en bloc amendments that CBO says will reduce the spending savings in the Chairman's Mark, and that are not offset with additional spending savings. A list of these amendments is also at your desk. CBO is still trying to score a few remaining amendments, so the list is not an exclusive one.

In addition, there are a handful of amendments that

may be in order and, therefore, are not on this list, depending on how the proposal is drafted. If staff cannot work out the drafting, then these amendments will be ruled out of order on a case-by-case basis.

Again, I would like to point out that there is a precedent for this approach. During the 1989 mark-up of child care proposals, imposed a similar rule.

Senator Moynihan. Mr. Chairman, just in the interest of procedure and comity, could I ask that our staff have an opportunity to look at these amendments before you rule them out of order and, if we have objections, that you hear our objections?

Senator Baucus. If the Senator would yield on that point.

Mr. Chairman, one reason there is no offset is because we are unable to get these amendments scored by CBO. And that is because we did not know it was in the bill until just yesterday. Many of us have tried to get some scoring so that we can figure out what the offset would be, but we could not get any scoring because CBO did not have an opportunity to look at any of these amendments.

Senator Moynihan. This is not meant to delay, but just to give us a chance to look and offer you, if there are occasions, to say that we think this is not the case.

The Chairman. Well, as I indicated, CBO has found that these do not have adequate offsets, but I would be pleased ----

Senator Moynihan. By noon tomorrow?

The Chairman. Yes, until noon tomorrow.

Senator Moynihan. Until noon tomorrow. Is that understood?

I thank the Chair.

Senator Bradley. Mr. Chairman?

The Chairman. Yes. Senator Bradley.

Senator Bradley. Mr. Chairman, I would just like to inquire why we are following this procedure. I know there is some minute precedent that one may cite, but it is not really going to prevent people from offering amendments because, when you rule them out of order, we will just appeal the ruling and we will have a vote.

To the very sophisticated observer, that would insulate somebody from a recorded vote on something, but in reality it will not. I have been on the Committee since 1979. It never happened when Russell Long was Chairman. It never happened when Senator Dole was Chairman. It never really happened during the bulk of the time when Senator Packwood was Chairman. And it really did not happen when Senator Bentsen was Chairman, except in the minute subject matter. And it did not

happen when Senator Moynihan was Chairman.

And I do not think it solves your problem because that does not mean that somebody is not going to offer an amendment. So I am just curious about what you hope to achieve by this.

The Chairman. Well, I would point out that part of our problem is that we have 125 amendments. So we are trying to expedite the process. As I said, there is precedent for it. CBO has ruled that these particular amendments listed on this page do not have adequate offset. The purpose of our meeting, of course, is to meet the requirements of the budget resolution, which requires certain targets to be met. That is what we are charged with, and that is what we intend to do. We are hopeful that we will get cooperation from both sides.

Senator Conrad. Mr. Chairman?

The Chairman. Yes, Senator Conrad.

Senator Conrad. Mr. Chairman, I notice that my durable medical equipment amendment was listed on your list of amendments without offset.

But on your amendments that are accepted en bloc, you have Dole amendment number 1, which is on durable medical equipment. Those two amendments are precisely the same amendment. Yet, when it is a Democratic amendment, it is ruled as not having an offset. When it

is a Republican amendment, it is accepted en bloc.

The Chairman. I have just been advised that you are correct, Senator Conrad.

Senator Dole. It is a Dole-Conrad amendment.

The Chairman. So it is a Dole-Conrad or Conrad-Dole amendment.

Senator Conrad. Some of my most successful amendments have been Dole-Conrad amendments. [Laughter.]

The Chairman. And we will be happy to accept it under those circumstances.

Senator Moynihan. That is why we need until noon tomorrow.

Senator Grassley. Mr. Chairman?

The Chairman. Yes, Senator Grassley.

Senator Grassley. Along the same lines as what Senator Conrad just said, only not because one is a Republican and one is a Democrat, I have two amendments on your list. Number 13 on your list, Grassley amendment number 1, disclosure plans, there is no cost to that whatsoever because that just says that, in the information given out by the organization, they have to put that information in their information.

The Chairman. Well, Senator Grassley, it shows that we are not discriminating on the basis of party on these matters.

Senator Grassley. But why did you do that?

The Chairman. As I said, we submitted these to the Congressional Budget Office. And it was on the basis of their findings that it was determined that there was not adequate offset.

Senator D'Amato. In fairness to the Chair, what is the explanation?

I think there are a number, if I might just mention this. I could mention a couple also, where we do not agree with CBO initially that there is not an adequate offset. One or two that Senator Moynihan and I have submitted, we believe, and staff is working on that, and they will come back and indicate that there is no offset necessary.

So I think we have a couple of these. And I am not going to bother the Chair at this point. But I mention it for all my colleagues.

The Chairman. I would point out to you, Senator D'Amato, that earlier on I pointed out that there were a number of amendments about which questions have been raised. An effort is being made to work them out, and hopefully that will be the case.

Senator Grassley. Then another one, number 6, is one of those Mennonite amendments I had for the Mennonite Church. Obviously, that cannot be a cost to the

taxpayers.

Senator Bradley. I do not think so.

Senator Moynihan. I am for that amendment.

Senator Chafee. Mr. Chairman, you have treated me with total consistency. You did not accept any of my amendments. [Laughter.]

Senator Rockefeller. Mr. Chairman?

The Chairman. Yes.

Senator Rockefeller. Over here. Mr. Chairman.

The Chairman. Senator Rockefeller?

Senator Rockefeller. Speaking on behalf of Senator Chafee and myself, Rockefeller number 7 is referred to as the same as Chafee number 8. And I appreciate the comparison, but I believe it does deal with foster care in the welfare reform bill. And I need to call the attention of the Committee to this because welfare reform is Section IV of what we are doing because it has budget implications. And that has not been discussed in this Committee at all. But it is a proper amendment. CBO is dead wrong when they say the offset is not proper because we have simply cut the Federal matching share from 50-50 with the States to 45 for the Feds and 55 for the States. By definition, that is a mathematical offset.

So my suggestion to you is, it is very well known by all of us at this table who have been working with CBO in

recent days, that they are absolutely overwhelmingly swamped, exhausted, absolutely dead on their feet--not by nature, but simply by circumstance.

To simply say that these things are ruled out of order, I do not know how many of Senator Graham's are done, but there are an endless number. He is a worthy legislator. It seems to me not fair to make such a spontaneous judgment from an exhausted group of people who, in the case of Chafee and Rockefeller on foster care, are absolutely wrong.

The Chairman. Well, as I have already stated, we will give until tomorrow the opportunity to review these.

Senator Rockefeller. But, Mr. Chairman, to be honest, I do not think that does it. There is going to be a staff briefing tonight, whenever that is. Then we come back in here at 9:00 o'clock. I presume we go ahead with amendments. When is this synergy going to take place between staff who have been briefed and us who have not. And then at 12:00 o'clock the amendments are due, which requires writing. And our staff is exhausted. There was one staffer here last night who gave birth to a baby 6 weeks prematurely. I am not saying it was because of the stress, but there are a number of staff people who are pregnant. There are a lot of staff people who are exhausted. And I really do not think it is fair to put

this burden on them. I do not think it represents the Finance Committee working at its best potential, and that includes us.

The Chairman. I have to say, every time there is a mark-up, the staff does work long hours, and I cannot say that this one is any different than the earlier ones.

But let me go back to the revised schedule for Thursday. There has been a request, and we have agreed that there would be a staff briefing on the Medicaid formula in the morning. So we will let that take place then. At noon, as I mentioned, there can be additional amendments filed on today's modifications only, and we will postpone our meeting because the Senate will not recess until 2:00 p.m. So we expect that the Finance Committee will begin about that time, and work late.

Senator Dole. Mr. Chairman?

The Chairman. Yes.

Senator Dole. Could I say, in reference to 2:00 o'clock, that is not definite because we are trying to dispose of the State Justice, Commerce Appropriation bill and the continuing resolution. We will try to accommodate the Committee because, otherwise, we are into next week. But we could do it next Tuesday or Wednesday if we cannot do it tomorrow, but we will vote on that later.

The Chairman. Well, hopefully, we will be able to.

The Chairman. Well, Senator Wellstone objects to our meeting. That is the problem.

The Chairman. Our understanding is that we will not be able to meet tomorrow because of the objections on the part of the Democrats.

Senator Moseley-Braun. Mr. Chairman?

The Chairman. Yes.

Senator Moseley-Braun. Just a little technical point. On the list of amendments without offset, you have Moseley-Braun number 1, Moseley-Braun number 2. And I cannot determine because there is a discrepancy on this list. I believe this refers to numbers 7 and 8, and not 1 and 2. But I could be wrong, it could be the other way around. Could I get the staff to clarify?

Senator Moynihan. We have a lot of scrubbing to do.

Senator Moseley-Braun. Excuse me.

Senator Moynihan. We have a lot of scrubbing to do.

Senator Moseley-Braun. A lot of scrubbing. All right. I just wanted to point that out that there is a discrepancy. Two of my amendments have fallen off the edge of the earth.

Thank you, sir.

Senator Moynihan. I do think, Mr. Chairman, we do have a list of amendments which are proposed to be accepted en bloc. If you could add one from the Senator from New York, I think we ought to do that.

Well, my dear friend and colleague has three, so that works out pretty good.

If there is no objection on our side, I move that we accept en bloc the amendments listed numbers 1 to 20 on the page you have given us.

Senator Rockefeller. Senator Moynihan, not meaning to disrupt anything, but I would like to add Senator Chafee's administrative foster care amendment to that.

Senator Moynihan. You are sure that there is no cost involved?

Senator Rockefeller. It is simply a change in the formula, absolutely budget neutral.

Senator Moynihan. That is true.

The Chairman. I would say to the distinguished Senator, if you work with the Committee, we will try to work out the problem so that can be done.

Senator Bradley. Mr. Chairman?

The Chairman. Yes.

Senator Bradley. I made my earlier point, that I think it would actually work better for you, but you have to make the decision since you are the Chairman, to just

bring the things up and debate them. I am not sure whether these appeals, if they are in public, are going to have a bigger impact. But I think some of my colleagues think so. Therefore, I am in line, and I would hope that, if you have included Senator D'Amato's amendment in the approved list, you would also put mine in. It deals with the same subject matter--a little different view on the subject matter, but the same subject matter.

Senator Moynihan. Could I say, Mr. Chairman, I do think we want to look at each of these amendments, and see if we agree. Why do we not just wrap up for the night, and let the staff go to work. [Laughter.]

The Chairman. I think that is a good suggestion, Senator.

So we will recess, and come back tomorrow at 2:00 p.m., or the call of the Chair.

Senator Grassley. Did you adopt these amendments?

Senator Moynihan. No, we did not, sir.

The Chairman. No.

Senator Grassley. All right.

The Chairman. The Committee is in recess.

[Whereupon the Committee recessed at 9:08 p.m., to reconvene at 2:00 p.m. on Thursday, September 28.]

LISTING OF AMENDMENTS

September 27, 1995

BAUCUS

1. Home and Family Farm protection (with Senator Conrad)
2. Rural Health Amendment

BRADLEY

1. HHS sanction for States out of compliance with Medicaid plans
2. Sense of Senate on EITC-tax cuts (with Breaux & Conrad)
3. Child Support Collections - striking 10% fee

BREAUX

1. EITC -- double taxpayer penalties
2. Vaccine Amendment
3. Sense of Senate on EITC-increasing poverty (with Bradley)

CHAFEE

1. State flexibility in Medicaid and guaranteed health coverage for low income seniors
2. Guarantee health coverage to low-income pregnant women & children
3. Guarantee health coverage to low-income disabled individuals
4. Assure minimum basic benefit package to low-income individuals
5. Assure safety-net for low-income individuals in medically underserved areas both urban and rural
6. Prevent disruption in services to low-income individuals in states spending up to their maximum allocation
7. Correct technical omission in Uruguay Round (URAA) on generic pharmaceutical products
8. Foster care - reduce federal match rate to 45%
9. Child Support - restricts how much a state may charge a custodial parent
10. Child support - changes incentive payments

CONRAD

1. Mental health services
2. Sense of the Committee--use any budget dividends for deficit reduction
3. Certified nurse anesthesia service payment - Medicare (with PRESSLER)
4. Medicare integrity
5. Spousal impoverishment (with BAUCUS)
6. Durable medical equipment upgrade policy (same as Dole #1)
7. Authorize psychologist supervision of partial hospitalization
8. Disabled individuals

D'AMATO

1. Mitigate IME and DSH payment reductions-a
2. Mitigate IME and DSH payment reductions -b
3. Establish Capital Transition Exceptions Process
4. Disproportionate Share to Eligible Hospitals through Identification of Medicaid Managed Care Enrollees
5. Actuarial methods for projecting expenditures and setting capitation payments
6. State plan process
7. Retroactive lawsuits
8. Closing out payments under Title XIX
9. No limits on states' practices for raising revenue to fund Title XXI expenditure
10. Governor's certification

DOLE

1. Durable Medical Equipment upgrade policy (same as Conrad #6)

GRAHAM

1. Medicaid access & quality protection -- per capita cap alternative
2. Uninsured rate -Sunset trigger (with Moseley-Braun)
3. Infant mortality rate -Sunset trigger (with Moseley-Braun)
4. Pre-existing conditions
5. Medicaid formula proposal
6. Medicaid funding distribution proposal
7. Maintenance of effort - real State dollars
8. Maintenance of effort-no cost shifting to local governments
9. Maintenance of effort- disallow supplanting of funds
10. Coverage standards if performance goals are not met
11. Continuation of treatment
12. Medicare Anti-Fraud and Abuse Program (with Pryor & Baucus)
13. Emergency Services

GRAHAM (continued)

14. Medicare dependent hospitals
15. Nondischargeability of certain Medicare debts
16. Improved Prevention in Issuance of Medicare provider numbers
17. Hospice Service Payments

GRASSLEY

1. Additional information on plan restrictions
2. Access to specialist services
3. Budget Expenditure Limit Tool (BELT)
4. Plan Informational Section -- enrollees can add own funds to Medicare payment amount.
5. Proposal for treatment of portable X-rays/EKGs. (same as Grassley #14)
6. Enrollment in Medicare choice
7. Solvency requirement in Medicare choice
8. Medicare Choice plan options
9. Beneficiary contributions
10. Medicaid restructuring proposal-secondary payor
11. Medicaid restructuring proposal-formulary
12. Medicaid restructuring proposal-drug rebate repeal
13. Medicaid restructuring proposal-additions to Advisory Group for Medigrant Task Force.
14. Proposal for treatment of portable X-rays/EKGs. (same as Grassley #5)
15. Amend Accrediation section for Medicare Choice

HATCH

1. Primary and Preventative Care
2. Information provided to beneficiaries of Medicare Choice plans
3. Children with special health care needs
4. Supplemental rebates
5. Skilled nursing facilities
6. Indian Health Service
7. Expand Medicare Chiropractic Services - authorized

MOSELEY-BRAUN

1. EITC- strike child support
2. EITC - strike qualifying children requirement
3. Cost Sharing Amendment
4. Transitional Medicaid
5. Civil Rights Amendment
6. Disabled Children Amendment
7. Child support - does not allow states to charge collection fee to custodial parents
8. Child support - strikes fee collection provision

MOYNIHAN

Substitute Amendment with Senator Rockefeller

1. Teaching Hospital Graduate Medical Education Trust Fund
2. Disproportionate Share Hospitals - Medicare
3. Disproportionate Share Hospitals - Medicaid
4. Medicaid federal funding
5. EITC - strike all but compliance initiatives
6. EITC- sunset proposed changes
7. Supplemental EITC
8. Additional EITC modifications regarding supplemental credit
9. Medicaid Federal funding - income no longer subject to squaring
10. Medicaid Federal funding - match is 50%

NICKLES

1. Prohibition of funds for assisted suicide-benefits
2. Provider-Sponsored Networks
3. Lock-box Provision
4. Prohibition of funds for assisted suicide-accountability
5. Prohibition of funds for abortion

PRYOR

1. Medicaid nursing home quality of care
2. HCFA approval of State nursing home standards
3. Medicaid drug rebate program
4. Medicaid drug rebate program - maintain inclusion of nursing facilities.
5. Medicaid drug rebate program - establish task force to study
6. Medicaid drug rebate program - Veterans' Health Care Act.
7. Quality standards for coordinated care plans
8. Medicaid drug rebate program - grandfather under Uruguay Rounds Agreement (URAA)

ROCKEFELLER

1. States must cover children under 19 living under 100% of poverty, and pregnant women living under 185% of poverty
2. States must cover all qualified Medicare Beneficiaries who have Alzheimer's and live under 100% of poverty.
3. State payments to hospitals and nursing facilities
4. CBO analysis of effects of proposed changes on children, elderly and disabled.
5. Medicaid beneficiaries must have access to health care within 30 miles of their residences.
6. Foster Care Amendment - reduce federal match to 44.1%
7. Foster Care Amendment - reduce federal match to 45%
8. Provider-sponsored network option
9. Strike budget-driven caps on managed care payments
10. Primary Care Access
11. Out-of-pocket protection for beneficiaries from BELT
12. Preserve Current Law Balance Billing protection for all Medicare Beneficiaries.

SIMPSON

1. Affluence-test Medicare Part B Premiums for the wealthiest 10% of Medicare recipients
2. Affluence-test Medicare Part B Premiums for the wealthiest 15% of Medicare recipients
3. Modify the Consumer Price Index
4. Requiring a co-payment of $15 for Medicare Part B beneficiaries each time they receive physician services
5. Penalty to Home Oxygen Services suppliers for discontinuing service

125 Amendments Total

SENATE FINANCE COMMITTEE

September 26, 1995
List of Amendments

# of Amendments	
1	Mr. Dole
0	Mr. Packwood
10	Mr. Chafee
15	Mr. Grassley
7	Mr. Hatch
5	Mr. Simpson
0	Mr. Pressler
10	Mr. D'Amato
0	Mr. Murkowski
5	Mr. Nickles
10 + Substitute	Mr. Moynihan
2	Mr. Baucus
4	Mr. Bradley
8	Mr. Pryor
12	Mr. Rockefeller
2	Mr. Breaux
8	Mr. Conrad
16	Mr. Graham
6	Ms. Moseley-Braun
0	Mr. Chairman
122	TOTAL

Dole #1

DURABLE MEDICAL EQUIPMENT

Between lines _____ add new subsection (b):

(b) "For purposes of this subtitle, any individual purchasing or renting customized or upgraded durable medical equipment may do so by paying the difference between such customized or upgraded equipment at the point of sale or rental from a supplier; such supplier shall bill and receive the amount equivalent to such covered durable medical equipment as specified in this section."

Purpose:

To permit medicare beneficiaries to rent or purchase customized or upgraded equipment. The amendment allows the beneficiary to pay the difference between the standard medicare payment and the cost of the equipment. The payment by the beneficiary is made directly to the supplier. The supplier then bills and receives payment directly from medicare or the health plan for the standard equipment.

Amendment offered by Senator Chafee **#1**

Purpose: To give States additional flexiblity in the Medicaid program while slowing the rate of federal spending under Medicaid, without eliminating federal standards for eligibility, quality and access to care. And providing a guarantee to health care coverage for low-income seniors.

Description: Strikes the Medicaid proposal in the Chairman's mark and retains the existing Medicaid program with the following changes: establishesa per capita cap. In addition, rather than repealing all federal standards for quality of care, eligibility, and access to care, the amendment provides States flexibility in the following areas:

Flexibility

Repeals payment requirements under Medicaid including payment to hospitals and nursing homes, federally qualified health centers, and rural health clinics.

Allows states to enroll Medicaid beneficiares in managed care plans without applying for a federal waiver from the Secretary of the Department of Heath and Human Services, provided plans meet minimum federal standards for solvency and quality of care.

Gives states the flexibility to determine the scope of treatment services to children. Does not require states to provide treatment services under the Early Periodic Screening, Diagnosis and Treatment program unless the treatment services are otherwise covered in the State Plan.

Per Capita Cap

States would receive a federal matching payment for each eligible individual based on the existing state matching formula up to a maximum amount. That amount would be based on state spending in fiscal year 1995 for each of four categories of eligibility. These categories include: non-disabled children, non-disabled adults under age 65, disabled individuals under age 65; and individuals aged 65 and over.

Amendment offered by Senator Chafee **#2**

Purpose: To guarantee health care coverage to low-income pregnant women and children.

Description: At the appropriate place, insert language which reinstates the current law guarantee to basic health care coverage for pregnant women and children aged 12 and under, living in families below 100% of the federal poverty level.

Amendment offered by Senator Chafee **#3**

Purpose: To guarantee health care coverage to low-income individuals with disabilities.

Description: At the appropriate place insert language which reinstates the current law guarantee to basic health care coverage for individuals who are eligible for Supplemental Security Income as amended by the welfare reform proposal.

Amendment offered by Senator Chafee **#4**

Purpose: To assure a minimum basic benefit package to low-income individuals.

Description: At the appropriate insert language which requires States to cover, under the revised Medicaid program, any services which they require private insurance plans to offer.

Amendment offered by Senator Chafee **#5**

Purpose: To assure a health care safety-net for low-income individuals in medically underserved areas, both urban and rural.

Description: Changes to Disproportionate Share Hospital program in the Chairman's mark, by earmarking $750 million each year for Federally Qualified Health Centers and Federally Certified Rural Health Clinics which meet certain requirements.

or At the appropriate place, set aside one percent of all Medicaid spending each year and establish a mechanism for direct federal payments to Federally Qualified Health Centers and Federally Certified Rural Health Clinics which meet certain requirements.

Amendment offered by Senator Chafee **#6**

Purpose: To prevent disruption in services to low-income individuals living in States which are spending up to their maximum allocation.

Description: Funds that states do not choose to spend under their state allocation for any fiscal year shall be made available during the next fiscal year to states which are spending all of their allocation. These funds shall be redistributed at the discretion of the Secretary of the Department of Health and Human Services.

Amendment offered by Senator Chafee **#7**

Purpose: Insert where appropriate an amendment to correct an inadvertent technical omission from the patent law provisions of the Uruguay Round Agreements Act (URAA) that denied manufacturers of generic pharmaceutical products the transition benefits available to all other manufacturers of generic products.

Description: When Congress enacted the URAA last year, a transitional provision was included to ensure the equitable application of this new law to existing patented subject matter. The transition provision sought to balance the interests of patentees receiving additional intellectual property protections with the legitimate expectations of persons who had made significant preparations to manufacture the product legitimately once the patents expired. Absent a conforming amendment to the Food, Drug & Cosmetic Act, FDA has ruled that it does not have the authority to approve pending applications to manufacture generic equivalents of several important patented drugs whose patents are about to expire. In essence, these patent holders have received an unintended windfall at the expense of generic manufacturers and consumers.

A conforming amendment would result in savings under the Medicaid program.

AMENDMENT BY SENATOR CHAFEE #8

Reduce the match rate for administration costs for foster care 10 percent, from 50 to 45 percent.

CBO estimates that this provision would save $1.2 billion over seven years (see attached)

Foster Care budget options for the Senate Finance Committee
Assumes November 15, 1995 effective date.
D-R-A-F-T
Compared to CBO baseline

(By fiscal year, outlays in millions of dollars)

Direct Spending		1996	1997	1998	1999	2000	2001	2002	Five-Year Total	Seven-Year Total
Reduce growth of foster care administrative costs to 10% a year at:	BA	-60	-190	-200	-230	-250	-270	-280	-960	-1510
	OT	-70	-180	-200	-220	-250	-270	-280	-920	-1470
Reduce federal match rate for foster care administrative costs from 50% to 45%.	BA	-140	-165	-180	-190	-205	-220	-235	-880	-1338
	OT	-115	-165	-175	-190	-200	-215	-230	-845	-1290

This is a preliminary estimate.
a/ This assumes that the 10% cap in growth of administrative costs would apply to each state.

W/ Chafee #8

AMENDMENT BY SENATOR CHAFEE #9

- States would be required to collect an amount equal to the $25 application fee and ten percent of collections for non-AFDC families who use the IV-D child support services.

- States may not charge more than one percent of a child support order for custodial parents with incomes below 185 percent of poverty, or more than 2 percent of the child support order for custodial parents with incomes over 185 percent of poverty.

- States would have the option of how to collect the money, including (1) charging interest, (2) sliding scale fees, (3) cost recovery from non-custodial parents who deny paternity and are later found to be the father, and (4) non-custodial parents that do not use administrative processes for the establishment and enforcement of support orders.

There is no loss of savings for this provision.

AMENDMENT BY SENATOR CHAFEE #10

Establish strict national standards for the areas of performance laid out in S. 1120 (i.e. the percentage of collections, ratio of child support collected to child support due, support orders established) that states must attain before receiving incentive payments. These standards would not be based on current average performance -- for example the current national average for percentage of cases with collections is 18.2 percent. Instead, they would be based on a threshold of, for example, 40 percent, before becoming eligible for incentive payments.

CBO estimates that this amendment will save approximately $600 million per year.

Grassley #1

Grassley Amendment on Information About Plan Restrictions

Chairman's Mark

Item 5 of Information subsection of Medicare Choice Section (p. 12) reads:

"The restrictions on Medicare payment for services furnished to the enrollee by other than the Medicare Choice plan's participating providers."

Amendment

Strike subsection c and replace with:

"c. The restrictions on coverage for services obtained other than through the plan's participating providers; any possible restrictions on services furnished through the plan, such as might occur through preauthorization review, concurrent review, post-service review, or post-payment review; and any financial incentives that might limit treatment or restrict referrals, such as economic profiling of providers, capitation, or bonuses or set-asides which might be furnished to providers who meet spending goals established by the plans."

Grassley #2

Grassley Amendment on Access to Specialist Services

Chairman's Mark

Item 3 of the Health Plan Standards subsection of the Medicare Choice Section (p. 15) reads:

"A Medicare Choice plan must make all Medicare covered services and all other services contracted for available and accessible lwithin its service area, with reasonable promptness and in a manner that assures continuity of care."

Amendment

At the end of Section 3a add:

"Services requiring specialist care must be provided by specialists qualified under quidelines developed by the appropriate medical specialty societies (to the extent that those quidelines exist). All health plans must establish arrangements to provide the full range of specialized care for enrollees, including enrollees with rare, unusual or highly complex conditions."

Grassley #3

Grassley Amendment on Budget Expenditure Limit Tool (BELT).

Chairman's Mark (p.53-54)

"A Presidential order to bring spending within the annual target for the fiscal year shall be issued on October 15. The order will specify the reduction in payment amounts for provider services which are necessary to meet the annual spending target. OMB will be required for purposes of this title to use CBO economic assumptions for purposes of reports required by this title.

"Under a BELT compliance order, each payment amount for covered services (as determined under Medicare law and regulations) would be reduced by a specified percentage which when applied proportionally to all payments will equal the amount of reduction needed to bring the previous or current fiscal year in compliance with the BELT targets. Rules similar to those under G-R-H Section 256 will apply to determine when a payment for services has occured."

Amendment

Amend Paragraph 4, beginning at the bottom of page 53, and paragraph 2 on page 54 of the Chairman's Mark to read:

"A Presidential order to bring spending within an annual target for the fiscal year shall be issued on October 15. **The order will identify the market areas (as established under the Medicare Choice Program) that have exceeded the annual targets based on allowable per capita spending in those areas.** The order will specify the reduction amounts for provider services which are necessary to meet the annual spending targets **in market areas exceeding the targets.** OMB will be required for purposes of this title to use CBO economic assumptions for purposes of reports required by this title.

"Under a BELT compliance order, each payment amount for covered services (as determined under Medicare law and regulations) **in market areas in which Medicare payments have exceeded allowable spending** would be reduced by a specified percentage which when applied proportionally to all payments will equal the amount of reduction needed to bring the previous or current fiscal year in compliance with the BELT targets. Rules similar to those under G-R-H Section 256 will apply to determine when a payment for services has occurred.

Add after the preceeding paragraph:

"(Congress recognizes that per capita spending varies widely from market area to market area. It intends to impose the BELT adjustments only on those markets that exceed the targets without interference in markets that are in compliance with annual targets.)

Grassley #4

Grassley Amendment to Plan Informational Section

Chairman's Mark

No provision.

Amendment

To item 5a on page 12 add:

"A statement informing potential enrollees that they may add their own funds to the Medicare payment amount."

Grassley #5

PROPOSAL FOR TREATMENT OF PORTABLE X-RAYS/EKGs IN MEDICARE REFORM

Current Law & Regulation

- Portable x-rays and EKGs for nursing home and homebound patients are billed to Part B and paid under the physicians' fee schedule (RBRVS).

- Reimbursement includes three codes:

  * Technical component (represents taking the x-ray/EKG) -- reimbursed at a national rate, the same as for physicians' office x-rays/EKGs

  * "Set-up" (Code Q0092) (represents setting up/taking down equipment, positioning patients, and other differences in patient type/setting between portable x-ray and physicians' office x-rays/EKGs) -- reimbursed at a national rate per procedure

  * Transportation (represents transportation of portable x-ray/EKG technologists and equipment to/from sites of service) -- reimbursed at local rates set by Medicare carriers.

- These and all RBRVS codes will be revised effective 1/1/98, pursuant to Congress' mandate for Resource Based Practice Expense (RBPE), based on a cost study underway by Abt Associates.

Proposal

- Continue physicians' fee schedule (RBRVS) reimbursement of portable x-rays/EKGs.

- Mandate that the portable x-ray/EKG "set-up" code (Q0092) and transportation codes (R0070, R0075, R0076) be analyzed individually in the Abt study to ensure fair and accurate evaluation of Resource Based Practice Expense for portable x-rays/EKGs.

- Direct HCFA that, if reimbursement for portable x-ray transportation is changed from a locality-based payment, the new reimbursement be regional (not national) to reflect geographic cost differences unique to portable x-ray/EKG transportation.

- Require national aggregate RBRVS reimbursement for these codes, as of RBPE implementation on 1/1/98, to be budget neutral with respect to national aggregate reimbursement as of 1/1/97 (adjusted for increases in Medicare population).

Purpose/Rationale

- To ensure that Congress' mandate for RBPE is accurately implemented for portable x-rays/EKGs by making the Abt study reflect portable x-ray/EKG resource costs, not physician office costs.

- To prevent further contraction of the most cost-effective, patient-oriented way of delivering x-rays and EKGs to nursing home and homebound patients.

Cost to Treasury

- None or savings

Grassley

Grassley #6

Proposed Amendment to Paragraph 3 of Enrollment Section on pages 10-11 of Section I-Medicare Choice of document distributed 9/22/95.

Current Provision in Chairmans Mark

Medicare beneficiaries will be enrolled in the Medicare Choice plan of their choice on a first-come basis up to the Medicare Choice plans capacity. The Secretary of HHS will develop special rules governing the enrollment of Medicare beneficiaries in union and association-sponsored Medicare Choice plans.

Amendment

Strike Paragraph 3 of Enrollment Section on pages 10-11 and replace with:

Medicare beneficiaries will be enrolled in the Medicare Choice plan of their choice on a first-come basis up to the Medicare Choice plans capacity. The Secretary of HHS will develop special rules governing the enrollment of Medicare beneficiaries in union and association-sponsored Medicare Choice plans. Mennonite Mutual Aid (a religious fraternal benefit society) shall be exempted from the requirement of enrolling individuals who do not share Anabaptist religious convictions.

Grassley

Grassley #7

Proposed Amendment to Item #3 dealing with solvency requirements of the Medicare Choice Plan Options Section on page 10 of Section I-Medicare Choice of document distributed 9/22/95.

Current provision in Chairman's Mark

"Meet solvency requirements satisfactory to the Secretary of HHS. Organizations licensed in states recognized by the Secretary of HHS as requiring solvency standards at least as stringent as those required by Medicare will be deemed to meet Medicare Choice plan solvency requirements."

Amendment

Strike Item #3 on page 10 dealing with solvency requirements and replace with:

"Meet solvency requirements satisfactory to the Secretary of HHS. Organizations licensed in states recognized by the Secretary of HHS as requiring solvency standards at least as stringent as those required by Medicare will be deemed to meet Medicare Choice plan solvency requirements. Mennonite Mutual Aid (a religious fraternal benefit society) shall be exempted from any Medicare Choice plan solvency requirements and from the jurisdiction of any authority in this area delegated to a state or federal agency."

Grassley #8

Grassley

Proposed Amendment to Item #4 of the Medicare Choice Plan Options Section on page 9 of Section I- Medicare Choice of Chairman's Mark.

Current Provision in Chairman's Mark

4. "Union or association sponsored health plans -- Health plans sponsored by unions or associations."

Amendment

Add at the end of ~~item~~ #4 on page 9 as modified by the Chairman's modification:

"Union or association sponsored health plans ~~including plans sponsored by unions or associations,~~ including religious fraternal benefit societies (organizations described in Section 501(c)(8) of the Internal Revenue Code of 1986 which are exempt from taxation under 501(a) of the Code and which bear the risk of providing health coverage to its members through certificates which are not available to the public)."

Grassley #9

Grassley Amendment on Beneficiary Contributions

Chairman's Mark

Amendment

(page 18 bottom) Require statement in Medicare Choice section of Chairman's mark to the effect that a Medicare beneficiary can add their own funds to the capitated amount provided by the Medicare program to a health plan.

Grassley #10

1) Grassley Amendment On Senate Finance
Medicaid Restructuring Proposal

Chairman's Mark

Page 76 of 125 - Following the second full paragraph that ends with the words "...assignment of such rights." Add the following paragraph:

Amendment

> Notwithstanding any other provision of law, as a payor of health care services a Medigrant Program established under this title shall, at the option of the State, be secondary to all federally operated or financed health care programs. The Secretary shall identify all such federal programs by rule.

Explanation

The Chairman's Mark is not clear regarding the Medigrant program as a secondary payor to such programs as Medicare and CHAMPUS. Current law at the Title XIX is clear that the Medicaid program is a secondary payor to Medicare and CHAMPUS.

Grassley #11

2)

Grassley Amendment on Senate Finance
Medicaid Restructuring Proposal

Chairman's Mark

Page 68 of 125: Following the fourth full paragraph reading: "The requirements of the...that uses a formulary." Add the following paragraph:

Amendment

A State participating in the MediGrant master rebate agreement may establish a formulary if the formulary meets the following requirement:

"(A) The formulary is developed by a committee consisting of physicians, pharmacists, and other appropriate individuals appointed by the Governor of the State, or a State Drug Use Review Board.

Explanation

The states must be given the flexibility to use a formulary without restrictions.

Grassley #12

3)

Grassley Amendment on Senate Finance
Medicaid Restructuring Proposal

Chairman's Mark

Page 68 of 125--The last full paragraph reading: The federal drug rebate program would be repealed, October 1, 1998."

Amendment

Delete this paragraph.

Explanation

The federal drug rebate program exists in the current law at Title XIX and should not be repealed.

Grassley #13

4)

Grassley Amendment On Senate Finance
Medicaid Restructuring Proposal

Chairman's Mark

Page 77 of 125 - Following the line that reads; "governing the state's activities under the program." insert the following paragraph:

Amendment

The following organizations should be added to the Advisory Group for the Medigrant Task Force:

National Healthcare Anti-Fraud Association

National Association of Health Data Organizations.

American Academy of Actuaries.

National Association of Medicaid Directors.

Explanation

These organizations will be important advisory bodies to the Medigrant Task Force due to their experience with he current Title XIX Medicaid program.

Grassley #14

PROPOSAL FOR TREATMENT OF PORTABLE X-RAYS/EKGs IN MEDICARE REFORM

Current Law & Regulation

- Portable x-rays and EKGs for nursing home and homebound patients are billed to Part B and paid under the physicians' fee schedule.
- Reimbursement includes three codes:
  - * Technical component (represents taking the x-ray/EKG) -- reimbursed at a national rate, the same as for physicians' office x-rays/EKGs
  - * "Set-up" (Code Q0092) (represents setting up/taking down equipment, positioning patients, and other differences in patient type/setting between portable x-ray and physicians' office x-rays/EKGs) -- reimbursed at a national rate per procedure
  - * Transportation (represents transportation of portable x-ray/EKG technologists and equipment to/from sites of service) -- paid at local rates set by Medicare carriers.
- These and all RBRVS codes will be revised effective 1/1/98, pursuant to Congress' mandate for Resource Based Practice Expense (RBPE), based on a cost study underway by Abt Associates.

Chairman's Mark Provision (p. 32, #9)

SNFs would also be required to bill Medicare for all Part B services used by nursing home patients subsequent to the Part A benefit expiring for a patient. SNFs must use the available fee schedule, if that has been the practice for Part B nursing home billings for the service in the past, or on a lesser of costs or charges basis. The cost portion of Part B billings will be reduced by 5.8 percent for fiscal years 1998-2002.

Proposal

Add the following paragraph at the end of p. 32, #9:

However, all portable x-rays/EKGs provided to Part B-only patients would continue to be reimbursed under the Part B physicians' fee schedule. Congress would direct the Secretary of HHS to do the following in implementing Congress' mandate in the Medicare Technical Amendments of 1994 for Resource Based Practice Expense under the physicians' fee schedule: (1) analyze the portable x-ray/EKG "set-up" code (Q0092) and transportation codes (R0070, R0075, R0076) individually in the ongoing Resource Based Practice Expense Study to ensure fair and accurate evaluation of portable x-rays/EKGs; (2) limit any possible change in the current locality-based payment for portable x-ray/EKG transportation codes to regional (not national)-based payments in order to adequately geographic cost differences unique to portable x-ray/EKG transportation; (3) make aggregate reimbursement for the portable x-ray set-up and transportation codes, as of Resource Based Practice Expense implementation on January 1, 1998, budget neutral with respect to the national aggregate reimbursement for these codes as of January 1, 1997 (adjusted for increases in Medicare population).

Purpose/Rationale

- To ensure that Congress' mandate for RBPE is accurately implemented for portable x-rays/EKGs by making the Abt study reflect portable x-ray/EKG resource costs, not physician office costs.
- To prevent further contraction of the most cost-effective, patient-oriented way of delivering x-rays and EKGs to nursing home and homebound patients.

Cost to Treasury

- *None or savings*

Grassley #15

Grassley

Proposed Amendment to the Transition Rules for 1996 on pages 21-22 of Section I-Medicare Choice of document distributed 9/22/95.

Current Provision in Chairman's Mark

No provision

Amendment

Amend the following sections of the Social Security Act to establish a transfer of certification authority by replacing the title "the First Church of Christ, Scientist, Boston, Massachusetts" with "the Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.":

Section 1861(e) of the SSA [42 U.S.C. 1395x(e)]

Section 1122(h) of the SSA [42 U.S.C. 1320a-1(h)]

Section 1162 of the SSA [42 U.S.C. 1320c-11]

Section 1861(y)(1) of the SSA [42 U.S.C. 1395x(y)]

Section 1902(a)(58) of the SSA [42 U.S.C. 1396(a)(58]

Section 1908(g) of the SSA [42 U.S.C. 1396(g)(1)]

The amendments made in the above sections shall take effect January 1, 1997.

Amendment by Senator Hatch #1

Medicaid State Grant Program for Health Centers

Amendment: (at the appropriate place, insert the following:)

From the total amount appropriated each year for Medicaid, one percent shall be set aside for grants to States for primary and preventive health care services provided at the local community level through health centers (including public or private non-profit rural health clinics, community health centers, homeless health centers, and migrant health centers) to individuals eligible for Medicaid assistance under the State plan and to low income uninsured persons.

The amount set aside for grants shall be allocated to each State under the same formula used for the allocation of Medicaid funds. The Secretary shall determine the method of allocation of funds to Community Health Centers and Rural Health Centers, and the amount of the grant to each center.

Explanation: Under current law, community health centers and rural health clinics receive cost-based reimbursement for services provided to Medicaid patients. That cost-based reimbursement would be eliminated under the Committee mark. This amendment ensures that these clinics will continue to receive the funds necessary to provide services to underserved populations.

Amendment by Senator Hatch #2

Information Provided to Beneficiaries on Medicare Choice Plans

Amendment:

On page 13, add a new 5.j. which reads as follows:

> "Information on the extent to which beneficiaries may select the provider of their choice under a Medicare Choice plan, including, if applicable, providers out of network."

Explanation:

This amendment makes certain that beneficiaries will be able to make more informed choices regarding selection of health care practitioners.

Amendment Offered by Senator Hatch #3

Amendment:

Medicaid State Plans (insert on page 73 after the sentence "Goals and objectives related to rates of childhood immunizations..." add the following:

> "Goals and objectives related to standards of care and access to services for children with special health care needs, as defined by the state, should also be included."

Explanation:

This amendment States shall include an explanation of children with special health care needs will be treated under the Medicaid plan.

Amendment by Senator Hatch #4

Drug Rebate Program (page 68)

Amendment:

Add a provision clarifying that States may not collect supplemental rebates while the Federal program remains in effect.

Explanation:

The Committee mark contains a provision which eliminates the Federal Medicaid rebate program at the end of FY 1998. During that period, States may not collect Federal rebates for drugs purchased by any entity which already negotiates discounts from manufacturers, such as health maintenance organizations, nursing homes, and other large purchasers. The amendment clarifies that States may not collect any additional rebate beyond that established in the Federal program during the three-year transition. States would continue to receive a manufacturer's best price for a drug.

Amendment by Senator Hatch #5

SKILLED NURSING FACILITIES

(at the appropriate place on page 30 insert a provision as follows:)

Amendment:

The provisions relating to capital reductions and limitations on the exceptions process would be deleted.

Implementation of a new prospective payment system for Skilled Nursing Facilities would be mandated to be implemented by 1999 and designed so that there would be program savings of $3.5 billion for three year period 1999-2002.

The blended rate for non-routine cost limits would not go into effect for one year, until October 1, 1998. During that time, reimbursement for indirect expenditures attributed to overhead would be limited to the 75th percentile in each region for each ancillary service, and allowable costs for each ancillary service would be limited to no more than a 5% percent increase over the previous year (unless the increase in excess of 5% over the previous year is attributable to changes in the SNF's case mix, increased admissions, increased length of stay, or other factors identified by the Secretary.) The provision shall be effective beginning October 1, 1995.

Explanation:

The prospective payment system would be developed through the enhanced collection of data by the Secretary resulting from consolidated billing and completion of current demonstrations underway at HCFA. Delaying implementation of the blended rate would limit any adverse effect on SNFs which are providing a higher accuity of services as we requirement implementation of an episodic Prospective Payment System.

Amendment by Senator Hatch -- Indian Health Service Medicare Reimbursement #6

Under current law, the Indian Health Service and IHS contract health programs participate in the Medicare program on the same basis and with the same opportunities as other health care providers. This amendment is designed to maintain the status quo by eliminating any unintentional provision of law that prevents IHS facilities and IHS contract providers from eligibility, to the same extent as any other provider, in the reformed Medicare program.

Amendment by Senator Roth #7

MEDICARE COVERAGE OF CHIROPRACTIC SERVICES

SEC. ____. COVERAGE OF CHIROPRACTIC SERVICES.

(a) EXPANDING COVERAGE AND ELIMINATING REQUIREMENT FOR X-RAYS.--Section 1861(r) of the Social Security Act, 42 U.S.C. § 1395x(r), is amended by striking "(5) a chiropractor" and all that follows to the end of the sentence and substituting the following:

> "(5) a chiropractor who is licensed as such by the State in which he performs services (or in a State which does not license chiropractors as such, is legally authorized to perform the services of a chiropractor in the State in which he performs such services), but only with respect to the provision of items and services which he is legally authorized to provide by the State in which he provides them.".

(b) BUDGET NEUTRALITY ADJUSTMENT.--

(1) BEGINNING IN 1997.--Notwithstanding any other provision of law, for each year beginning in 1997, the Secretary of Health and Human Services (hereinafter "the Secretary") shall reduce the amount of payments under section 1833 of the Social Security Act with respect to services furnished by chiropractors by such uniform percentage as the Secretary determines to be required to assure that the amendment made by subsection (a) will not result in expenditures under title XVIII of the Social Security Act in any year that exceed the amount of such expenditures that would have been made in such year if such amendment had not been made.

(2) DETERMINATION OF COST IN 1996--The Secretary shall determine the amount (if any) by which the expenditures in 1996 under title XVIII of the Social Security Act exceed the amount of expenditures that would have been made if the amendment in subsection (a) had not been made.

(3) AMORTIZATION OF 1996 COST OVER 1997-2000.--In addition to any adjustment required under paragraph (1), the Secretary, in each of the years 1997 through 2000, shall further reduce the amount of payments under section 1833 of the Social Security Act with respect to services furnished by chiropractors by such uniform percentage as the Secretary determines is required to assure that the amount of expenditures under title XVIII of the Social Security Act in each such year is reduced by one-quarter of the amount determined under paragraph (2).

(c) EFFECTIVE DATE.--The amendment made by subsection (a) shall apply to items and services furnished on or after January 1, 1996.

Simpson #1

AMENDMENT TO THE MEDICARE PORTION OF THE BUDGET RECONCILIATION BILL

PROPOSAL: AFFLUENCE-TEST MEDICARE PART B PREMIUMS FOR THE WEALTHIEST 10% OF MEDICARE RECIPIENTS.

SUMMARY: MEDICARE BENEFICIARIES WITH INCOMES OF $50,000 OR MORE (INDIVIDUALS) AND $75,000 OR MORE (COUPLES) WOULD BE ASKED TO PAY A GREATER PORTION OF THEIR MEDICARE PART B PREMIUMS, UP TO 100% FOR INDIVIDUALS WITH INCOMES GREATER THAN $100,000 AND COUPLES WITH INCOMES GREATER THAN $150,000.

REDUCTION IN OUTLAYS: $15.4 BILLION OVER 7 YEARS ($27.4 BILLION OVER 10 YEARS).

Simpson #2

AMENDMENT TO THE MEDICARE PORTION OF THE BUDGET RECONCILIATION BILL

PROPOSAL: AFFLUENCE-TEST MEDICARE PART B PREMIUMS FOR THE WEALTHIEST 15% OF MEDICARE RECIPIENTS.

SUMMARY: MEDICARE BENEFICIARIES WITH INCOMES OF $40,000 OR MORE (INDIVIDUALS) AND $58,000 OR MORE (COUPLES) WOULD BE ASKED TO PAY A GREATER PORTION OF THEIR MEDICARE PART B PREMIUMS, UP TO 100% FOR INDIVIDUALS WITH INCOMES GREATER THAN $67,000 AND COUPLES WITH INCOMES GREATER THAN $100,000.

REDUCTION IN OUTLAYS: $28.4 BILLION OVER 7 YEARS ($50.4 BILLION OVER 10 YEARS).

Simpson #3

AMENDMENT TO THE MEDICARE PORTION
OF THE BUDGET RECONCILIATION BILL

PROPOSAL: MODIFY THE CONSUMER PRICE INDEX

SUMMARY: NOTWITHSTANDING ANY OTHER PROVISION OF LAW, WITH RESPECT TO CALCULATIONS MADE AFTER DECEMBER 31, 1995, THE BUREAU OF LABOR STATISTICS OF THE DEPARTMENT OF LABOR SHALL REDUCE THE ANNUAL PERCENTAGE CHANGE IN THE CONSUMER PRICE INDEXES BY 0.7 PERCENTAGE POINTS.

REVENUE: THIS PROPOSAL WOULD INCREASE REVENUES BY $70 BILLION OVER 7 YEARS ($147.9 BILLION OVER 10 YEARS).

THIS PROPOSAL WOULD DECREASE OUTLAYS BY $101.9 BILLION OVER 7 YEARS ($219.7 BILLION OVER 10 YEARS).

THIS PROPOSAL WOULD DECREASE DEBT SERVICE BY $27.? BILLION OVER 7 YEARS ($84.9 BILLION OVER 10 YEARS).

Simpson #1

AMENDMENT TO THE MEDICARE PORTION OF THE BUDGET BILL

OFFERED BY SENATOR ALAN K. SIMPSON

PROPOSAL:

REQUIRE MEDICARE BENEFICIARIES TO PAY A $15 CO-PAYMENT EACH TIME THEY RECEIVE PHYSICIAN SERVICES UNDER PART B.

THESE CO-PAYMENTS WOULD NOT BE APPLIED TO A BENEFICIARY'S ANNUAL DEDUCTIBLE, NOR WOULD THEY BE CONSIDERED IN CALCULATING THE 20 PERCENT CO-PAYMENT. UNDER THIS AMENDMENT, MEDIGAP POLICIES COULD NOT COVER THIS $15 CO-PAYMENT. IT MUST COME DIRECTLY FROM THE BENEFICIARY. MEDICARE'S PAYMENT TO THE PROVIDER WOULD BE REDUCED BY $15.

REVENUE: Pending CBO score.

Alan K. Simpson #5

AMENDMENT TO THE MEDICARE PORTION OF THE BUDGET RECONCILIATION BILL

PROPOSAL: IN THE EVENT OF ANY KIND OF REDUCTION IN THE MEDICARE [redacted] PAYMENTS FOR HOME OXYGEN SERVICES, ANY OXYGEN SUPPLIER THAT DISCONTINUES HOME OXYGEN SERVICES FROM EXISTING PATIENTS SHALL BE SUBJECT TO A FURTHER REDUCTION OF TEN PERCENT IN ALL MEDICARE PAYMENTS RECEIVED IN THE FOLLOWING TWELVE MONTHS. AN EXCEPTION IS GRANTED IN SITUATIONS WHERE SERVICES CAN NOT BE DELIVERED DUE TO CIRCUMSTANCES BEYOND THE SUPPLIER'S CONTROL AND ALSO WHEN SERVICES ARE NO LONGER REQUIRED.

REVENUE: CBO SCORING PENDING.

D'Amato #1

Amendment to Mitigate IME and DSH Payment Reductions (A)

Set IME adjustment levels at 6.7 percent for FY 1996; 6.7 percent for FY 1997; 5.6 percent for FY 1998; and 4.5 percent for Fys 1999-2002. In addition, limit DSH reductions to 4% a year from 1996-2000, such that in the years 2001 and 2002, the amounts will continue at about 20 percent less than the baseline amounts projected in March of 1995. The adjustment in these payment levels shall be offset by an increase in assumed savings from increased managed care enrollment from $47.5 billion over 7 years to $50 billion over 7 years.

D'Amato #3

Amendment to Mitigate IME and DSH Payment Reductions (3)

Set IME adjustment levels at 6.7 percent for FY 1996; 6.7 percent for FY 1997; 5.6 percent for FY 1998; and 4.5 percent for Fys 1999-2002. In addition, limit DSH reductions to 4% a year from 1996-2000, such that in the years 2001 and 2002, the amounts will continue at about 20 percent less than the baseline amounts projected in March of 1995. The adjustment in these payment levels shall be offset by a corresponding reduction in the threshold for affluence-testing of Medicare Part B premiums.

D'Amato #3

Proposal #4 Establish Capital Transition Exceptions Process in Law

Background. Medicare capital payments are currently transitioning from a cost-based system to a prospective based system. During the transition, HCFA regulations provide a minimum floor of payment for hospitals with major redevelopment projects. However, there are two critical issues which need to be addressed legislatively. First, these transition rules need to be made statutory so that hospitals which have made long-term financial commitments to modernization projects can pay back their bonds. Second, the transition rules do not provide equal treatment for all projects. Hospital capital projects completed before 1996 are eligible for a higher level of reimbursement than those capital projects completed between 1997 and 2002.

Proposal. Make statutory the transition payments to ensure predictability in financing for hospitals underway with major modernization projects. In addition, provide the same payment floor for hospitals completing their projects later in the transition period as those completing earlier in the transition period. There are several other minor technical changes concerning eligibility for payments.

D'Amato #4

AMENDMENT TO ENSURE PAYMENT OF DISPROPORTIONATE SHARE TO ELIGIBLE HOSPITALS THROUGH IDENTIFICATION OF MEDICAID MANAGED CARE ENROLLEES

Amendment

On page 66 of the Chairman's mark, add after the words "actuarial methods." the following new sentence:

"The state will also specify the method by which hospitals will be able to identify Medicaid managed care enrollees for the purposes of qualifying and billing for Medicare and Medicaid disproportionate share payments."

Justification

The Chairman's mark recognizes the importance of continuing to provide some support to hospitals that serve a high proportion of low-income patients through the Medicare and Medicaid disproportionate share programs. The mark continues the current practice of including Medicaid patient days as a criterion for qualification and payment of Medicare and Medicaid disproportionate share. The mark also discontinues the current law requirement that states must gain waivers to enroll Medicaid recipients in managed care plans, thus encouraging greater Medicaid managed care enrollment. Under Medicaid managed care, Medicaid recipients often lose their identity as Medicaid recipients because they are enrolled in private managed care plans under contract with the State. While this may be desirable, it has the unintended consequence of making it impossible for hospitals to count Medicaid patient days for the purposes of disproportionate share qualification and payment. This amendment, therefore, would require states to specify to the Secretary a method by which hospitals will be able to count Medicaid patient days attributable to Medicaid managed care enrollees for the purposes of qualification and payment of disproportionate share.

D'Amato #5

PROPOSED MEDICAID CHANGES

Problem:

In the Senate proposal, there are requirements that the State must describe its actuarial methods for projecting expenditures and utilization for enrollers and setting capitation payment rates for HMOs or similar entities. (Reimbursement-Pg 63, Deliver Systems-Pg 66). This requirements amount to "back door Boren Amendments".

Recommended Solution:

These requirements should be deleted.

D'Amato #6

PROPOSED MEDICAID CHANGES

Problem:

In the House bill, there is still a State Plan approval process. It appears that the Senate eliminates the Federal approval requirement of State Plans. However, both proposals leave New York vulnerable to litigation initiated by providers who cite the State's failure to meet the State Plan PROCESS.

Recommended Solution:

It does not appear likely that either the House or Senate will back off on their requirements to maintain a State Plan process. Accordingly, language needs to be incorporated to protect the State against PROCESS lawsuits. The following language should be entered on page 74 of the Chairman's Mark after the listing of State Plan information::

"There shall be no cause of action for anyone based upon a failure of a State to comply with a State Plan or with the manner in which the Plan is developed."

D'Amato #5

PROPOSED MEDICAID CHANGES

Problem:

In the House bill (page 161, line 24) Medicaid Transition - Treatment of certain causes of action - there is concern that this language may not protect states from retroactive Boren lawsuits.

Recommended Solution:

The following language would remedy this issue:

Page 162, after the word "title"

"or any claim for reimbursement for any past period based on claimed failure to comply with Title XIX..."

In the Chairman's Mark, language should be added on page 63 at the end of the first paragraph under "Proposed Change" to clarify that no claims for reimbursement for any past period my be pursued.

D'Amato #8

PROPOSED MEDICAID CHANGES

Problem

The bill does not fully address the processes ans procedures by which the current Title XIX (Medicaid) program will be closed out. Under current federal rules, significant time delays in payment if claims form the date of service may exist. For example, providers generally have one year to submit claims to states, states have one year to pay all claims submitted and states have two years within which to submit claims fro federal participation. Language must be inserted assure a smooth transition to the new Title XXI and assure proper accounting of federal funds spent.

Solution

The following provisions should be inserted, where noted, in the House bill and on page 71 of the Chairman's Mark, Senate Finance Committee:

The following language should be substituted for lines 3-14 on page 39 of the bill:

"(ii) REDUCTION FOR ITEMS AND SERVICES UNDER TITLE XIX FURNISHED IN THE SAME FISCAL YEAR AND PAYMENT FOR ITEMS AND SERVICES UNDER TITLE XIX FURNISHED IN PRIOR FISCAL YEARS. - The amount of the allotment otherwise provided under this section for a fiscal year for a state shall be reduced by the amount paid to the state under section 1903 (a) in the fiscal year for items and services furnished under such section in the fiscal year; and the amount paid to the state in any fiscal year after October 1, 1996 for items and services furnished under section 1903 (a) in any fiscal year prior to October 1, 1996 and prior to the first day of the calender quarter on which a State's plan under title XXI is first effective and any amounts paid in any such fiscal year which are attributable to an adjustment in a previous payment made under such section for a calender quarter before October 1, 1995, shall be treated as fiscal year 1995 expenditures under such section and shall not reduce the allotment otherwise provided under this section for a fiscal year for a state."

The following language, which is similar to language inserted into the welfare bill to accomplish this, should be inserted as item (3) on page 162 of the bill line 18.

(3) CLOSING OUT ACCOUNT FOR THOSE PROGRAMS TERMINATED OR SUBSTANTIALLY MODIFIED BY THIS TITLE ---.In closing out accounts for State expenditures payable under section 1903 (a) of the Social Security Act, federal ans State officials may use scientifically acceptable statical sampling techniques. State claims for payment under such section 1903 (a) for items or services which were provided during a fiscal year prior to October 1, 1996, shall be treated as fiscal year 1995 expenditure is made by a State on or after October 1, 1995 but before January 1, 1996 and payment is sought thereafter. However, States shall submit all claims for payment under such section 1903 (a) no later than September 30, 1997. The secretary of Health and Human Services and any designated federal agency personnel shall: (1) use the single audit procedure to review and resolve any claims in connection with the close out if medical assistance program expenditures, including expenditures for the

administration thereof, under such section 1903 (a) ; and (2) payments to States for any , and all, such expenditures made for items or services provided during a fiscal year prior to October 1, 1995 shall be made from FY 1995 funds, rather than funds allocated to the State under Title XXI of the Social Security Act, as enacted hereby.

D'Amato #4

PROPOSED MEDICAID CHANGES

Problem:

Currently, many states use provider taxes as part of their required state match to federal funds. It is possible that HCFA could interpret that provider taxes are not a valid match under Title XXI. It is our understanding that neither the House nor the Senate intends to be more restrictive with respect to State match.

Recommended Solution:

Clarifying language should be incorporated on page 71 of the Chairman's Mark to allow states flexibility with respect to state match. The following language would remedy this issue:

"There shall be no limitation on states' practices for raising revenue to fund the state share of Title XXI expenditures".

DAmato #1C

Legislative Action
Governor's Certification

(1) Except as provided in paragraph (2) hereof, in order for a state with a state allocation greater than or equal to $10 billion in fiscal year 1996 to receive funds pursuant to the provisions of Title XXI of the social security act, as enacted hereby, for calendar quarters beginning on and after April 1, 1996, the Governor of such a state shall certify to the secretary of the department of health and human services that the state has enacted legislation authorizing the implementation of such title.

(2) In the case of a state whose legislature meets biennially, and does not have a regularly scheduled session in calendar year 1995, the requirement contained in paragraph (1) hereof shall be effective no later than the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature ~~beginning after the close of the first regular session of the state legislature~~ that begins after the date of enactment of this act.

Nickles #1-3

AMENDMENTS TO THE MEDICARE REFORM PROPOSAL
SENATOR DON NICKLES

Amendment 1- Prohibition of funds for Assisted Suicide

Under the Benefits section, on Page 15 of the Chairmans mark:

Insert the following:

7. (a)Medicare funds cannot be used to purchase services with the purpose of causing deaths, suicide, euthanasia or mercy killing; (b) providers are not required to inform patients of the availability of such services.(Legislative language included)

Amendment 2 - Provider-Sponsored Networks

Inclusion of a provision regarding the development of solvency and consumer protection standards relating to Provider-Sponsored Networks.

Amendment 3 - Lock-Box Provision

Under this provision, the Trustees would estimate Part B savings that resulted from this bill. The Treasury Secretary would then credit the [redacted] trust fund with government securities in this amount to insure that all savings in the Medicare reform proposal are use to keep the Medicare program solvent.

Nickles #4-5

AMENDMENT TO MEDICAID REFORM PROPOSAL
SENATOR DON NICKLES

Amendment 4 - Prohibition of funds for Assisted Suicide

Under the Accountability section, on Page 77 of the Chairmans mark:

Insert the following:

(a)Federal Medicaid funds cannot be used to purchase services with the purpose of causing deaths, suicide, euthanasia or mercy killing; (b) providers are not required to inform patients of the availability of such services. (Legislative language included)

Amendment 5 - Prohibition of funds for Abortion

Under the Accountability section, on Page 77 of the Chairmans mark:

Insert the following:

Federal Medicaid funds cannot be used to pay for abortions except in the cases of rape, incest and the life of the mother.

(a)

At the appropriate place, insert the following:

SEC. ___. PROVISION ASSURING NO REQUIREMENT THAT HEALTH CARE PROVIDERS INFORM PATIENTS CONCERNING ASSISTING SUICIDE.

(a) MEDICARE.--Section 1866a(1)(f)(1)(A)(i) of the Social Security Act (42 U.S.C. 1395cc(f)(1)(A)(i)) is amended by inserting the following immediately before the final "and":

"; provided, however, that no health care provider or employee of a health care provider be required under this section to inform or counsel a patient regarding assisted suicide, euthanasia, mercy killing, or other service which purposefully causes the death of a person,".

(b) MEDICAID.--Section 1902(w)(1)(A)(i) of such Act (42 U.S.C. 1396a(w)(1)(A)(i)) is amended by inserting the following immediately before the final "and":

"; provided, however, that no health care provider or employee of a health care provider be required under this section to inform or counsel a patient regarding assisted suicide, euthanasia, mercy killing, or other service which purposefully causes the death of a person,".

(b)

SEC. ___. PROHIBITION OF PAYMENTS FOR ASSISTED SUICIDE UNDER THE MEDICARE AND MEDICAID PROGRAMS.

(a) MEDICARE.--Section 1862(a) of the Social Security Act (42 U.S.C. 1395y(a)) is amended--

(1) by striking "or" at the end of paragraph (14);

(2) by striking the period at the end of paragraph (15) and inserting ";or"; and

(3) by inserting after paragraph (15) and before the flush language at the end the following new paragraph:

"(16) where such expenses are for items or services, or to assist in the purchase, in whole or in part, of health benefit coverage that includes items or services, with the purpose of causing, or assisting in causing, the death, suicide, euthanasia, or mercy killing of a person."

(b) MEDICAID.--Section 1903(i) of such Act (42 U.S.C.A. 1396b(i)) is amended--

(1) by striking "or" at the end of paragraph (14);

(2) by striking the period at the end of paragraph (15) and inserting ";or";

(3) by inserting after paragraph (15) and before the flush language at the end the following new paragraph:

"(16) with respect to any amount expended for, or to assist in the purchase, in whole or in part, of health benefit coverage that includes coverage of, a drug, biological product, service, or means provided to cause, or to assist in causing, the death, suicide, euthanasia, or mercy killing of a person."

Substitute

Moynihan/Rockefeller Medicare Substitute Amendment

The amendment strikes the Medicare portion of the Chairman's mark (page 1 through first two lines of page 56). It substitutes the following:

Medicare Part A Provisions:

- The amendment adopts the Medicare Secondary Payer and Fraud and Abuse provisions that are in the Chairman's mark. Savings from these two proposals would be deposited in the Part A Trust Fund. **Score: -$10 billion.**
- The amendment adopts all of the Medicare Part A savings proposals of the Chairman's mark except: the reduction to indirect medical education payments, the reduction to disproportionate share payments, the reduction for hospice services. The remaining Part A provisions would be recalibrated to a level where CBO scores them as saving $79.5 billion. **Score: - 79.5 billion.**
- The amendment retains the provisions in the Chairman's mark that provide special assistance to Critical Access Hospitals and Medicare Dependent Hospitals. **Score: +$0.5 billion.**

Medicare Part B provision

- Extend the Medicare Part B premium at 25 percent of program costs through 2002. **Score: -$16 billion.**

Fiscal Dividend

In an April report to Congress, CBO found that because of lower interest rates and higher economic growth, balancing the budget would yield a fiscal dividend of $170 billion

over the period of fiscal years 1996-2002. In a letter dated May 17, 1995, CBO indicated that:

> Given the size of the economy, budget plans that would result in a projected surplus or deficit of approximately $50 billion can be considered to have about the same effect on interest rates and long-term growth as proposals that would exactly balance the budget in 2002.

The Chairman's Mark as modified by this amendment would, in 2002, when combined with the legislative recommendations of other authorizing and appropriation Committees that satisfy the instructions of the budget resolution, produce a budget that is within $50 billion of exact balance.

Based on the CBO positions just noted, CBO would then indicate that the budget as amended by this amendment would result in a 7-year fiscal dividend of $170 billion, including $50 billion in fiscal year 2002.

It is thus the Sense of the Committee that this fiscal dividend should be used for deficit reduction, in lieu of savings in the Chairman's Mark beyond those Medicare proposals in this amendment.

Medicare Commission

- A commission, modeled after the Social Security Commission of 1983, would be established to make recommendations for ensuring the long-term soundness of the Medicare program.

Moynihan #1

Moynihan Amendment Establishing

Teaching Hospital and Graduate Medical Education Trust Fund

This amendment would strike the section Indirect Medical Education Payments which begins on page 27 (ending on page 28) of the Chairman's mark, and substitute a new section -- Teaching Hospital and Graduate Medical Education Trust Fund.

Medicare direct graduate medical education payments (DGME) and Medicare indirect medical education payments (IME) would be deposited into a new trust fund -- Teaching Hospital and Graduate Medical Education Trust Fund. At the beginning of each year the Secretary of Health and Human Services would estimate total DGME and IME expenditures for the year and deposit that amount of Medicare funds into the trust fund.

Teaching hospitals would submit a request for payment to the Secretary each year. Payments from the Trust Fund to teaching hospitals would be based upon the percentage of IME and GME payments each hospital received in 1994. The Secretary would have some authority to adjust these payments for teaching hospitals which have experienced a substantial change in their teaching mission (these adjustments would be budget neutral). The amendment would also set up a Teaching Hospital and Graduate Medical Education Commission to study the following:

- alternative and additional sources of graduate medical education financing, including an all-payer financing mechanism
- the role of teaching hospitals in an increasingly competitive health system, and ensuring that research and educational activities are maintained
- alternative methodologies for compensating teaching hospitals for graduate medical education

- expanding eligibility for graduate medical education payments beyond teaching hospitals

The $9.9 billion cost (over seven years) of this amendment would be offset with a portion of the fiscal dividend scored by CBO for bringing the federal budget to near balance.

Moynihan #2

AMENDMENT FROM SENATOR MOYNIHAN

MEDICARE DISPROPORTIONATE SHARE HOSPITALS

Strike the provision of the Chairman's Mark regarding Proposed Change in Medicare Disproportionate Share Hospital Payments on page 26, paragraph 5 and continuing through page 27, paragraph 1. The $4.5 billion cost (over seven years) of this amendment would be offset with a portion of the fiscal dividend scored by CBO for bringing the federal budget to near balance.

Moynihan*

AMENDMENT FROM SENATOR MOYNIHAN

MEDICAID DISPROPORTIONATE SHARE HOSPITALS

Strike the provision of the Chairman's Mark regarding proposed change in Medicaid Disproportionate Share Hospital Payments on page 69, paragraph 4 and continuing through page 69, paragraph 3. The $35 billion cost (over seven years) of this amendment would be offset with a portion of the fiscal dividend scored by CBO for bringing the federal budget to near balance.

Moynihan #

AMENDMENT FROM SENATOR MOYNIHAN

MEDICAID FEDERAL FUNDING

Strike the provisions of the Chairman's Mark regarding "Federal Funding" (page 71, paragraph 3) so as to allow all states' Medicaid spending to grow at the same national rate annually. This amendment would be budget neutral since it would not change the aggregate national annual Medicaid growth rate as specified in the congressional budget resolution.

#5

AMENDMENT TO THE CHAIRMAN'S MARK

Strike All EITC Provisions Other Than Compliance Initiatives

Strike all of the proposed changes to the EITC other than the compliance provisions. The compliance provisions are those relating to limiting the EITC to individuals authorized to work in the U.S., requiring correct primary and secondary Social Security Numbers, authorizing math error procedures under certain circumstances, and increasing certain return preparer penalties.

#6

AMENDMENT TO THE CHAIRMAN'S MARK

Sunset Proposed Changes at the End of 2002 and Reinstate Current Law

Effective for taxable years beginning after December 31, 2002, the credit rates, phaseout amounts, phaseout percentages, adjusted gross income, and disqualified income would be determined under current law (including inflation adjustments for the intervening years) without regard to the amendments contained in the Chairman's mark.

#7

AMENDMENT TO THE CHAIRMAN'S MARK

Supplemental EITC

Workers eligible for the EITC who have 2 or more qualifying children would be allowed a supplemental credit. The rate of the supplemental credit will be set such that the revenue cost of the credit exactly equals the increased revenues resulting from the changes to the EITC in the Chairman's mark (approximately 3 percent of earned income, subject to a phaseout over the same range of income applicable to the regular EITC).

Unlike the regular EITC, this supplemental credit would not be refundable. However, the credit would be transferable in exchange for cash or other property. For eligible taxpayers with a tax liability in excess of their regular EITC, this supplemental credit would be transferable only to the extent it exceeded the current year's liability. Instead of selling the credit, the worker could carry the credit forward indefinitely to a year in which he or she has a tax liability (net of any regular EITC to which the worker is entitled in such future year).

A supplemental credit that is transferred could be applied by the transferee against its own income tax liability. The amount of the credit would be determined by the IRS (based on the eligible worker's tax return) and evidenced by a certificate issued under procedures outlined in the statute and supplemented by regulations. The amount received by an eligible worker in exchange for the supplemental credit would not be included in the worker's income (and would not be deductible by the transferee).

The IRS would be granted regulatory authority to carry out the purposes of the supplemental credit.

#8

AMENDMENT TO THE CHAIRMAN'S MARK

Additional EITC Modifications

Under this amendment, all revenue increases resulting from the Chairman's mark (and not just those resulting from the EITC changes) would be taken into account in setting the credit rate of the Supplemental EITC and, to the extent such rate would exceed 4 percent, limiting the rate to 4 percent and extending a supplemental EITC to workers with 1 qualifying child eligible for the regular EITC.

Moynihan #9

MOYNIHAN AMENDMENT TO THE CHAIRMAN'S MARK FOR MEDICAID FEDERAL FUNDING:

On page 71, stipulate that in determining the Federal Medical Assistance Percentage (FMAP) match rate for the 50 States, the District of Columbia, Puerto Rico, Guam *et al,* State and U.S. per capita income shall no longer be subject to squaring, effective October 1, 1996.

To the extent this amendment is not budget neutral, the shortfall, if any, will be made up by the fiscal dividend derived from a balanced budget.

Moynihan #10

MOYNIHAN AMENDMENT TO THE CHAIRMAN'S MARK FOR MEDICAID FEDERAL FUNDING:

On page 71, stipulate that the Federal Medical Assistance Percentage (FMAP) match rate for the 50 States, the District of Columbia, Puerto Rico, Guam, *et al* shall be 50 percent effective October 1, 1996.

To the extent this amendment is not budget neutral, the shortfall, if any, will be made up by the fiscal dividend derived from a balanced budget.

Baucus #1

BAUCUS/CONRAD HOME AND FAMILY FARM PROTECTION AMENDMENT

Amendment: No Medicaid plan shall impose a lien against a home of moderate value, as determined by the Secretary, or family farm, as a condition of the spouse of the individual receiving nursing facility or other long term care benefits under the plan.

Explanation: The Chairman's mark currently does not safeguard long term care beneficiaries from state liens on homes and family farms. This amendment would prohibit states from imposing liens on homes and family farms.

Baucus #2

BAUCUS RURAL HEALTH AMENDMENT

Amendment: Extends the permitted length of stay at a limited-service hospital from 72 hours to 96 hours (p. 47, paragraph 4).

Explanation: This amendment would extend the length of time a patient can stay in a limited service hospital by one day. Reports from the General Accounting Office and Mathematica Policy Research show that downsized hospital demonstration projects with a four day length of stay save money.

Bradley #1

Amendment to Allow HHS Secretary to Apply Sanctions on States Which Are Out of Compliance with their State Medicaid Plans

Introduced by Senator Bradley

Description:

This amendment would give the Secretary of HHS the ability to reduce a state's federal Medicaid grant by 5% if he or she determines that the state is out of compliance with their state Medicaid plan. Once the Secretary determines that the state is out of compliance with their plan, the state has 6 months to come into compliance before the sanction is applied.

Rationale:

The Chairman's mark requires each state to develop a public plan describing which population groups it will cover, what eligibility requirements it will impose, and what services it would provide. However, the mark provides no method to ensure that states adhere to the standards continued in their plans. Without such enforcement mechanisms, states are free to ignore their own official standards, and instead to run a system which is arbitrary and discriminatory. This amendment allows the Secretary to apply sanctions on states which violate their own official standards, as described in their plan.

This amendment does not specify what standards states must include in their plans; it simply seeks to ensure that states will adhere to the standards which they publicly announce in their plans.

CBO estimates for Bradley Amendment on State Medicaid Plans

This amendment was submitted to the CBO for an estimate on Friday, September 22. CBO has not yet produced a formal estimate for this bill.

Bradley #2

MOSELY-BRAUN

Sense of the Senate Amendment

(Sen Bradley, Breaux, Conrad, Rockefeller, et al)

The amendment will set forth a number of findings related to the earned income tax credit and then express the Sense of the Senate regarding the use of the economic dividend and the need to alleviate EITC reductions before providing tax cuts for upper-income Americans.

Bradley #3

Sense of the Senate Amendment

(Sen. Breaux, Bradley, Conrad, Mosely-Braun, Rockefeller etc.)

The amendment will express the Sense of the Senate that the proposed cuts in the EITC should not take effect if they would increase the number of American families living below the poverty line.

Bradley #4

AMENDMENT STRIKING 10% FEE ON CHILD SUPPORT COLLECTIONS

INTRODUCED BY SENATOR BRADLEY

Proposal Strike the provision requiring states to impose a 10% fee on all child support payments collected through the Child Support Enforcement program.

Rationale The provision in the Chairman's mark takes money away from single parents payments in order to meet federal budget deficit goals. The money would be taken from the amount which the court has determined that the parent requires to meet their child-raising responsibilities. In addition, this provision charges single parents a high price for having a court order enforced.

Nursing Home Quality of Care

Amendment to Medigrant Bill

Offered by Sen. David Pryor / Rockefeller

Proposal: Maintain current federal standards, survey and certification process, and enforcement mechanism to ensure quality of care in nursing homes.

The amendment would reinstate the nursing home reform provisions enacted as part of the Omnibus Budget Reconciliation Acts of 1987, 1989, and 1990, appearing at 42 USCS @ 1396r, "Requirements for nursing facilities." All current provisions would be retained.

Cost Impact: No expected cost impact. The aggregate cap in the Medigrant bill would not be revised as a result of this amendment.

HCFA Approval of State
Nursing Home Standards
Amendment to Medigrant Bill
Offered by Sen. David Pryor

Proposal: To provide for Federal approval of State nursing home quality standards.

The amendment would require all States to submit their proposed nursing home quality standards as part of their state plan to the Health Care Financing Administration for approval before being approved to participate in the Medigrant program. This is to ensure that States adequately provide for protection of frail nursing home residents.

Cost Impact: No expected cost impact. The aggregate cap in the Medigrant bill would not be revised as a result of this amendment.

Medicaid Drug Rebate Program

Amendment to MediGrant bill

Offered by Sen. David Pryor

Proposal: Retain the Medicaid drug rebate program as an option for state Medicaid programs. The amendment would strike bill language repealing the Medicaid drug rebate program, effective October 1, 1998. States may elect to participate in the existing rebate program or to negotiate and implement rebates independently.

Cost Impact: Continuation of a voluntary Medicaid drug rebate program would generate additional Federal and state savings after October 1, 1998. The aggregate cap in the MediGrant bill would not be revised as a result of this amendment.

Medicaid Drug Rebate Program

Amendment to MediGrant bill

Offered by Sen. David Pryor

Proposal: Maintain current inclusion of nursing facilities in the Medicaid drug rebate program. The amendment would strike bill language excluding nursing facilities from the rebate program. States may elect to exclude nursing facilities, if their unit drug acquisition costs are shown to be equal or lower than historic unit costs under existing rebate agreements.

Cost Impact: Continued inclusion of nursing facilities would generate additional Federal and state savings. The aggregate cap in the MediGrant bill would not be revised as a result of this amendment.

Medicaid Drug Rebate Program

Amendment to MediGrant bill

Offered by Sen. David Pryor

Proposal: The Secretary of HHS shall convene a task force for the purpose of determining whether the Medicaid drug rebate program should be retained or repealed. The task force shall be convened no later than June 1, 1998, and shall report its findings to the Secretary by October 1, 1998.

The report shall assess the extent to which state Medicaid programs rely on the drug rebate program to manage prescription drug expenditures; the impact of repeal of the drug rebate program on recipient access to prescription drugs and pharmacy services; and the likely actions states would take to manage prescription drug expenditures in the absence of drug rebate revenue.

The task force shall consist of volunteer representatives appointed by: the chair and vice chair of the National Governors Association (NGA); the State Medicaid Directors Association; associations representing the prescription and generic drug industries; an association representing pharmacies; and an association representing the interests of Medicaid recipients.

The report shall be transmitted to the Senate Committee on Finance, House Committee on Commerce and the Senate Special Committee on Aging.

Cost Impact: No expected cost impact. The aggregate cap in the MediGrant bill would not be revised as a result of this amendment.

Medicaid Drug Rebate Program

Amendment to MediGrant bill

Offered by Sen. David Pryor

Proposal: Provide for rebate master agreements and statutory definitions necessary to the implementation of the Veterans Health Care Act of 1992 (P.L. 102-585).

The amendment reinstates the requirement that drug manufacturers sign rebate master agreements with the Secretary of Veterans Affairs. The Department of Veterans Affairs and the Veterans Health Administration manage a prescription drug rebate program wholly independent of the Medicaid rebate program. The Veterans Health Care Act refers to specific provisions in the Medicaid statute (section 1927 of the Social Security Act), including key definitions. The amendment would provide such definitions, solely for the purposes of the rebate agreements reached under the Veterans Health Care Act.

Cost Impact: No expected cost impact. The aggregate cap in the MediGrant bill would not be revised as a result of this amendment.

Pryor #7

FINAL VERSION

QUALITY STANDARDS FOR COORDINATED CARE PLANS
Amendment to the Chairman's Mark (Medicare Choice)
Offered by Senator David Pryor

PROPOSAL: The amendment would restore existing regulations and laws pertaining to quality standards that apply to Medicare risk plans (Social Security Act, Section 1876), repealed or altered under the Mark. In addition, new provisions described here would supplement these current regulations and laws.

These new enrollee-protection provisions - as would existing laws and regulations - would apply to all coordinated care organizations that accept Medicare beneficiaries. including HMOs, preferred provider organizations, and "provider service networks" (all referred to in this document as "plans").

The following are the new quality assurance standards that would be added to those already in place in Section 1876.

1. Access To Services/Appeals Process

The Secretary shall:

- Provide information to enrollees concerning their rights to appeal plans' decisions not to provide covered services and their rights to address grievances with their health plans to HCFA and the Peer Review Organizations, at time of enrollment and on an annual basis (insert p. 13).
- Ensure that participating plans respond to the request for health services of enrollees in a reasonable amount of time after the request is made. The Secretary would also ensure that plans respond to enrollees' appeals in a reasonable amount of time. The Secretary shall define "reasonable" and may establish different timetables for different types of medical conditions and services (insert page 15).
- Review in an expedited manner plan denials for cases in which denial of care could result in significant harm (insert page 15).

2. Data Collection, Analysis, and Dissemination

The Secretary shall:

- Establish and integrate into ongoing external quality assurance activities a

new set of quality indicators, developed specifically for the Medicare population, that would be used to determine whether a plan is providing quality care and appropriate continuity and coordination of care (insert p. 15).

- Require plans to report complete encounter data, including data on physician visits, nursing home days, home health days, hospital inpatient days, and rehabilitation services, using HCFA Form 1500, UB92, or any other form selected by the Secretary (insert p. 15).
- Require plans to provide information to prospective enrollees on the plans' specialist referral process, and on request, the number of referrals to specialists requested by the enrollee and the primary care provider that were denied and reasons for these denials (insert p. 13).
- Publish for use by beneficiaries (i) comparative data it collects on plans such as complaint rates, disenrollment rates, and rates and outcomes of appeals, and (ii) the results of its major investigations or any findings of significant noncompliance by plans (insert p. 13).

3. **Marketing Protections/Enrollment And Disenrollment Issues**

The Secretary shall:

- Require plans to provide standardized, easy-to-read, information at all marketing presentations describing the rules of plan enrollment, including "lock-in" and requirements for referrals to specialty care (insert p. 13).
- Prohibit the payment of commissions to plan marketing agents if a new enrollee disenrolls within three months of enrollment (insert p. 11).
- Prohibit plans' sales agents from visiting the residence of eligible enrollees for purposes of enrolling the individual or providing enrollment information to the individual other than at the individual's request (insert p. 13).

COST IMPACT: No expected cost impact. Under current law, as explained in Social Security 1876(i)(7)(B), the cost of managed care quality oversight activities are born by the health plans.

#8

MEDICAID DRUG PROGRAM
AMENDMENT TO MEDIGRANT BILL
Offered by Sen. David Pryor

CURRENT LAW

Under the Uruguay Rounds Agreement Act (URAA) transition "grandfather" provisions, current patent holders are granted a conditional patent term extension. Patent holders may receive up to three additional years of patent protection. However, if a generic manufacturer has made a "substantial investmentt" prior to the date of URAA's enactment (June 8, 1995), the generic manufacturer may bring its product to the market on the original, pre-GATT date of patent expiry, so long as "equitible remuneration" is paid to the patent holder.

Despite the intent of the Congress to apply the grandfather provisions to all industries, the prescription drug industry was inadvertently excluded from their scope. This error prevents qualifying generic drug manufacturers who made a "substantial investment" prior to June 8, 1995, from marketing their products on the original date of patent expiry, as was intended in the URAA.

PROPOSAL

This amendment applies the URAA transition provisions to the prescription drug industry.

COST IMPLICATIONS

According to CBO, the amendment saves Medicaid $150 million over five years.

Rockefeller Medicaid Amendment #1

As a condition of receipt of federal Medicaid funding, each state will cover all children, under age 19 years of age, living under 100% of federal poverty and all pregnant women living under 185% of federal poverty.

Rockefeller Medicaid Amendment #2

As a condition of receipt of federal Medicaid funding, each state will cover all Qualified Medicare Beneficiaries, as defined in the Social Security Act, and all individuals with a diagnosis of Alzheimer's disease living under 100% of federal poverty.

Rockefeller Medicaid Amendment #3

Insert in the appropriate section referencing state payment rates to hospitals and skilled nursing facilities the language from Title XIX of the Social Security Act, Section 1902 (a)(13)(A):

"for payment, which the state finds, and makes satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable state and federal laws, regulations, quality and safety standards ...."

insert due process protections for providers

Rockefeller Medicaid Amendment #4

The Congressional Budget Office shall prepare an analysis of the effects of the changes in the Medicaid program on the health insurance status of each of the following populations: 1) children, 2) the elderly, and 3) the disabled. This report shall be made annually, and submitted to the Committees of jurisdiction of the Medicaid program, the Senate Finance and House Commerce Committees, by May 15th.

Rockefeller Medicaid Amendment #5

As a condition of receipt of federal Medicaid funds, each state shall insure that Medicaid beneficiaries have access to primary care services within 30 miles of their residences.

FOSTER CARE AMENDMENT #6
Senator Jay Rockefeller

The amendment would strike the provision that limits a state's cost for administering the foster care program to 10 percent growth per year (on page 12 of the modifications to the mark.)

Replace this proposal with a provision to reduce the federal matching rate for foster care administrative costs from 50% to 44.1%.

This option would exclude the expense of installing new computer systems which are eligible for 75% federal funding through September 30, 1996.

FOSTER CARE AMENDMENT #7
Senator Jay Rockefeller

The amendment would strike the provision that limits a state's cost for administering the foster care program to 10 percent growth per year (on page 12 of the modifications to the mark.)

Replace this proposal with a provision to reduce the federal matching rate for foster care administrative costs from 50% to 45%.

09/21/95

05:02 PM

Foster Care budget options for the Senate Finance Committee
Assumes November 1, 1995 effective date.
D-R-A-F-T
Compared to CBO baseline

By fiscal year, outlays in millions of dollars

Direct Spending		1996	1997	1998	1999	2000	2001	2002	Five-Year Total	Seven-Year Total
Reduce growth of foster care administrative costs to 10% a year a/	BA	[illegible]	[illegible]	[illegible]	-220	[illegible]	-270	[illegible]	[illegible]	-1519
	OT	-70	-160	-200	-220	-250	-270	[illegible]	-920	-1470
Reduce federal match rate for foster care administrative costs from 50% to 45%.	BA	-140	-165	-180	-190	-205	-220	-225	[illegible]	-1335
	OT	-115	-165	-175	-190	-200	-215	-230	-845	-1290

This is a preliminary estimate.
a/ This assumes that the 10% cap in growth of administrative costs would apply to each state.

09-21-95 04:18PM FROM FINANCE COMMITTEE TO 62853 P004/004
09-26-95 03:50PM P002 #17
FROM CBO/BAD/HRCEU ID PAGE

Rockefeller #8

Rockefeller/Grassley Amendment
Provider-Sponsored Network Option

Page 9 of the Chairman's mark:

Modify #2 under Medicare Choice Plan Options to read as follows

"Coordinated care plans -- Health plans that provide health care services through an integrated network of providers, including health maintenance organizations (HMOs), point-of-service (POS) plans, preferred provider organizations (PPOs), and provider sponsored networks (PSNs).

On page 9 of the Chairman's mark:

Add the following after #1 under Organizations eligible to contract with the Secretary of HHS as Medicare Choice plans must:

"There would be a separate federal certification process for provider-sponsored networks. They would not be subject to state regulation but would be subject to federal Medicare Choice standards and federally certified until at least December 31, 2000. By no later than December 31, 1999, the Secretary is required to report to Congress on an evaluation of whether certification of PSNs should be transferred to states with PSN regulatory processes that meet federal criteria."

on page 10 of the Chairman's mark

Insert at the end of #3 under Organizations eligible to contract with the Secretary of HHS as Medicare Choice plans must:

"In developing solvency requirements, the Secretary shall take into account a Medicare Choice plan's delivery system assets and its ability to provide services directly to its enrollees through its affiliated providers.

on page 15 of the Chairman's mark:

Insert at the end of #2, under Capacity and enrollment:

"Provider sponsored networks that have experience in providing coordinated care under arrangements with other health plans would not be subject to rules regarding minimum levels of enrollees, commercial or otherwise."

Rockefeller/Grassley Amendment
Provider-Sponsored Network Option

on page 18 of the Chairman's mark:

Add item #6 under Medicare Payments

"6. The Secretary will conduct a partial capitation demonstration and report to Congress no later than December 31, 1998 on the administrative feasibility of partial capitation methods, and on empirical information necessary for defining threshold levels and risk-share percentages."

on page 21 under Transition Rules for 1996 add #3

The Secretary would be required to publish federal Medicare Choice standards by April 1, 1996.

Rockefeller #9

Rockefeller Amendment
Strike Budget-Driven Caps on Managed Care Payments

Finance Mark: indexes Medicare base payment amount for Medicare Choice plans to the "per capita growth in the gross domestic product (GDP)"

Amendment: strike "per capita growth in the gross domestic product" and insert "and indexed each year to the growth of private health insurance premiums"

Rockefeller #10

Rockefeller Amendment
Primary Care Access Amendment

Add new item under section 3.) Access, Health Plan Standards, (pages 15,16)

d.) A Medicare Choice plans must make primary care services available within 30 minutes or 30 miles from a beneficiary's place of residence in rural areas.

Rockefeller #1

Rockefeller Amendment
Out-of-Pocket Protection for Beneficiaries from BELT

Page 54, line 12, in lieu of following sentence

"The payment reductions would not affect the coinsurance, deductible, or premium amounts payable by Medicare beneficiaries.

insert the following sentence:

The payment reductions would <u>reduce</u> the coinsurance, deductible, and premium amounts payable by Medicare beneficiaries by the same percentage reduction that applies to provider payments.

Rockefeller #12

Rockefeller Amendment
Preserving Current Law Balance Billing Protection
for all Medicare Beneficiaries

Current Law HMOs are protected from paying the full charges of providers when beneficiaries obtain out-of-plan care services. Hospitals and skilled nursing facilities, under section 1866(a)(1)(0), are required to accept Medicare amounts as payment in full for inpatient hospital and extended care services. Medicare participating physicians, under section 1876(j), must accept the fee schedule amounts as payment in full, and nonparticipating physicians must comply with the limiting charge amount. In this current structure, the beneficiary is not vulnerable to extra billing, the HMO is responsible for guaranteeing payment in full for all plan services provided to Medicare enrollees.

Chairman's Mark All Medicare providers, physicians, and suppliers could require payment of full charges. This situation will, undoubtedly, ensure that the real costs to plans and beneficiaries will be higher than today. Traditional Medicare may cease to exist is some geographic areas if, for example, physicians decide to accept payment only from private fee-for-service plans that allow them to collect full charges. To avoid this and to protect Medicare beneficiaries from extra billing charges, it is necessary to extend protections in current law to all Medicare Choice plans.

Amendment

Add to section 4.) Consumer Protections (page 16) g.

g. For services provided by Medicare Choice plans, beneficiary liability would be limited to the cost sharing amounts specified in the plan's marketing materials. For all non-network services (e.g. medical savings account enrollees, private fee for service plan enrollees, network plan enrollees seeking out-of-plan services), apply the payment principles in sections 1866 and 1876 to all items and services covered by Medicare. Thus, participating physicians and suppliers paid under a fee schedule would accept the fee schedule amounts as payments in full. Nonparticipating physicians would be prohibited from billing beyond the limiting charge for their services. All other providers would accept Medicare's payment as payment in full, e.g. DRG and pass-through amounts for hospitals. In fee-for-service plans, beneficiary liability, i.e. deductibles and coinsurance amounts, would be computed using the lesser of the actual charge or the Medicare payment amount.

Breaux #1

EITC Amendment

(Sen. Breaux)

The amendment will require a doubling of taxpayer penalties in areas where fraud, tax underpayment and the like are of similar magnitude to those which have plagued the EITC in the past.

Breaux #2

VACCINE AMENDMENT
(Sen. Breaux)

This amendment would clarify that states would have the option of using Medicaid or other state funds to purchase vaccines at a discounted rate for children the state deems eligible for Medicaid. It would thus ensure that states, which under the chairman's mark would be required to offer vaccines to children on Medicaid, could purchase them at a reduced rate as they now do.

It would allow the Secretary of HHS, where appropriate, to contract with multiple vaccine manufacturers.

It would provide the Sense of the Committee that states adhere to the Advisory Committee on Immunization Policies guidelines.

Conrad #1

CONRAD AMENDMENT ON MENTAL HEALTH SERVICES

AMENDMENT:

On page 61, after "department of health", insert the following:

1. States also have the flexibility to provide the following options:

- Outpatient and intensive community-based mental health services, including psychiatric rehabilitation, day treatment, intensive in-home services for children, and partial hospitalization.

- (i) Acute inpatient mental health services, including services furnished in a State operated mental hospital and, (ii) residential treatment center services for children

2. States have complete authority to elect the scope of assistance available to Medicaid recipients, but they may not impose treatment limits or financial requirements on mental illness services which are not imposed on services for other conditions. States shall not be prevented from requiring pre-admission screening, prior authorization or services or other mechanisms limiting coverage of mental illness services to those that are medically necessary.

EXPLANATION:

Current Medicaid law permits states great flexibility in defining a range of community-based services for adults and children who have serious mental disorders. Virtually all mental health services provided by state Medicaid programs are optional. This amendment retains the optional nature of mental health coverage, while ensuring that the new program does not unintentionally preclude states that wish to do so from providing a full array of services.

The provisions of this amendment on outpatient community-based services are intended to guarantee state flexibility. There is concern that any legislative language that only refers to "outpatient" services without including options like rehabilitation, day treatment, etc., could be perceived by states as limiting their authority to fund such options.

The inpatient services language is intended to ensure states will not substitute federal dollars for state funds that have historically been spent on the residents of state operated mental hospitals. The Chairman's Mark completely repeals the so-called "IMD" exclusion, under which the Federal government has historically refused to pay the costs of individuals between ages 21 and 65 in Institutions for Mental Disease. Like the Chairman's Mark, the Conrad Amendment permits Medicaid reimbursement for acute care coverage in state-operated facilities and private psychiatric hospitals. However, unlike the Chairman's Mark, the amendment ensures that states will continue to pay the cost of long term services that have been a state responsibility since the 1870s.

The non-discrimination language merely prohibits states from applying arbitrary blanket limits to mental health services that are not applied to other services. The provision does nothing to preclude states from conducting pre-admission screening, prior authorization, etc. Nor does it require that particular groups of people with mental disorders be covered, or that any specific range of mental health services be covered States would be free to set any amount, duration and scope limits.

Conrad #2

CONRAD SENSE OF THE COMMITTEE AMENDMENT

It is the Sense of the Finance Committee that in the event the Congressional Budget Office declares that a fiscal dividend exists in accordance with the Budget Resolution, that such a dividend should be used for further deficit reduction so that Social Security surpluses are not used to balance the budget, and to reduce savings from:

- federal health programs for the elderly, children, disabled and poor;
- programs that benefit working and middle class Americans, and;
- programs that invest in education, infrastructure and research.

Conrad #3

CONRAD/PRESSLER MEDICARE ANESTHESIA SERVICES AMENDMENT

AMENDMENT:

On page 48, at the end of the section entitled "Improving Access to Health Services and Improving Medicare in Rural Areas," insert the text of S.1263, the Medicare Anesthesia Services Reform Act.

EXPLANATION:

This proposal consists of two provisions. The first provision requires the Health Care Financing Administration to defer to state law when determining whether to condition Medicare reimbursement to Certified Registered Nurse Anesthetists (CRNA's) on physician supervision. Current Medicare regulations require physician supervision of CRNA's as a condition for hospitals and ambulatory surgical centers to receive Medicare reimbursement. This federal requirement is in direct conflict with numerous state laws that allow nurse anesthetists to practice without such supervision.

The second provision ensures payment equity between CRNA's and anesthesiologists. Under current Medicare regulations, if an anesthesiologist and a CRNA work together on one case and Medicare later decides that the use of two anesthesia providers was not "medically necessary," neither the hospital nor the CRNA receives payment. This provision does not require Medicare to pay additional funds. Rather, it requires that the fee be split evenly between the two practitioners who jointly worked on the case.

Conrad #3 cont.

104TH CONGRESS
1ST SESSION

S. 1263

IN THE SENATE OF THE UNITED STATES

Mr. CONRAD (for himself, Mr. PRESSLER, Mr. THURMOND, and Mr. INOUYE) introduced the following bill; which was read twice and referred to the Committee on _____

A BILL

To direct the Secretary of Health and Human Services to revise existing regulations concerning the conditions of payment under part B of the medicare program relating to anesthesia services furnished by certified registered nurse anesthetists, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Medicare Anesthesia Services Reform Act".

SEC. 2. REVISION OF CONDITIONS OF PAYMENT TO FOSTER CONSISTENCY WITH STATE SUPERVISION STANDARDS.

(a) PROMULGATION OF REVISED REGULATIONS.—The Secretary of Health and Human Services shall revise any regulations describing the conditions under which payment may be made for anesthesia services under the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) to provide that payment may be made under the medicare program for anesthesia services furnished in a hospital or an ambulatory surgical center by a certified registered nurse anesthetist who, under the law of the State in which the service is furnished, is permitted to administer anesthesia services without supervision by the physician performing the operation or the anesthesiologist.

(b) EFFECTIVE DATE.—The revisions to the regulations referred to in subsection (a) shall apply with respect to anesthesia services furnished on or after January 1, 1996.

SEC. 3. ENSURING PAYMENT FOR PHYSICIAN AND CERTIFIED REGISTERED NURSE ANESTHETIST FOR JOINTLY FURNISHED SINGLE CASE ANESTHESIA SERVICES.

(a) PAYMENT TO PHYSICIAN.—Section 1848(a)(4) of the Social Security Act (42 U.S.C. 1395w-4(a)(4)) is

amended by adding at the end the following new subparagraph:

"(C) PAYMENT FOR SINGLE CASE.—Notwithstanding section 1862(a)(1)(A), with respect to physicians' services consisting of the furnishing of anesthesia services for a single case that are furnished jointly with a certified registered nurse anesthetist, if the carrier determines that the use of both the physician and the nurse anesthetist to furnish the anesthesia service was not medically necessary, the fee schedule amount to be applied shall be equal to 50 percent of the fee schedule amount otherwise applicable under this section if the anesthesia service were personally performed by the physician alone.".

(b) PAYMENT TO CRNA.—Section 1833(*l*)(4)(B) of such Act (42 U.S.C. 1395l(*l*)(4)(B)) is amended by adding at the end the following new clause:

"(iv) Notwithstanding section 1862(a)(1)(A), in the case of services of a certified registered nurse anesthetist consisting of the furnishing of anesthesia services for a single case that are furnished jointly with a physician, if the carrier determines that the use of both the physician and the nurse anesthetist to furnish the anesthesia service

was not medically necessary, the fee schedule amount shall be equal to 50 percent of the fee schedule amount otherwise applicable under this section if the anesthesia service were personally performed by the physician alone.".

(c) EFFECTIVE DATE.—The amendments made by subsections (a) and (b) shall apply with respect to services furnished on or after January 1, 1996.

Conrad #4

CONRAD MEDICARE INTEGRITY AMENDMENT

AMENDMENT:

On pages 52 through 54 of the chairman's mark, strike the Budget Expenditure Limit Tool.

EXPLANATION:

The Chairman's mark allows seniors to choose coverage options other than traditional Medicare fee-for-service. The Congressional Budget Office scores the savings of this provision at $47.5 billion. However, if those savings are not realized, the BELT provision will cut fee-for-service Medicare spending. Repeated additional cuts in Medicare fee-for-service could erode the integrity of the program and force seniors into health care plans that they do not wish to join.

Conrad #5

CONRAD/BAUCUS SPOUSAL IMPOVERISHMENT AMENDMENT

AMENDMENT:

Current law protections that guarantee that spouses of nursing home residents will be able to retain enough monthly income to remain in the community are reinstated.

EXPLANATION:

Since 1988, states have been required to allow spouses of institutionalized Medicaid beneficiaries to keep a specified amount of the couple's total income and assets. Without these protections, spouses could be forced to sell their home, sue each other for support, or even divorce in order to avoid destitution. The Chairman's mark repeals this protection.

Conrad #6

CONRAD AMENDMENT ON DURABLE MEDICAL EQUIPMENT

On page 41, at the end of the section entitled "Payments for Durable Medical Equipment," insert the following:

> Any individual purchasing or renting customized or upgraded durable medical equipment may do so by paying the difference between such customized or upgraded equipment at the point of sale or rental from a supplier; such supplier shall bill and receive the amount equivalent to such covered durable medical equipment.
>
> The Secretary of Health and Human Services shall promulgate appropriate beneficiary protection safeguards.

Conrad #7

CONRAD AMENDMENT ON ACCESS TO PSYCHOLOGICAL SERVICES

AMENDMENT:

Section 1861 (ff)(1) of the Social Security Act is amended by inserting at the end thereof the following:

Notwithstanding the previous sentence, to the extent permitted under the law of the State in which the services are provided, a clinical psychologist may prescribe and supervise partial hospitalization services, and establish and periodically review an individualized plan of treatment for such services.

Conrad #8

CONRAD AMENDMENT TO PROTECT ALL INDIVIDUALS WITH DISABILITIES

AMENDMENT:

On page 61. amend the paragraph that reads, "For each group, the minimum percentage to be spent would be equal to 85 percent of the average percentage of the state's Medicaid spending during FY1992 through FY1994 devoted to mandatory services for members of that group who were required to be covered under current Medicaid law", shall be amended by replacing the portion of the sentence between "FY1994" and the period with the following:

"all state Medicaid expenditures for members of that group."

RATIONALE:

The Chairman's mark only guarantees that states will spend 85 percent of funds currently spent on "mandatory" Medicaid services. Such a requirement provides virtually no protection for non-elderly people with disabilities who require long term services. For example, federal -state Medicaid expenditures for long term developmental disabilities services currently total about $13.5 billion (of which about $8 billion represents the federal share). Because intermediate care facilities for the mentally retarded and home and community-based waiver services are both "optional" state plan coverages exercised by every state, none of the expenditures for their services are included in the Chairman's 85% figure.

Any definition or description of home and community-based services and related supportive services should include habilitation services, non-medical transportation services, assistive devices and minor modifications in a person's home or personal vehicle, as options for states.

Graham #1

AMENDMENT BY SENATOR GRAHAM

"Medicaid Access and Quality Protection Act of 1995" -- Per Capita Cap Alternative

pp. 56-77: Strike the "Medicaid Reform Proposal" and replace with the "Medicaid Access and Quality Protection Act of 1995". This alternative to Medicaid block grants seeks to reduce funding by $60 billion over seven years as opposed to $182 billion in the Republican block grant.

* Per Capita Cap: Maintains the individual entitlement to Medicaid coverage but controls spending by restraining the inflationary growth per person covered. Demographic and economic changes would be automatically adjusted for, but spending per person would be restrained. The federal government would make payments to each state based on the statutory federal matching rate or the per capita cap, whichever is lower.

  Stated in Inflation-Adjusted Terms: Protects states from potential increases in inflation.

  Separate Caps by Category: Caps would be applied separately to the (1) elderly, (2) the disabled, (3) children and (4) adults.

  Non-Discrimination: Prohibits de jure or de facto enrollment discrimination on the basis on age, health and other risk factors. Further prohibits de jure or de facto discrimination in the access to or delivery of services within a category of enrollees.

* State Flexibility: Provides for greater state flexibility and innovation in the Medicaid program by repealing the 1115 waiver process (language from Sen. Chafee's Medicaid Managed Care Act of 1995 or S. 839).

  Phase-Out of Boren Amendment and Cost Reimbursement for Federally Qualified Health Centers and Rural Health Centers.

  Eliminate the 1915(c) waivers for home and community based care and make it a state option.

  Permit nominal copayments for Medicaid services other than prenatal care, well-child exams and immunizations for those above 100% of poverty.

* State Accountability/Performance Measures and State Rankings: States would be held accountable for performance measures they develop in conjunction with the Health Care Financing Administration with respect to quality and access to care.

* Maintenance of Effort: Maintains state effort.

* Disproportionate Share: Retargets disproportionate share funding, as outlined in the "Medicaid Reform Proposal". However, creates a set-aside for community health centers and rural health centers.

* Health Access and Quality Fund: Sets aside $10 billion over the next seven years for the expansion of access and the improvement of quality for states to access. This fund would be over and above the allocations under the per capita cap.

* Freezes Administrative Costs: In exchange for greater flexibility, saves additional funding by freezing administrative costs over the seven year period.

* Caps Payments to Institutions for Mentally Retarded Persons: Average Medicaid reimbursement in 1991 for large ICF/MRs ranged among states, according to the HHS Inspector General, from $27,000 to $158,000 per resident. This proposal establishes a national ceiling of reimbursement at the present average cost of payments by states to institutions for the care of mentally retarded persons.

Savings is obtained by implementing a per capita cap, retargeting disproportionate share funding, freezing administrative costs and capping payments to institutions for mentally retarded persons.

Cost Estimate: $60 billion could be saved over seven years.

Graham #2

AMENDMENT BY SENATOR GRAHAM AND MOSELEY-BRAUN

Uninsured Rate -- Sunset Trigger

On page 77, at the end of the "Medicaid Reform Proposal" section, add a sunset provision to the Medicaid provisions of this Act. The sunset provision would apply and revert back to Medicaid law prior to enactment of this Act if the uninsured rate for the general population, according to Current Population Survey estimates, exceed 45 million for any year or 10 million for children.

Graham #3

AMENDMENT BY SENATOR GRAHAM AND MOSELEY-BRAUN

Infant Mortality Rate -- Sunset Trigger

On page 77, at the end of the "Medicaid Reform Proposal" section, add a sunset provision to the Medicaid provisions of this Act. The sunset provision would apply and revert back to Medicaid law prior to enactment of this Act if the infant mortality rate increases nationwide. However, if the infant mortality rate increases for an individual state but not for the entire nation, the state must cover up to 133% for all prenatal and pregnancy-related services to pregnant women and infants to age one.

Graham #4

AMENDMENT BY SENATOR GRAHAM

Pre-Existing Conditions

At the appropriate place, "prohibit Medicaid plans from instituting preexisting condition exclusions for coverage of any item or service for an eligible individual."

Graham #5

AMENDMENT BY SENATOR GRAHAM

Medicaid Formula Proposal

On page 71, strike the Medicaid formula proposal and insert an alternative funding formula. It would include --

* Each state's Medicaid program would be allowed to grow at a rate of 3 percent per year.

* The amount above the 3 percent growth allowed under the federal budget would be allocated through an equity index which would work as follows:

    * Growth Factor: One-fourth would be allocated to the 25 states with the highest rate of growth with each state receiving a pro-rata share based on the FY 1995 base.

    * Efficiency Factor: One-fourth would be allocated to the 25 states with the least cost per person with each state receiving a pro-rate share based on the FY 1995 base.

    * Elder and Disabled Factor: One-fourth would be allocated to the states above the mean plus one standard deviation of the SSI population with each state receiving a pro-rata share based on FY 1995 base.

    * Poverty Factor: One-fourth would be allocated to the states above the mean plus one standard deviation of the poverty population with each state receiving a pro-rata share based on FY 1995 base.

Rationale

The principle is rather simple: any restructured Medicaid program should distribute federal funds on the basis on need. It is a compromise between two other major proposals -- a flat growth cap and a total redistribution of federal funds based on need.

Cost Estimate

None. A redistribution of funding among the states.

Graham #6

AMENDMENT BY SENATOR GRAHAM

Improved Medicaid Funding Distribution Proposal

On p. 70, add the following program efficiency measures:

* Freezes Administrative Costs: In exchange for greater flexibility, save additional funding by limiting a state's administrative expenditures to 4% and by freezing administrative costs for all states over the seven year period.

* Caps Payments to Institutions for Mentally Retarded Persons: Average Medicaid reimbursement in 1991 for large ICF/MRs ranged among states, according to the HHS Inspector General, from $27,000 to $158,000 per resident. This proposal establishes a national ceiling of reimbursement at the present average cost of payments by states to institutions for the care of mentally retarded persons.

With the scorable savings by the Congressional Budget Office, raise the funding formula cap on p. 71 from "no more than 133 percent above the national growth rate" to a higher allowable figure that more quickly moves states to equity.

Rationale

Rather than moving all states to a common payment per person in poverty, the present proposal expands the inequity.

Cost Estimate

None. A redistribution of savings from present program inefficiencies.

Graham #

AMENDMENT BY SENATOR GRAHAM

Maintenance of Effort -- Real State Dollars

At the appropriate place, insert language that clarifies that states may only use provider donations and taxes to match federal funds if such donations and taxes would quality for federal matching funds under present law.

Rationale

Current limits on provider donations and taxes were enacted in response to state abuses. A few states have used "creative financing" methods to increase their receipt of federal funds without spending additional state resources. In effect, these states avoided their state match responsibilities. These abuses creates significant interstate inequities, as a few states evaded their obligations.

The proposed amendment would clarify that states cannot use these "creative financing" techniques to avoid their state match responsibilities under the bill. For example, without the amendment, a state could meet its matching obligations with supposed "provider tax revenues" that are returned automatically to the taxpaying providers through Medicaid payments. This amendment is needed for the bill's state match requirement to have any meaning.

Graham #8

AMENDMENT BY SENATOR GRAHAM AND BRADLEY

Maintenance of Effort -- No Cost Shifting to Local Governments

At the appropriate place, insert language that clarifies that states may not shift the burden on their matching rate requirements to local units of government without their expressed consent.

Rationale

This amendment would seek to clarify that states cannot shift their federal matching rate requirements on to local units of government.

Graham #9

AMENDMENT BY SENATOR GRAHAM

Maintenance of Effort -- Disallow Supplanting of Funds

At the appropriate place, insert language that clarifies that states cannot supplant present state health funding for activities such as the provision of health care services, including public health activities, with Medicaid block grant funding.

Rationale

This would ensure that states do not supplant their present in-state health spending with federal Medicaid block grant dollars.

Graham

AMENDMENT BY SENATOR GRAHAM

Coverage Standards if Performance Goals are Not Met

In order to assure that the Medigrant program does not cause severe deterioration in the health status of children or pregnant women in any state because that state's choices cause a significant increase in the number of uninsured children or pregnant women not getting timely prenatal care:

- if the Secretary of HHS makes two successive annual findings that the uninsured rate, as defined by the Secretary consistent with Bureau of the Census Current Population Survey Data, among children in a state is higher than that state's average rate of uninsured children under age 18 over the three most recent years for which Current Population Survey Data is available, then the state shall provide coverage for all children with family incomes below the federal poverty level until such time as the uninsured rate falls below the average in the base years.

- if the Secretary of HHS makes two successive annual findings that a state's rate of women receiving prenatal care in the first trimester of pregnancy, as defined by the Secretary consistent with official National Center for Health Statistics data, is lower than the state's rates available for the most recent year prior to enactment of this legislation, then the state shall provide coverage for all pregnant women and infants with family incomes below 133⅓% of the federal poverty level until such time as the early prenatal care rate rises above the average in the base years.

Each year the Secretary shall develop a report to Congress based upon data for children's insurance coverage, low birth weight, early prenatal care, infant mortality and immunization rates with respect to each state participating in the program. The Secretary shall provide the report to all states and shall provide each state the opportunity to respond to such determinations made in the Secretary's report. If the response by a State does not result in the Secretary reversing a determination that the state's rates fail to meet the targets for children's insurance coverage or early pre-natal care, then the Secretary shall notify the state of the coverage required under this section.

Graham #

AMENDMENT BY SENATOR GRAHAM

Continuation of Treatment

This amendment would require a State plan to provide, once an eligible individual received services for a condition, illness or injury under the plan, that ongoing treatment necessary for that same condition, illness or injury would continue so long as the individual's or family's income or resources did not change in a way to create ineligibility under the plan. Such an amendment would prevent states from making arbitrary decisions to terminate necessary medical care in situations such as "Baby Doe" cases. This would especially protect seriously ill or injured persons, or persons who have received partial treatment or are in the middle of an ongoing treatment plan and acting in reliance on it.

Graham #12

AMENDMENT BY SENATORS GRAHAM, PRYOR AND BAUCUS

Medicare Anti-Fraud and Abuse Program (MAAP) -- Program Integrity

On p. 49, add a provision that would assure a dependable mandatory source of funds for all Office of Inspector General (OIG) and Department of Health and Human Services (HHS) Medicare anti-fraud and abuse activities by supporting them through the Medicare HI Trust Fund. Program integrity activities will be better able to protect the Trust Funds as their growth will be able to keep pace with the increase in Medicare claims.

Funding would include $200 million in FY 1996, $225 million in FY 1997, $250 million in FY 1998, and for each succeeding fiscal year, an amount equal to the greater of --

* $250 million increased by a percentage equal to the percentage increase in expenditures under Title XVIII for the preceding fiscal year over fiscal year 1997; or

* an amount equal to the aggregate amount expended for anti-fraud activities in fiscal year 1998, increased, as determined by the Secretary, to reflect inflation and any costs attributable to oversight responsibilities added with respect to periods after fiscal year 1998.

Scorable savings will be used expressly to restore funding to hospitals in Part A and to reduce the deductible increase to Medicare beneficiary in Part B.

Rationale

The Office of Inspector General estimates this would save the Medicare Trust Funds at least $8 billion over 7 years by ensuring a stable source of funding for OIG and HHS activities, removing them from discretionary budget limits. For example, this would support a dramatic expansion of OIG's anti-fraud activities to protect Medicare and its investigative capacity from 24 states to all 50 states and Puerto Rico.

Graham #1

Amendment by Senator Graham

Purpose

To assure equitable coverage and treatment of emergency services under managed care plans which contract to provide health care services for Medicare beneficiaries. The amendment would require such health care plans to cover and pay for their fare share of emergency services for Medicare beneficiaries that hospital emergency departments and emergency physicians are required to provide. In addition, the amendment would do the following:

(1) it would protect Medicare beneficiaries by establishing a "prudent layperson" definition of emergency;

(2) it would prohibit managed care plans from requiring prior authorization for emergency medical services;

(3) it would require managed care plans to provide emergency services without regard to contractual arrangment;

(4) it would require managed care plans to instruct Medicare beneficiaries that it is appropriate to use 911 in the event of an emergency.

Rationale

Federal law requires emergency physicians, emergency nurses, and other health care providers to evaluate, treat and stabilize any individual seeking treatment in a hospital emergency department. This law specifically prohibits emergency physicians from delaying treatment needed to evaluate or stabilize an individual in order to determine the health insurance status of the individual.

Today, managed care plans participating in the Medicare program routinely deny payment for emergency services provided to Medicare beneficiaries, basing such denials on (a) failure to obtain prior approval of such services from the plan, or (b) an "after-the-fact" determination that the medical condition identified through the federally required evaluation was not an emergency medical condition.

In 1992, a study conducted for the Health Care Financing Administration of disputed claims by Medicare beneficiaries participating in the HMOs found that 60 percent of disputed claims involved disputes over emergency care. The study's authors described these cases as "dispute prone" and recommended that HCFA's definition of emergency be amended to take into account the actions of a reasonable or prudent layperson when confronted with a potential medical emergency.

These denials by managed care plans impose significant financial burdens on Medicare beneficiaries who based upon symptoms that reasonably suggest a medical emergency, prudently seek care in the a hospital emergency department. These burdens discourage Medicare beneficiaries from seeking emergency care in cases where it is appropriate and, ultimately, threaten the financial livelihood of hospital emergency departments in providing emergency services to the entire population, including the Medicare population.

ORGANIZATIONS THAT SUPPORT THE GRAHAM AMENDMENT

American College of Emergency Physicians
National Association of EMS Physicians
Coalition for American Trauma Care
American Ambulance Association
Emergency Medical Services Section of the International Association of Fire Chiefs
International Association of Firefighters
Emergency Nurses Association
National Association of Emergency Medical Technicians
Association of Air Medical Services
National Association of State EMS Directors
American College of Cardiology
American College of Surgeons
Congress of Neurological Surgeons
American Association of Neurological Surgeons
American Association for the Surgery of Trauma
Consumer's Union
Citizen Action
Public Citizen
National Committee to Preserve Social Security and Medicare
American Heart Association
American Academy of Pediatrics

Graham #14

AMENDMENT BY SENATORS GRAHAM AND BRADLEY

Medicare Dependent Hospitals

On p. 47, add the requirement that the Prospective Payment Advisory Commission (ProPAC), in addition to its recommendations on payment rate updates for all hospitals, make a separate recommendation on updates for urban Medicare dependent hospitals.

In addition, the bill would require ProPAC's Annual Report to Congress to include recommendations to ensure that beneficiaries served by the nation's 1400 Medicare dependent hospitals would retain the same access and quality of care as Medicare beneficiaries nationwide.

Rationale

According to the most recent report by the ProPAC, "The ability to use cost shifting to fill the revenue gap where Medicare cost increases exceed payment increases varies across hospitals. Facilities that treat larger shares of Medicare, Medicaid and the uninsured patients have a lesser ability to cost shift to the private sector. In view of growing price competition in the marketplace, these facilities will face a greater risk of declining margins, which eventually could threaten their financial viability and their ability to care for Medicare beneficiaries."

Graham #15

AMENDMENT BY SENATORS GRAHAM

Nondischargeability of Certain Medicare Debts

On p. 49, add a provision that would prevent providers and suppliers from using the Bankruptcy Code as a vehicle to defeat the Secretary's effort to recoup overpayments from the Medicare Trust Funds.

This provision would further prevent an excluded individual or entity from attempting to halt exclusions imposed by the Office of Inspector General (OIG) by filing a bankruptcy petition immediately prior to the effective date of the exclusion, asserting that the automatic stay precludes the OIG from imposing an exclusion.

Rationale

Providers and suppliers, who owe financing obligations to Medicare, are seeking relief from bankruptcy courts to have their outstanding overpayments, which are unsecured, discharged or greatly reduced. The Medicare program has been unsuccessful in efforts to halt such actions. A 1992 report issued by the Office of Inspector General entitled Federal Recovery of Overpayments from Bankrupt Providers found that as of March 1991, the Medicare Trust Funds lost $109 million due to the ability of providers and suppliers to discharge their outstanding overpayments. Therefore, this provision would amend the Social Security Act to state that providers and suppliers cannot use the bankruptcy forum to avoid these outstanding obligations. Note that education loans already have this status.

Graham #16

AMENDMENT BY SENATORS GRAHAM

Improved Prevention in Issuance of Medicare Provider Numbers

On p. 49, add a provision that allows the Secretary of Health and Human Services to impose fees to providers for the expressed purpose of upfront investigation and recertification of providers prior to the issuance of Medicare provider numbers.

• GRASSLEY

Moseley Braun #1

EITC AMENDMENT

SENATOR CAROL MOSELEY-BRAUN

STRIKE CHILD SUPPORT AS PART OF THE DEFINITION OF ADJUSTED GROSS INCOME USED FOR PHASING OUT THE CREDIT AND OFFSET THE SPENDING CUT BY DECREASING THE INVESTMENT INCOME CAP FROM $2,350 TO AN AMOUNT SUFFICIENT TO REPLACE THE CHILD SUPPORT OUTLAY AMOUNT.

Moseley Braun #2

EITC AMENDMENT

SENATOR CAROL MOSELEY-BRAUN

STRIKE THE REPEAL OF THE EITC FOR INDIVIDUALS WITHOUT QUALIFYING CHILDREN AND OFFSET THE SPENDING OUTLAYS BY LOWERING THE INVESTMENT INCOME CAP FROM $2,350 TO AN AMOUNT NECESSARY TO CUT SPENDING OUTLAYS BY $4.2 BILLION.

CENTER ON BUDGET
AND POLICY PRIORITIES

September 13, 1995

THE CONSEQUENCES OF ELIMINATING THE EITC FOR CHILDLESS WORKERS

Legislation is moving forward in Congress that would repeal the small EITC for poor workers without children. While those leading efforts to reduce the EITC often describe their proposals as necessary steps to reduce errors and slow the growth of the program, this proposal would do little to accomplish either objective. Indeed, the EITC for workers without children provides needed tax relief for a group of poor workers who generally receive little aid from other government assistance programs, who experienced an exceptionally sharp increase in their tax burdens from 1980 to 1993, and who frequently pay a substantial percentage of their very small incomes in federal taxes.

If the childless workers credit is ended, poor workers without children would face a large increase in their federal tax burdens; the payroll taxes they pay on their first $4,230 of earnings would no longer be offset. Moreover, their federal tax burdens would rise to still higher levels than these tax burdens had reached before the childless workers credit was established in 1993. These workers would be affected by the gasoline tax increase enacted in 1993 while losing the EITC they received that year designed, in part, to offset the effects of the gas tax hike on them.

The Treasury Department estimates that 4.4 million workers would face an average tax increase of $173 if the credit for workers without children is repealed, with households who would have qualified for the maximum credit experiencing a tax increase exceeding $300. Every dollar reduction in the childless workers tax credit translates to an effective increase of a dollar in taxes since the value of the credit is never greater than the amount of employee payroll taxes owed.

As a consequence, single workers with incomes at the poverty line would see their already-high federal tax liability climb still higher. Under current law, a single worker at the poverty line — projected to be $8,200 in 1996 — would owe nearly $1,400 in income and payroll tax in 1996. If the EITC for these workers is eliminated, this worker's tax liability will rise by $100 to $1,500.[1]

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[1] In accordance with standard economic analysis, these figures include the employer's and the employee's share of the payroll tax. The Congressional Budget Office data used for Figure 1 also include both the employer's and the employee's share of the payroll tax.

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Robert Greenstein, Executive Director

still in poverty. They should not be taxed further by the elimination of their small EITC.

Table 1

Changes in Federal Tax Burdens, 1980-1993

Household Category	Change in the Percentage of Income Consumed by Federal Taxes
Non-elderly households without children	
poorest fifth	+38%
middle fifth	5
top fifth	-3
Families with children	
poorest fifth	-19%
middle fifth	1
top fifth	1
Aged	
poorest fifth	-22%
middle fifth	-14
top fifth	-11
All households	
poorest fifth	4%
middle fifth	-2
top fifth	-3

Source: Congressional Budget Office data published in House Committee on Ways and Means, *1992 Green Book*, pp. 1526-7.

MOSELEY-BRAUN AMENDMENT #3

COST-SHARING AMENDMENT

On page 62, insert language that would prohibit states from denying Medicaid services to individuals who are unable to meet cost-sharing obligations required by the state.

MOSELEY-BRAUN AMENDMENT #4

TRANSITIONAL MEDICAID

On page 61, insert language that would require states to provide Medicaid coverage to persons who are transitioning off of either AFDC or Temporary Employment Assistance (TEA). States would be required to extend Medicaid coverage to these persons for twelve months from the time the person stopped receiving AFDC or TEA benefits.

MOSELEY-BRAUN AMENDMENT #5

CIVIL RIGHTS AMENDMENT

Strike from the bill any provision that bars any cause of action against states in relation to the modified Medicaid program.

MOSELEY-BRAUN AMENDMENT #6

DISABLED CHILDREN AMENDMENT

On page 73, after the sentence, "Goals and objectives related to rates of childhood immunizations . . . will be developed," insert the following:

Goals and objectives related to standards of care and access to services for children with special health care needs, as defined by the state, will also be included.

On page 92, the Secretary of HHS would be required to:

(1) Fund the refinement and validation of a national, quantifiable classification system for the purposes of defining children with special health care needs. Such children would be those with conditions that are, or can be anticipated to be, of at least a year's duration and service needs significantly greater than well children. The classification system should be based on commonly recognized diagnostic codes, be compatible with state and health plan data systems, and be capable of serving as a basis for identifying these children and their medical expenditures and monitoring the quality of care they receive. The system should be further expanded to incorporate the consideration of the child's (1) severity status, (2) prognosis, and (3) desired outcome, including tertiary prevention, maintenance of function, or improvement of function.

(2) Fund state or regional demonstration projects which would:

- develop methods of providing and assuring the quality of managed care for children with special health care needs. This would include the development of adequate capitation rates specific to this population and quality indicators such as system performance standards, care guidelines for specific populations, outcomes measures and patient/parent satisfaction;

- provide for initial methods for identifying children with special health care needs based on the diagnoses accounting for the majority of the chronic conditions affecting children in the state or region which are likely to require significant medical interventions whether in number o interventions or costs;

- include appropriate representatives of providers of services to children with special health care needs and representatives of appropriate state agencies and programs in the development of initial methods of identifying children with special health care needs and in the design and implementation of the demonstration projects; and

- test the reliability and validity of the national classification system for children with special health care needs described in paragraph (1).

LIST OF NONGERMANE AMENDMENTS

1. **Chafee #7** -- Amends the Food, Drug, and Comestic Act with respect to patent laws impacting pharmacuetical manufacturers.

2. **Pryor #8** -- same as Chafee #7

3. **Simpson #3** -- Instructs the Bureau of Labor Statistics to modify the Consumer Price Index.

LIST OF AMENDMENTS WITHOUT OFFSET

Medicare/Medicaid

1. **Baucus #2** -- Rural health
2. **Conrad #3** -- Anesthesia services
3. **Conrad #6** -- Durable medical equipment
4. **Conrad #7** -- Psychological services
5. **D'Amato #1** -- IME and DSH payment reductions
6. **D'Amato #3** -- Capital transition exceptions
7. **Graham #1** -- Medicaid access and quality protection
8. **Graham #2** -- Medicaid sunset proposal
9. **Graham #3** -- Infant mortality sunset trigger
10. **Graham #10** -- Medicaid coverage standards
11. **Graham #13** -- Emergency services
12. **Graham #17** -- Hospice payments
13. **Grassley #1** -- Disclosures for plans
14. **Grassley #2** -- Access to special services
15. **Grassley #5 and #14** -- Portable X-rays/EKGs
16. **Grassley #6** -- Medicare Choice enrollment
17. **Hatch #7** -- Chiropractic services
18. **Moynihan #1** -- Teaching hospital and GME trust fund
19. **Moynihan #2 and #3** -- DSH
20. **Pryor #7** -- Quality standards for coordinated care plans
21. **Rockefeller #9** -- Strike growth restrictions
22. **Rockefeller #10** -- Primary care
23. **Rockefeller # 12** -- Balance billing protection

EITC/Welfare

24. **Bradley #4** -- Strikes child support collection fee
25. **Chafee #8** -- Administrative costs
26. **Chafee #9** -- Child support collection fees
27. **Moseley-Braun #1** -- Child support collection fees
28. **Moseley-Braun #2** -- Child support collection fees
29. **Moynihan #5** -- Strike EITC provisions
30. **Moynihan #7** -- Supplemental credit
31. **Rockefeller #7** -- same as Chafee #8

AMENDMENTS ACCEPTED EN BLOC

1. **Breaux #1** -- Taxpayer penalties
2. **D'Amato #4** -- Identification of DSH hospitals
3. **D'Amato #6** -- State plans
4. **D'Amato #7** -- Retroactive lawsuits. Accept if budget neutral.
5. **Dole #1** -- Durable medical equipment
6. **Graham #4** -- Pre-existing conditions
7. **Graham #15** -- Discharge of Medicare debts
8. **Graham #16** -- Medicare provider numbers
9. **Grassley #4** -- Enrollee payments
10. **Grassley #9** -- Beneficiary contributions
11. **Grassley #10** -- Medicaid secondary payer. Accept if state option language is removed.
12. **Grassley #11** -- Medicaid drug formularies
13. **Grassley #13** -- Advisory groups
14 **Hatch #2** -- Disclosures to beneficiaries
15. **Hatch #3** -- Children with special needs
16. **Hatch #4** -- Supplemental rebates, if current state is grandfathered.
17. **Hatch #6** -- Indian Health Service
18. **Moseley-Braun #5** -- Non-Discrimination Rules
19. **Nickles #3** -- Lock-Box
20. **Rockefeller #11** -- Out-of-pocket protections for beneficiaries