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STAFF OPTIONS TO REFORM MEDICARE CATASTROPHIC BENEFITS

THURSDAY, SEPTEMBER 7, 1989

U.S. Senate

Committee on Finance

Washington, D.C.

The meeting was convened, pursuant to notice, at 10:18 a.m., the Honorable Lloyd Bentsen (Chairman) presiding.

Also present: Senators Matsunaga, Moynihan, Boren, Bradley, Mitchell, Pryor, Riegle, Rockefeller, Daschle, Packwood, Dole, Danforth, Chafee, Heinz, Durenberger and Armstrong.

Also present: Mr. William Diefenderfer, Mr. Jerry Olson, and Mr. Charles Seagrave.

Also present: Mr. Ronald Pearlman, Dr. Marina Weiss, Ms. Anne Weiss, Mr. Pat Oglesby and Ms. Shannon Salmon.

(The press release announcing the hearing follows:)

STATEMENT OF THE HONORABLE LLOYD BENTSEN, A U.S. SENATOR FROM TEXAS

The Chairman. Good morning. The purpose of this hearing this morning is to consider a number of revisions to the Catastrophic Coverage Act which was signed into law just about a year ago.

I do not need to remind anyone that this piece of legislation got off to a very rocky start. And as with any piece of major legislation that affects a program as large as Medicare, midcourse corrections are needed in order to try to bring about a smooth implementation and to address legitimate questions that are always brought up by individuals and organizations once you begin the implementation of such a major piece of legislation, once you talk about the premiums being collected and they begin to understand some of the benefits.

We're talking about something more than just a mild midcourse correction. I know that there are some that will talking about repeal. As we consider restructuring some of these benefits, my intent is to work toward a consensus by this Committee on a substantial reduction in the supplemental premium. I will seek to see that that cap on the supplemental is less than the cost of medigap policies with comparable benefits.

While others may have a different view, I want to make it

clear at the outset that, as Chairman, I will oppose any increase in the flat premium paid by retirees of modest means. Now obviously reducing this surtax will require cuts in benefits. The greater the reduction in the supplemental premium the more benefits would have to be reduced.

On June 1st and again on July 11th this Committee had hearings on which we took testimony from some 30 witnesses. In addition, we had hundreds of pages of written testimony submitted to this Committee. I know that the members of this Committee had enumerable meetings with their constituents discussing the benefits and the costs of this particular program. All of us received thousands of letters from our respective States and they suggested that changes had to be made in this legislation.

First, the supplemental premium or the surtax is troublesome to many. Both because it raises more revenue than had been projected and because some view it as a discriminatory taxation of the elderly and disabled. As you recall, it was first presented by the Administration as something that had to be paid for by the potential beneficiaries. The major of this Committee and the Congress went along with that point of view.

One of the other troubling things has been the difficulty in relying on numbers that have been given to us by the so-called experts. Early estimates of the prescription drug benefit assumed that just under 17 percent of Medicare enrolles would

spend $600 or more for drugs in 1990. Just under 17 percent. In fact, nearly 30 percent of the elderly and the disabled will have drug expenses that exceed $600. That really changes the equation.

Providing drug coverage to almost one in three of the participants in this program is exceedingly costly. In fact, the drug benefit accounts for 34 percent of the total cost of this legislation in FY-1993.

The next point, some retirees with better than average private insurance through their former employers do not believe they need catastrophic coverage under Medicare. Nearly one million Medicare enrolles do not even participate in the physician coverage portion of the Medicare program before January 1st -- nearly one million -- and that is when the mandatory premium took place.

One question before the Committee then is whether those who choose not to participate in Medicare Part B should be allowed to drop catastrophic coverage too. The original version of the program approved by this Committee had such an approach. I will strongly support returning it to that approach where people have the option to out on it.

Today, I would like to begin to address these and other concerns that the members may wish to raise. Each of us is going to have his own priorities and given the opportunity I'm sure would craft a reform package to fit those particular

priorities and views. But I expect there's going to have to be a lot of give and compromise as we try to bring back a consensus.

The Catastrophic Coverage Act is front end loaded. That is, revenues are collected first to build up the funds needed to pay for benefits that are phased in over a five year period. The build up of that affects the deficit in the early years. Therefore, if the program and the revenues to fund it are paired back, there will be an increase in the deficit. In my view, any proposal approved by this Committee should not increase the deficit and should not trigger a sequester under Gramm-Rudman.

In other words, to the extent we agree to the package of provisions that increases the deficit we should find a way to offset that increase. I met with the Majority Leader and the Republican Leaders, with the Ranking Member, of this Committee to discuss options for reform. I have every reason to believe that they agree with me that the revisions to the Catastrophic Coverage Act be undertaken on a bipartisan basis. I am going to work to try to bring about that kind of a result.

I came back a week early from the recess and left a week late to try to work on some of these options, to try to better understand how we could accomplish our objectives here. I must say I sure enjoyed the two weeks in between.

(Laughter)

The Chairman. But let me say that the options that you are

going to look at are a point of departure for our discussion as a way of enabling the Joint Tax Committee and CBO to prepare the revenue and the cost estimates for it. Now before the Staff describes each of these options -- and I must say I'm going to start with the Joint Tax Committee first because I want to talk about the premiums. Well, better yet, I may just start with OMB first when we get to that, and let them state their position.

But before all of that, I would like to turn to the Ranking Minority Member, my distinguished colleague, Senator Packwood.

STATEMENT OF THE HONORABLE BOB PACKWOOD, U.S. SENATOR FROM OREGON

Senator Packwood. Before I make my substantive comments, Mr. Chairman, could I welcome Mr. Diefenderfer back to the Committee. This is his first appearance I believe. He used to occupy a position in Government of immense importance, when he was Chief of Staff of the Finance Committee. He has since fallen from grace and is only the Deputy Director of OMB. But in any event, we are glad to have him back with us under whatever his circumscribed circumstances may be.

Mr. Diefenderfer. Thank you, Senator.

Senator Packwood. Now, when we passed this a year ago there was bipartisan goodwill and we thought we had done a decent thing. What did not pass on a partisan basis, President Reagan endorsed it, and we all thought it was a nice piece of legislation.

At the time I had only one misgiving and that was about the cost estimates. And only because I have been here 20 years and on this Committee for a long and I have never seen a medical expense cost estimate that did anything but go up. I feared that we might not have scaled our premiums sufficiently to pay for it. But early on we were euphoric and we have seen what has happened over the year. If we do not act now, if we wait another month or two or three, the cost estimates will go up

again as they always do. So I did have misgivings about those at the time.

But when we passed this, other than the cost estimates, we really had two thoughts in mind. (1) Who should pay for these benefits; and (2) among those who should pay, how much should they pay? I thought we did a wonderful thing in an entitlement program that we had not done before. We said for the first time we thought the beneficiaries should pay for the benefits. That got rather significant editorial support -- public support around the country. Yes, it is a good idea.

Then, following a tradition of taxation in this country, we said that those who are somewhat poorer would pay less than those who had somewhat more money. This, of course, is in keeping with the progressive income tax that we have had for years and years and years. As we passed it, those were the thoughts we had in mind. Are we really on it on the cost? Isn't this a good policy, that the benefits will be paid for by the beneficiaries? And haven't we done a decent thing by saying those that are poor will not have to pay quite as much as those who are better off?

From that we have arrived at where we are today. You almost have a sense when you go home on this issue of being unwanted and unloved and unappreciated. You almost close to the place of saying, "Oh, the hell with it." If they do not want it, you know, it is grassroots and it is public, we tried and it did not

work; let's repeal it. You can get that sense when you are in enough of these meetings. I do not feel that. But I can understand the frustration.

But I would say this. I hope when we consider what we are going to do that we do not forget the three problems we face: (1) cost; (2) should the benefits be paid for by the beneficiaries -- and I hope we continue to say, yes, no matter what we decide the benefits are; (3) should those who are poorer pay somewhat less than those who are better off? I would hope we would stick with that decision also.

The Chairman. Thank you.

Let me ask if there are any members that want to make a comment before we go on.

All right. Senator Matsunaga. Let me ask you, please, to not go over five minutes because we have a very crowded agenda this morning.

STATEMENT OF THE HONORABLE SPARK M. MATSUNAGA, U.S. SENATOR FROM HAWAII

Senator Matsunaga. Thank you, Mr. Chairman.

Mr. Chairman, while I have not been pursued on the beach at Waikiki by irate seniors as has Chairman Rostenkowski down the streets of Chicago, I have been getting my share of visits, telephone calls, letters, postcards and petitions from Medicare beneficiaries. They are concerned mainly about the supplemental premium, the so-called surtax, and duplication of benefits that they are already receiving from medigap policies and employer-provided retiree policies.

While I do share their concerns, I also believe we enacted Public Law 100-360 in good faith to provide needed protection against devastating catastrophic medical expenses for many of the elderly and disabled covered by Medicare. When it was determined that these program expansions had to be self-financed we built progressivity into into the finance mechanism. Those with the greater ability to pay would carry a larger portion of the costs. We should neither repeal the catastrophic coverage program, nor should we shift more of the costs of the program or penalize through benefit cuts or elimination the beneficiaries who can least afford them.

Perhaps more than any other State in the Union a large portion of beneficiaries in my State of Hawaii are Federal civil

service or military retirees. I realize that the solution to their problems lies within the jurisdiction of other Committees. However, there is urgency in further addressing the generic issue of duplication and benefits here.

Whatever solutions we reach, we much ensure that accurate and understandable information gets out to the beneficiaries about what the benefits are who is paying how much. It seems that everyone who is protesting the supplemental premium believes that they will be paying the maximum $800. We have heard that so often -- $800, $800, $800.

We are also up against the public perception that health benefits and health insurance should not operate like other forms of insurance unless a benefit is triggered. It is not a benefit.

In this education effort, we should lay the foundation for future long term care legislation at the same time by increasing public awareness of the existing services and benefits as well as the gaps. Perhaps the aging network, the State units on aging, for example, could be involved more closely in supplementing the Social Security Administration's initiative.

As Chairman of the Labor and Human Resources Subcommittee on Aging, which covers the administration and aging programs, I will intend to pursue this area.

The Chairman. Thank you, Senator.

Senator Matsunaga. Thank you.

The Chairman. Senator Durenberger.

STATEMENT OF THE HONORABLE DAVE DURENBERGER, U.S. SENATOR FROM MINNESOTA

Senator Durenberger. Mr. Chairman, I want to make just two or three quick observations. One, the more we look at what we did the more we understand how far beyond catastrophic we have gotten. During the course of the discussion today we may talk about the new estimates on the Smith benefit and how much that may end up costing us by next year or sometime.

It now becomes fairly clear that if you look at this program two or three years from now, about a third of the costs are going to be in catastrophic, about a third of the costs are going to be in long-term care and about a third of the costs are going to be in new acute care benefits, like principally drugs and maybe mammography.

I do not know whether looking at it as really three bills rather than -- or three kinds of coverage rather than one may help us at some point in our discuss. But the reality is of what you said earlier, what we thought was going to be catastrophic, actually also become long-term care and a set of new benefits.

The second point that I would make is, I guess, to the generational aspects of this because most of us felt, as the Ranking Member just said, that we wanted these new benefits to be paid for by the beneficiaries of the legislation. One of the

things that I have heard a lot by objectors is that social insurance is supposed to be generational. We are supposed to have our children and our grandchildren pay for; and social security is such a system; and the bulk of Medicare is such a system. Many other things we do is such a system. Just look at 15 percent of the payroll tax which is going into financing it right now.

So our efforts to add benefits and ask the beneficiaries to pay for it is not abandoning the generational aspects of social insurance. It is trying to deal with the realities that today's sixty-five year old when he retires gets back everything he paid into the system, plus all of his premiums that he pays to the system during his lifetime, plus it takes $2300 from his children to pay for his Medicare. And if it is a woman, that figure is $2600. So it is abandoning -- We are not abandoning the notion of generational or intergenerational system here when we say that something that costs so much and is needed so much we have to look at whether or not some of it should not be contained within the benefiting generation.

The third comment is on the matter of income-related premiums. Senator Rockefeller and I, and a couple of other people on this Committee -- Dave Pryor is on it and John Heinz -- sit on the bipartisan commission. I think one thing that is coming very clear to us is that if next year we want to provide universal access to health care in this country to all

Americans, in some way or another we are going to have to deal with the way the current system is income-related.

If you belong to the communication workers union and you want to march up and down the streets of New York and all the rest of those places unwilling to give up your $600 a month tax subsidy when some poor farmer in Texas cannot afford health insurance and he has to buy what little insurance he gets with after-tax dollars, you know the current system is already unfairly income-related.

So my thought is that as we deal with the issue of income relating access to this system we had better keep in mind that we really have not seen nothing yet until we get to the issue of universal access. Because it is at that point that we must somehow or other deal with America as it is and deal with that element of payment.

The Chairman. Thank you very much, Senator.

Were there others? Yes, Senator Rockefeller.

STATEMENT OF THE HONORABLE JOHN D. ROCKEFELLER, IV, U.S. SENATOR FROM WEST VIRGINIA

Senator Rockefeller. I thank the Chairman and I will be brief.

When we enacted the Medicare Catastrophic Coverage Act last year most of us, which included the President and the Congress, were very proud of the fact that we had achieved the largest expansion of benefits in the history of the program and that we had paid for these benefits in a way that was intended to be both fair and fiscally sound.

All of us have seen President Bush's letter written earlier this spring expressing his strong and continuing support for this important new program and I share his strong support as well. Obviously we are here today because of concerns that have been raised about the catastrophic program's cost and its financing. We are here to take a second look to see if further improvements are possible.

Given that options do exist, my inclination is to change the program, Mr. Chairman, as little as possible. That is because the Medicare Catastrophic Coverage Act made some fundamental improvements in the Medicare program which we should strive to preserve in this member's judgment. We introduced important new health benefits, such as prescription drugs, respite care, protection against spousal impoverishment, a list of a dozen

extraordinary benefits that few seniors are able to purchase anywhere at any price. We built into Medicare permanent protection against catastrophic acute care cost that is more secure, that is more efficient, that is more comprehensive than the average private medigap coverage available anywhere.

We introduced the concept of a "bully to pay" in the Medicare financing, while retaining the principal of a national social entitlement program. We were careful not to add to the national deficit.

As we begin our deliberations then, Mr. Chairman, I hope the Committee will fight to protect these accomplishments. They are important. Not only within the context of the catastrophic program, but as principals to guide us in our deliberations on health benefits in general. Even so, we are here and we understand that the math may not add up. To simultaneously protect as many benefits as possible, to make the financing as fair as possible, and not increase the deficit, we may have no choice but to consider options for raising revenues from sources other than beneficiary premiums.

However, in this regard, I would ask my colleagues to keep in mind the task that remains before us that the Senator from Minnesota indicated -- more than 30 million Americans, more than one-third of them children, have no health insurance whatsoever, and their ability to find decent health care is severely impeded. As a result, another 30 million senior citizens have

no protection against the high cost of long-term care. And as we have heard from constituents seniors want this protection very much.

The Pepper Commission is working diligently on a plan to begin to meet these enormous health care needs. There is no question that the solution will require new resources, probably both public and private. If we vote today to pay for a significant portion of the new Medicare Catastrophic Program with outside revenue, we will limit the options enormously before the Pepper Commission, in consideration of the uninsured and long-term, and we will limit options for the country and for moving ahead on a variety of other fronts.

In conclusion, I hope this Committee will resist efforts to repeal any of the new benefits. I hope it will reject the proposal passed in the House to transfer financing for the new program onto regressive monthly Medicare premiums. And I hope we will come out of this process with a revised financing system that is as far as possible and that preserves as many resources as possible for the remainder of the nation's health care agenda facing us today.

I thank the Chair.

The Chairman. Thank you, Senator.

Are there others?

Yes, Senator Danforth.

STATEMENT OF THE HONORABLE JOHN C. DANFORTH, U.S. SENATOR FROM MISSOURI

Senator Danforth. Mr. Chairman, thank you very much. I know you want to get on with the proceedings. I am a member of the Judge Hastings Impeachment Committee and, therefore, I regret that I will not be able to participate as closely as I would like to in the work of the Committee on catastrophic.

I would, however, like at this point to express my doubts about the comments that were just made by Senator Rockefeller. Mr. Chairman, my hope is that the Finance Committee will use this as an opportunity not only to examine the details of the financing mechanism but that we will examine in addition what we bought.

My view is that we should repeal the catastrophic bill that we passed last year and that we should start over again. I assume that the cost of health care for our senior citizens is not going to go down; that it is going to go up. I assume that we have a major commitment and that we want to have a major commitment to health care for our senior citizens. But I question the kind of commitment that we made last year. I do not think we thought it out.

What I am hearing from senior citizens in my State is not only criticism of the financing mechanism, but what I hear is criticism of the underlying program. Now I am not sure that I

have heard a representative sample.

I think what we should do in the Finance Committee is to start work immediately on a new program. Therefore, my proposal would be that we repeal what we have and that we, in six months, report back with whatever we are going to do. Maybe we want catastrophic health insurance. But the nature of catastrophic health insurance, what we intended to do last year, was to provide for heroic care, long-term hospitalization in excess of nine months in institutions -- very expensive procedures -- often times for people in their final days.

What I find in talking to people in my State, many of them, and others as well, is that this is not something they want; it is something they fear. That what they fear is getting caught up in the web of institutional medicine. Often times when they cannot even make decisions about what is happening to them and being hooked up.

So I really raise an ethical question about what we are doing. Maybe we are doing the right thing. Maybe this is exactly right. Maybe we will decide this is exactly right. On the other hand, we might decide that such resources as are available would be better spent for home health care or for nursing home care or for long-term care.

I do not know the answer to that. But I do know that we reached a fundamental decision last year, on very short notice, with very little input. The decision was that we wanted to put

such eggs as we had in the basket of major medical care in institutions -- very, very expensive -- and I question whether this is what our seniors want. I believe we should repeal the bill and open it up for reconsideration.

The Chairman. Other further comments?

(No response.)

The Chairman. Let me state for the record on that last comment, you can restructure this just as with your offer for amendments just as far as you want to go in offering them. We know about as much now as we are going to know. We have spent a year in watching the implementation of this. We have heard from every interest group that possibly wanted to talk to us. We listened to all of their options. And we listed to our constituency. I think it is time we face up to what we think will be a better solution, if we can bring it about.

Mr. Diefenderfer, I would like to let you start out because one of the major consideration is what this does affecting the budget and trying to bring out something that is revenue neutral. I would like your comments.

STATEMENT OF MR. WILLIAM DIEFENDERFER, DEPUTY DIRECTOR, OFFICE OF MANAGEMENT AND BUDGET

Mr. Diefenderfer. Thank you very much, Mr. Chairman. If I may, I would also like to thank you for the opportunity to appear before the Committee. This is a place where I have many happy memories. But I am reflecting that most of the happy memories started with a knot in my stomach like I have today on addressing issues such as this. But the successful resolution turns those into happy memories. I am sure that is going to happen here.

This is also my maiden appearance testifying for the Administration and there is some irony in that too. Because while I was Chief of Staff here I avoided this table for two years, letting those who worked for me do that.

The Administration's concern or position on catastrophic as it regards to budget is this: As you know, Senator Rockefeller mentioned, on April 21st the President indicated in a letter to the Congress that he would prefer no change in the program whatsoever. That does not seem to be what is going to happen. It seems to us that there are going to be changes and when we went over to Ways and Means to discuss reconciliation they, in fact, voted on some changes, all of which we could not support.

In fact, they paid for some of the changes with a $2 billion payment shift which would not be scored under GRH scoring and

would increase the deficit by that amount. Sequester of the deficit, I might mention that we put our initial sequester report out -- which most you I am sure have seen -- which says that we are very, very close to coming under the guillotine of sequester. It is very technical.

But to summarize and if somebody wants to go into the details, I am glad to do that, is that we believe that if everything works right and we get about $14 billion out of reconciliation, we are going to come in around $109 billion on the GRH measurement. As you know, $110 billion is the trigger for sequester. We are actually figuring about $109.4 billion right now, but it is hard to be perfectly accurate on these things.

Any major action such as this that would increase the deficit $1 billion or $2-3-4 billion would almost ensure sequester. We, therefore, very much support the position that you announced at the beginning of this markup -- and I know you have held previous to this -- is that whatever solution we proceed to, if we can agree on policy terms, which the representatives from Health and Human Services will comment on, we would want it to be deficit neutral in Gramm-Rudman and Hollings measurement terms.

The Chairman. Let me ask you specifically, then would the Administration support or oppose repeal of catastrophic?

Mr. Diefenderfer. Repeal. Any model I have seen for repeal

increases the deficit.

The Chairman. Does that mean you would oppose it?

Mr. Diefenderfer. Any model that increases the deficit we would absolutely oppose. Yes, sir. If there is another model out there that does not, it has not been looked at by me or by HHS or anybody else. But every model that we have seen, and we have looked at everything, and have examined it as best we can, they all increase the deficit. So, therefore, we have to oppose it.

The President's letter did not talk about the deficit effects. He was talking about the program itself. He wants the program to continue. So at this point in time, if even I guess we could find a deficit neutral solution, that is our position.

The Chairman. So the President wants the program to continue and so long as there is a deficit resulting from repeal -- and you know of no way that it would not result in that -- you would oppose repeal?

Mr. Diefenderfer. That is our present position, sir.

The Chairman. Thank you.

Senator Moynihan. Mr. Chairman.

The Chairman. Yes.

Senator Moynihan. Could I ask, sir, if you would ask Mr. Diefenderfer, does this program make money? Is that it? And that is why you want it -- the surplus goes on and on.

Mr. Diefenderfer. My personal opinion is that it in fact

will over time it will lose money. The new estimates that come in are showing that, I think, trend to be true. In the early years what you have set up or what the Congress along with President Reagan has set up is a can do insurance program where you are bringing in premiums and stockpiling them in the event of having to pay out. That is counted for budget purposes as a surplus in these years. Well, not a surplus, but it accounts to the --

Senator Moynihan. I see. This is one of those surpluses you get, like paying the Army the day before the fiscal year begins.

Mr. Diefenderfer. It's not exactly the same.

Senator Packwood. Well, it isn't quite the same thing.

Can I ask him a question now?

The Chairman. Yes, of course.

Senator Packwood. We have a surplus because we followed an intelligent insurance principal. We said, let's try to collect some of this money before we pay it out. We all understood that when we did it. But now what the Administration is up against is -- it is almost up against the $110 billion sequester figure. And because we front loaded this program, you have money coming in. If we now terminate the program, the money does not come in and you are over the $100 billion; and you do not know of any way at this stage -- because you have counted the money -- to get you under the $110 billion -- you do not know of any way

that we could repeal or fashion or change the program with putting you over the sequester amount because of the front loading of the insurance program.

Mr. Diefenderfer. Yes, sir. We are obligated by law, and being so, we did count it.

Senator Moynihan. My question, sir, is your position on the program driven by your views about the program or the need to have some monies in the next fiscal year?

Mr. Diefenderfer. Well, the President's letter, which is our last official statement on it, does not refer to budget. He said he wanted the program to continue with no changes, when there were changes being proposed at that point in time.

If changes are going to occur -- and we are not the ones initiating the changes -- if changes are going to occur, we want them to be revenue neutral. Because the effect, if they are not, is to cause a sequester which will cause more harm than the good that the changes that you may enact bring upon us.

The Chairman. Any further questions for Mr. Diefenderfer?

Senator Bradley. Mr. Chairman.

The Chairman. Senator Bradley.

Senator Bradley. How much will the deficit be increased if the repeal takes place?

Mr. Diefenderfer. It depends on how it is done. But I have seen models that go from $4 billion to $7 billion.

Senator Bradley. In the first year?

Mr. Diefenderfer. In the first year. Yes, sir.

Senator Bradley. What about in the second year?

Mr. Diefenderfer. The second year it is less. It is in the $2-3 billion range. And then it starts to get positive. Now what will happen -- Do not rely on those numbers for one reason. Right now we are under Gramm-Rudman restrictions. We cannot re-estimate economics or technicals. On January 1 we are going to re-estimate SNF, for example, and that number is going to way up. So the second year numbers may start to turn positive again once we are able to re-estimate. But these are all based on the little box we are in now. But it is the year that we are mainly worried about right now.

Senator Bradley. So you are saying that a vote for repeal is a vote for sequester, unless alternative budget measures are taken -- either raising taxes or cutting additional programs -- so that the effect of repeal would be that the senior citizen has no catastrophic health insurance. Right?

Mr. Diefenderfer. Yes.

Senator Bradley. And that other programs must be cut to allow the Government to deliver the senior citizen no catastrophic health insurance?

Mr. Diefenderfer. Absolutely.

Senator Bradley. Or taxes have to be raised in order to deliver the senior citizen no catastrophic health insurance?

Mr. Diefenderfer. Or there is one other option which we do

not favor either, is waive Gramm-Rudman. But that is the scenario.

Senator Bradley. I think, Mr. Chairman, it is important to focus on that. When people come in here and argue for repeal, they are arguing for several other steps. They are incumbent upon those who argue for repeal to say what programs are they going to cut to avoid the sequester or do they accept the sequester or which taxes are they going to raise.

The Chairman. Are there further questions?

Senator Rockefeller.

Senator Rockefeller. Mr. Chairman, I would simply ask, in that there are obviously have been monies coming in, this being front loaded, my question would be: Have those monies been spent? And if they have not been spent, would the Government then be in the position of trying to return, if the program were repealed, return to individual seniors by which calculation method I have no idea, the money which has been sent in?

Mr. Diefenderfer. We do not keep cash balances around. They have in normal parlance, they have been spent. They have been used to pay current operating costs of the Government. There are Treasury Bonds issued when they are paid back. That funds the money. But there is no bank account that says, "X" number of dollars; just as there is no bank account, as you all know, in social security.

Senator Rockefeller. So in essence, if there were a repeal,

there would be no money coming back to seniors across this country?

Mr. Diefenderfer. Oh, well, I would presume. I would presume. I mean that is up to you. If you repeal and say the monies have to be refunded, we would end up, since we are in deficit, we would end up borrowing more money and refunding it. Sure.

Senator Rockefeller. But then that would lead us to sequestration automatically?

Mr. Diefenderfer. Yes, sir.

The Chairman. Thank you.

Senator Durenberger. Mr. Chairman.

The Chairman. Senator Durenberger.

Senator Durenberger. Can I raise a question that has just been recently raised, mainly by way of definition and not at the imperative that maybe it has to be dealt with. I made some reference earlier to some of the information we are just beginning to understand about the skilled nursing facility benefit.

My State is one of those creative places where when they recognize a little hole in the dike they do not put their finger in it; they expand it. It would appear that somewhere between the nursing home operators and the State Medicare/Medicaid medical assistance people, this opportunity to go to 150 days of skilled nursing facility without prior hospitalization has

created at least the potential for some substantial growth in the use of that particular benefit. I have heard figures upwards of $3 billion a year, I think, Mr. Chairman, potentially in this area. Which is why I referred earlier to this bill as one-third long-term care; one-third acute care and one-third new benefits.

Would you try to describe that a little bit for the Committee and what is causing it? Give us some dimension.

Mr. Diefenderfer. Well, I am not sure that I am the best person to describe what is causing it. The people from HHS might be better to talk about the specific policy problems. But certainly the immediate entrance into the long-term care for the 150 days, not having the three-day gate is part of it.

But you are right in the new estimates, while they are not final, could be as much as $3 billion; it could be more. But we know it is substantially more than estimated. I think estimates were around $300 million. So it is a factor of ten perhaps or greater that we are off in the first year.

So you understand -- and there is some confusion about this -- those estimates came in after we were locked into our economics and technicals. So they are in none of our computations. It is not in the -- When we said that the Gramm-Rudman number was around $116 billion, that is assuming the $300 million number. We are forbidden by law to change that estimate. A rational system would say, well, okay, we just

found another $3 billion guys; it is really $119 billion. But we are forbidden under Gramm-Rudman to change that estimate.

Unless, you act in that area and significantly change the economic or technical underlying assumptions we made, and then we are obliged to re-estimate it. As a warning, you could make $100 million change theoretically that could trigger a $3 billion negative re-estimate. It is a crazy result. But that is what the law requires us to do.

The Chairman. I would like to defer. We are very pleased to have the Majority Leader here and I know he has many other demands on his time. He is adamantly familiar with this piece of legislation, done a lot of work on it. We would be pleased to have any comment.

Senator Mitchell. Thank you, Mr. Chairman. Mr. Diefenderfer, welcome back to the Committee and thank you for coming. You have made clear this morning that the President is opposed to repeal of the Catastrophic Coverage Act and favors continuation of the program without change. You also indicated -- I think your words were, "It now looks like that is not going to happen. That there are going to be some changes." And have asked only that any changes made have the result that they be revenue neutral.

May I take it from your remarks, therefore, that you will not be making specific recommendations for change with respect to the various options that have been presented to us in the

Staff document today and that will be discussed, but rather will limit yourself only to the general recommendation that if any changes are made that they be neutral in revenue effect?

Mr. Diefenderfer. Yes, sir. But there is a parameter for that. I represent OMB and we worry about the beans.

Senator Mitchell. Right.

Mr. Diefenderfer. HHS is here who will have comments to make on what policy changes you might consider and whether we support them or do not support them.

Senator Mitchell. I see.

Mr. Diefenderfer. And if we get into the area of new financing mechanisms -- ducks or robins, or whatever you want to call it -- Treasury will have opinions on whether the new financing mechanisms, should they be taxes or acceptable or not acceptable.

Senator Mitchell. Right.

Mr. Diefenderfer. My comment was meant to be OMB.

Senator Mitchell. I see. But with respect to the question of the President's opposition to repeal of the program and opposition to any change in the program, I assume that that position holds Administration wide and Mr. Olson will be responding to specific proposed changes if the Committee intends to proceed with them. Have I accurately stated the Administration's position in that regard, Mr. Diefenderfer and Mr. Olson?

Mr. Olson. That's correct.

Mr. Diefenderfer. Yes.

Senator Mitchell. Thank you very much.

The Chairman. Thank you.

Are there other questions?

(No response.)

The Chairman. If not, Mr. Diefenderfer, thank you.

Mr. Diefenderfer. Thank you.

The Chairman. Mr. Olson, did you have any comments you wanted to make on the part of the Administration?

STATEMENT OF MR. JERRY OLSON, ASSISTANT SECRETARY, HEALTH AND HUMAN SERVICES

Mr. Olson. Mr. Chairman, I do not have any formal comments, other than to say that we welcome the opportunity to appear here to be of whatever assistance that we might be. We have brought with us our colleagues from OMB and from Treasury, as well as some people from HCFA and our own Office of Management and Budget.

Dr. Sullivan has also asked me to convey to you and the Committee that he is available at any time to come here personally to appear to talk with you about this problem. It is in that spirit of cooperation that we hope we can respond to whatever changes that you are thinking about doing in a forthful and forthright way.

Thank you.

The Chairman. Mr. Olson, I want to say that Secretary Sullivan has been most cooperative in his appearance and has always been quite willing to do so as you have stated.

We will now go to the revenue sources -- the financing of the Medicare benefits -- and I would ask to have the Chief of Staff of the Joint Tax Committee, Mr. Pearlman, to deal with those.

STATEMENT OF MR. RONALD PEARLMAN, CHIEF OF STAFF, JOINT COMMITTEE ON TAXATION

Mr. Pearlman. Mr. Chairman, thank you.

The Chairman. You have a set of options before us, do you not?

Mr. Pearlman. There is a document before the members. It is captioned, ''Present Law and Possible Revenue Options Relating to Catastrophic,'' dated September 7. It has a summary of existing law in it, which I do not intend to spend any time on. I would note to you that on pages 5 and 6 are the schedules of the current flat and supplemental premiums in the event you want to refer to them.

I will direct your attention -- I might also note that there are four distribution tables at the back of the document that relate to current law. Just so that they are not totally confusing to you, you will see the first two look a lot alike. They relate to different years -- 1989 and 1993. So if you look at those note that difference. You will see the same difference between the ones on pages 11 and 12.

I would direct your attention first to page 7 of the document. That page contains three possible options to the current supplemental premium structure. As you know, the current supplemental premium has a 1989 premium of 15 percent and then it rises in percentages fixed in the law through 1993.

It also has a maximum. It begins in 1989 at $800 and again by statute increases incrementally to $1,050 in 1993.

The options which you have in front of you, which as the Chairman noted, are not the only ones are a variety of permutations of these. A key off of the rate and the current maximum.

Option No. 1 would freeze the current law 15 percent rate through 1994 and would reduce the current $800 maximum premium to $585; and then hold that constant through 1994. The revenues are before you. As you can see, at least in relative terms, this option has the lowest cost of the three options before you. So it is a freezing of the rate and a reduction in the maximum premium.

Option No. 2 reduces the rate to 10 percent from the current law 15 percent rate, holds that 10 percent rate constant through 1994 and reduces the maximum to $585. It is a more expensive option. The difference between the two is the reduction in the rate.

The third option is a combination -- a mix of the first two. It reduces the rate for 1989 to 10 percent, then kicks it up to 15 percent in 1990. That is still below the 25 percent that is scheduled under current law for 1990, holds that 15 percent rate constant then through 1994. As in the first two options, that option also reduces the maximum premium to $585 and holds that maximum constant through 1995. It is a middle ground option;

and as you can see, if you look at the 1990 to 1994 totals, it is in between -- not exactly -- but in between Options 1 and 2.

Page 8 has a totally different approach. It does not do anything to the premiums. Instead, it looks at a different revenue source, specifically increasing the wage base under the medical HI tax. The proposal before you increases it to $60,000. You can see the revenues that that picks up.

There is another option that, frankly, we should have included on this Table and failed to. That option would grow the $16,000 with inflation. The option in front of you does not do that. But if you were to start with an increase in the wage base from the projected $50,700 in 1990 -- that is what it is projected to go to in 1990. It is currently $48,000, but it does go up to $50,700 on a projected basis in 1990. If you increase that to $60,000 and then let that grow with inflation over the five-year period, then the early year numbers are very similar. For example, $600 million in 1990; $1.7 billion in 1991; but the five-year total is substantially greater. Instead of $3.9 billion, it is $8.4 billion.

Those are the options that we put in front of you. We put them in front of you obviously with no recommendations and as the Chairman intimated, certainly we are happy to try to assist you as you discuss other options in trying to help quantify those.

The Chairman. Are there questions?

Senator Bradley.

Senator Bradley. Mr. Chairman, I wondered, I did not see one possible revenue option there and I wondered if you could explain what the revenue option would be if you raise the threshold before which anyone had to pay a supplemental premium. As it is now, about 40 percent of the people have to pay a supplemental; 60 percent do not pay a supplemental. What would be -- How high would you raise the threshold, for example, in order to exempt, say, 80 percent or 82 or 85 percent of the people from paying any supplemental at all?

Mr. Pearlman. Senator, you are correct that there is no option on the threshold and certainly it had probably failed in that regard. You might recall during our testimony before the Committee earlier in the year we did indicate that obviously the threshold could be increased. At that point we are aiming at a target dollar and we were able to present the Committee a threshold that met that dollar target.

The reason we did not include a threshold option here was because we did not have a target dollar to target, to aim at. If you want us -- I mean that is not presented as an excuse. It was just a conclusion we reached, that we can set the threshold at any dollar or percentage amount you want to. And if 80 percent is what you would like us to run, we will come back and tell you what the threshold would be to exempt 80 percent of the Medicare population or if you want us to aim at a certain

program cost or revenue cost, we could do that.

Senator Bradley. Well, I think there are two questions here. One is, among the things you laid out in your testimony, you said you could reduce the cap from $800 to whatever; or you could reduce the rate from 15 percent to whatever; or you could raise the threshold before which anyone had to pay any supplemental whatsoever. Those decisions have distributional effects.

In other words, if you cut the cap, the primary beneficiary of cutting the cap from $800 to whatever are people that make more than $50,000 a year. If on the other hand you did something like increase the threshold, the primary beneficiaries of increasing the threshold would be people whose income would then be below the threshold and they would not have to pay any supplemental premium whatsoever.

In our conversations, for about the same amount of money that it would take to cut the cap from $800 to $400, you could essentially take 80 to 82 percent of the people out of the supplemental at all -- no payment whatsoever. And the distributional effect of that would be that people who were then no longer reaching the threshold would primarily be middle income taxpayers. Isn't that -- That's what I --

Mr. Pearlman. Yes, I think that is correct. That if you were to conclude that the way you want to provide the relief from the premium here is through the threshold, then obviously

provide about $500 million in cut for people between $20,000-$30,000 in income; whereas, raising the threshold would be $940 million. Almost double for the middle income taxpayer. Then you compare that to the cap for the same thing and you provide $130 million. I mean the difference between the cap cut for $20,000-30,000 is a difference between $940 million in relief and $130 million.

Mr. Pearlman. Yes, I would like to -- I am not going to comment. I am not going to disagree or ratify what you just said. I would suggest this to the Committee. That if we want to make these distributional analyses -- because I am nervous that we might be comparing apples and something other than apples -- that we select, you tell us sort of a target, you know, one or all three of these options and let us run the threshold distribution so that we have exactly the same thing in front of you because I want to make sure we do not mislead you.

Senator Mitchell. Mr. Chairman, may I ask a question?

The Chairman. Yes, of course.

Senator Mitchell. May I ask a follow-up question of Senator Bradley?

The Chairman. Yes, of course, Senator Mitchell.

Senator Mitchell. Just for purposes of information, Mr. Pearlman, so that I understand it. Senator Bradley used the figure estimating 9, 10 or 12 percent for the respect to the cap. But in the Tables distributed by the Committee, Appendix

that means that you start at the lower income end of the distribution table on the supplemental premium and those people get the benefit first. Then it creeps up and it creeps up certainly into the middle income level.

Again, one of the things we might do for you is if one or -- you know, if one of these options seems to be most attractive, if you are going to compare distribution, it probably would be best to select a dollar amount.

Senator Bradley. Right.

Mr. Pearlman. And then, say, run a threshold option that uses the same dollar amount. We certainly can do that.

Senator Bradley. In Table 3 of the document that you presented to us you show income class and average income per return and average tax liability. Right now the supplemental goes into effect when someone has an average tax liability of about $150; is that correct?

Mr. Pearlman. That is correct.

Senator Bradley. So that if you were about to raise that threshold to say $3,000 in income, then essentially anybody earning under about $45,000 or $46,000 would pay no supplemental whatsoever; is that correct?

Mr. Pearlman. That's correct. You would -- There would be some liability in that we divide the category $40,000 to $50,000.

Senator Bradley. Right.

Mr. Pearlman. But you would essentially take everyone out below that number. Or to put it a different way, you would take about 84 percent of the enrolles out of the supplemental premium.

Senator Bradley. Eight-four (84%) percent?

Mr. Pearlman. Yes.

Senator Bradley. Well, I think that is a very important number for us to focus on. Because we know that the public attention has been focused on the cap, which is $800. The cry is: "Reduce the cap." Well, if you reduce the cap; you help about, what, 10 percent or 12 percent of the population of seniors. If you raise the threshold, you are taking over 82 percent out of the cap out of the supplemental.

So I think that the information you provide is extremely important for us. Because all the public focus has been on, ''How do we take care of the $800 person?'' When I think the focus should also be, ''How might we alternatively provide relief for the middle income senior citizens?'' That would be defined in this case as those people who are earning under $47,000 a year.

Mr. Pearlman. Let me just make one little footnote.

The Chairman. If I may interrupt a minute here.

Mr. Pearlman. Certainly.

The Chairman. When you talk about the option of 15 percent flat, rather than raising it up to 25 percent or something like

that, you very much help middle income in that one. It retains the progressivity of the situation.

Mr. Pearlman. That is correct. You can certainly give benefit and, in fact, the 15 percent rate -- either the 10 or 15 percent rate does that at the middle income level, clearly.

Let me mention one other thing because I think it is very important and it is something that I neglected. That is, if you deal with the threshold, if you choose to deal with the threshold, you really have to be careful of the cliff. We all know what happens in social security with cliffs. That in itself could be a very -- That is something that you have to be very careful about. It really means you probably cannot just pick a number. You are going to have to have a phase out or otherwise someone on one dollar of either side of that threshold you are going to have some unhappy people out there.

That is going to be something that the Committee would have to pay some attention to.

Senator Bradley. In some of the Tables that you have developed here though, Ron, for the cap and the rate and the threshold, if you compare the rate -- a 50 percent rate cut -- with raising the threshold for the supplemental premium to $3,000, which is about $47,000, there is still a significantly larger benefit for middle income taxpayers by raising the threshold.

According to your estimates, for example, a rate cut would

provide about $500 million in cut for people between $20,000-$30,000 in income; whereas, raising the threshold would be $940 million. Almost double for the middle income taxpayer. Then you compare that to the cap for the same thing and you provide $130 million. I mean the difference between the cap cut for $20,000-30,000 is a difference between $940 million in relief and $130 million.

Mr. Pearlman. Yes, I would like to -- I am not going to comment. I am not going to disagree or ratify what you just said. I would suggest this to the Committee. That if we want to make these distributional analyses -- because I am nervous that we might be comparing apples and something other than apples -- that we select, you tell us sort of a target, you know, one or all three of these options and let us run the threshold distribution so that we have exactly the same thing in front of you because I want to make sure we do not mislead you.

Senator Mitchell. Mr. Chairman, may I ask a question?

The Chairman. Yes, of course.

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The Chairman. Yes, of course, Senator Mitchell.

Senator Mitchell. Just for purposes of information, Mr. Pearlman, so that I understand it. Senator Bradley used the figure estimating 9, 10 or 12 percent for the respect to the cap. But in the Tables distributed by the Committee, Appendix

A, Table 1 on the distribution by level of supplemental premium, if I read it correctly, 5.6 percent of the Medicare enrolles will pay at the cap. Is that correct?

Mr. Pearlman. That is correct. That is current law.

Senator Mitchell. Current law.

Mr. Pearlman. At 1989 levels.

Senator Mitchell. Right.

Mr. Pearlman. That is correct.

Senator Mitchell. So that a reduction of the cap would immediately affect only 5.6 percent of the enrolles. And then depending to what level the cap is reduced, looking at this Table, one would add in ascending order the percentages in the column entitled ''Percent Distribution.'' Is that correct?

Mr. Pearlman. Yes. I would qualify that a bit, Senator. That is, if you reduce the cap to $585 then you benefit people -- looking at that same Table -- you will benefit people in the those lower categories as well. So the percentage is slightly above.

Senator Mitchell. Which adds up to about 7.8 percent?

Mr. Pearlman. Yes. I mean, it is not dramatically different but it is somewhat different.

Senator Mitchell. Yes. So those are the numbers involved. If you took it down to $700, for example, you would benefit 6.4 percent of the elderly.

Mr. Pearlman. That is right. I should note -- I mean it is

sort of back to the point the Chairman made as long as you are focusing on that Table -- that you do get benefit -- obviously, not as much as eliminating the supplemental premium totally; but you get fairly significant benefit at the middle income levels through a combination of the cap and the rate reduction. It is really the rate reduction that produces it.

The Chairman. The rate reduction does it. Yes.

Senator Mitchell. Yes. I think the Chairman is correct. That is the real issue that has caught people's attention. I think what has not been made clear is that, according to these figures at least, fewer than 6 percent of the elderly will pay the maximum premium -- that is, of the beneficiaries under it. Whereas, at the other end of the scale 58.8 percent will not be subject to the supplemental premium at all. Is that correct, Mr. Pearlman?

Mr. Pearlman. That is correct.

Senator Mitchell. Thank you, Mr. Chairman.

The Chairman. That is a very valid point. The problem is the perception and trying to hit that perception and how they have been able to convince so many people they are paying $800. That is what we are up against when we understand that is not the reality. Then you have the other problem. Even though we feel that with all the benefits in this, this is the best possible deal and it still has substantial subsidy in it for those people.

Now you turn around and you look at the Consumer's Union as to what their best buy is on a medigap policy and that number is $635. Now we all know it does not have as many benefits as this. But you have people out there that have bought it. They want to feel that they are not paying something extra to the Government in the way of buying their medigap policy. I see that their high cost medigap policy, according to Consumer's Union, costs $987. But it is that kind of a perception that is the frustration in what we have done in trying to get the message across and we obviously have not been able to get that message across.

Now, Senator Heinz.

Senator Heinz. Mr. Chairman, excuse me. I thought you were just making a brief comment. I apologize.

I would like to ask Joint Tax this. When we developed the financing -- and some of it was done in Conference Committee on which some of us did not serve -- but the general convention wisdom that came out of both this Committee and to the best of my recollection, the Conference, was that the people who are paying the surtax who are in the upper 40 percent -- excuse me, who are the 40 percent of higher income beneficiaries, as I understand about where the supplemental premium currently goes in -- that that 40 percent of Medicare beneficiaries were going to pay approximately 60 percent of the cost of the program totally.

That at the time seemed reasonable. But I would like to ask if that is true today as we look at the five-year totals that you provided.

Mr. Pearlman. We do not know the answer to that question. We can obviously provide it, Senator.

(The answer appears in the appendix.)

Senator Heinz. Let me give you my quick and my dirt back of the match book analysis. Assuming that 40 percent of the -- this is taking your five-year totals which add up to $40.3 billion in total revenues, $28.1 billion for the supplemental, $12.2 billion for the flat premium -- Those are the base numbers I am working with. Assuming that my right number is 40 percent, obviously all $28.1 billion comes from the 48 percent and then 40 percent of the flat premium because everybody pays it comes from the $12.2 billion. That is about $4.9 billion. If you add those numbers up you get $33 billion. As a percent of $40.3 billion that is, as I figure it, 82 percent of the total program cost is being borne by 40 percent of the beneficiary population.

What I think we are all hearing when we go back to our States and Districts is that that is ridiculous. There is no basis for 40 percent of the people paying 82 percent of the cost of the program. I do not detect that a resistance to some progressivity in the financing of this program. I have had many conversations, many town meetings, many specialized meetings with seniors throughout my State. But I do think the 82

percent, if that number is accurate, explains how far we erred someway along the line.

I know people are looking for an explanation as to how we got this so messed up. To the best of my knowledge, that is how we did it. We did not check and recheck our numbers. We allowed ourselves to be misled by the conventional wisdom of the time, which is that 40 percent of the people are going to pay 60 percent of the cost.

Now my question to you is, please find out if that is so -- more or less in the ball park.

Do you have any numbers referring to Table 1 on page 9?

Dr. Weiss. Senator Heinz.

Senator Heinz. Yes.

Dr. Weiss. We have done a quick calculation here and these are July numbers which may change a little bit. But over five years, based on CBO numbers, it appears that approximately 68 percent of the revenues for the program are generated by the supplemental.

Senator Heinz. Right. That's pretty close.

Dr. Weiss. The amount of money involved is $28.5 billion in the supplemental; $13.4 in the flat.

Senator Heinz. Okay. That is a little different -- $28.5 billion.

Dr. Weiss. .5 and $13.4 billion from the flat.

Senator Heinz. $13.4 billion. And your total revenues is

up a little bit to $41.9 billion.

Dr. Weiss. That is correct.

Senator Heinz. It is pretty close then. Because when you factor in the 40 percent of the $13.4 billion, which is the flat premium and you add that in, you are up pretty close to 80 or 82 percent.

Mr. Pearlman. I think she said that 64 -- whatever it was --

Senator Heinz. She said that the supplemental premium.

Mr. Pearlman. Right.

Senator Heinz. Which is not all that that set of beneficiaries pays.

Mr. Pearlman. Correct.

Dr. Weiss. That is correct.

Senator Heinz. Amounts to 68 percent. Roughly 68 percent.

Dr. Weiss. That is correct.

Senator Heinz. And in any event, neither number is close to 60 percent, which is my point. I think that proves the point.

Now to move on from that. Ron, do we have any numbers that show -- would add another column to Table 1, page 9, as to how much revenue we are generating from each of these groups of Medicare beneficiaries that are defined by amount of their taxes that they -- Well, for instance Senator Bradley was saying, or Senator Mitchell was saying, that 5.6 percent of the people are at the cap. How much money does that amount to? What percent

of the money raised from the supplemental premium, how many dollars, some measure of that? Do we have those numbers?

Mr. Pearlman. We have those numbers but again I do not have them at my fingertips.

Senator Heinz. All right.

Mr. Pearlman. We can provide those numbers to you.

Senator Heinz. That would be very helpful.

(The numbers appear in the appendix.)

Senator Heinz. Mr. Chairman, thank you.

Mr. Chairman, I'm sorry. I just want to make one other comment in the form of a question. Obviously we have three tasks that we have to complete before us, if we are able to save the catastrophic program. The first is to figure out a fairer financing system. The second is to do something about some of the runaway costs, both in the skilled nursing home benefit, which I do not think we can ignore. For the longer we wait to attack it, the bigger problem we are going to have.

And by the way, I would just observe on the hugely escalating skilled nursing home cost benefits, as far as I can tell, there is not one additional person in Pennsylvania who is getting nursing home care because of that skilled nursing home benefit. We have the same number of beds. They are all full. As far as I can tell, the only difference is that someone is being reimbursed at a different rate. I pass that along for what it is worth, which is probably a great deal of money to

some providers, but little, as far as I can tell, to my beneficiaries -- my Medicare beneficiaries and recipients. We have to deal with that. There may be some other cost problems we have to deal with.

Thirdly, and I think this is critical, we have to deal with this -- and it has been mentioned -- the duplication of benefits problem really effectively. If we do not do that just as well as we want to handle the issue of the supplemental premium or costs, count me out. Because it is fundamentally wrong when you tell someone, you know, you are going to pay for something you already have. We have got to address that problem.

We have to address all three of those problems. Otherwise, we are going to be back here wondering what hit us all over again at our very next post-reconciliation meeting.

Thank you, Mr. Chairman.

The Chairman. Thank you.

Senator Rockefeller.

Senator Rockefeller. Mr. Chairman, a point of clarification from Mr. Pearlman. These figures are very rough and therefore I am not sure, but I just am looking for clarification from you.

If one is to roughly calculate the actuarial value of the catastrophic program, one might conclude that it is about $300. For all of those whose supplemental premium is up to $300 -- up to $299, let's say -- if my assumption were correct and understanding that there is a caveat in my assumption that, of

course, many of those people will not be receiving those benefits, so that the actuarial value is more of a theoretical discussion -- nevertheless, if I am correct in that, then I would have to assume that 27 percent of seniors under the catastrophic program are being subsidized in fact because they will be receiving, should they need it, more benefits than in fact they would be paying for; and that that is 27 percent of seniors and it represents 64 percent of all supplemental payers under this program; and in fact 29 percent of all the revenue.

I am not sure of my figures. But I would seek confirmation from you, right or wrong, whether those are true. Because it is interesting if, in fact, up to $299 there is subsidy involved; and then if one turns to Table 5 of the Committee's submission I cannot find on an annual basis $300, but what you are suggesting then is somewhere between the $40,000-45,000 or the $45,000-50,000 level of joint return is being subsidized.

I do not need an answer on that now unless you can give me one.

Mr. Pearlman. No, I cannot. But we will try to give you one.

Senator Rockefeller. Thank you.

The Chairman. Senator Daschle.

Senator Daschle. Mr. Chairman, I just want to make sure I understand Table 1 correctly. It leads to a question. But assuming that Table 1 indicates that approximately half of the

40 percent fall into a category of those who pay less than $199 a year in supplemental premium. I read that correctly?

Mr. Pearlman. You read it correctly.

Senator Daschle. So we are talking about -- As I understand it, we are talking about 60 percent of the people who pay either the flat premium or something less per year than $200.

Mr. Pearlman. That is true.

Senator Daschle. I have not seen -- I really have to admit this. I should have asked for it sooner. I would be interested if the Committee Staff has any available information about the comparability of coverage in the private sector. I would like to know whether that is a good deal, whether they are getting taken, as some of my letters would indicate. But if I could compare that 60 percent to something in the private sector, which is what we are talking about. We have heard people advocate repeal this morning. I would like to see what we are presenting as an alternative.

If the Staff could give that -- I would assume you would not have it available at this moment. But if you would have it available for distribution at our next meeting, I would be very interested in seeing that. I am sure the Committee members would be interested in seeing that.

(The information appears in the appendix.)

The Chairman. If I might comment not specifically on that, but we had cited to us the Consumer's Union Best Buy Medigap

Policy for 1989, costing $635. And that their high cost medigap policy was $987; and that more relates to what you are looking at at the top end of the spectrum, of course, rather than what you are referring to.

But I am also told that that one -- the one that is their so-called best buy -- that that one has extremely tough underwriting with an estimate of some 40 percent of the people rejected. So you just really are not comparing apples to apples. It is a very difficult thing to do.

Senator Daschle. Well there has to be a comparable private sector plan that would give us a rough estimate. If medigap's best buy is what we are talking about here and it provides similar coverage -- I think we do have to be concerned about apples and apples here. But I do think we also know what it is we are -- I mean, before I'm ready to vote for --

The Chairman. Well, I agree with you. I agree with you. There is no question of what we are talking about is much more coverage and obviously not highly selective underwriting. We are talking about for everyone.

Senator Daschle. I mean, I think if anyone votes for repeal we are voting -- we've really got to be sure we understand what we are voting for. We are voting for something that is going to be extraordinarily more expensive if my judgment is correct. That is why I say, I think the Chairman's examples were helpful, but I think something on paper, a tangible demonstration of

comparability could be helpful to us as we consider some of this later on.

The Chairman. The Senator makes a very valid point and one that has been a very difficult one for us to get over to the American people.

Had you finished, Mr. Pearlman?

Mr. Pearlman. I have, sir.

The Chairman. All right. Then I would like to ask Dr. Weiss to proceed.

Senator Chafee. Mr. Chairman.

The Chairman. Yes.

Senator Chafee. I just want to say that because I am involved with the Nixon impeachment trial --

The Chairman. Would you like to make a comment?

Senator Chafee. Just briefly, if I might.

I regret that I am unable to be here in these very, very important hearings. I will try and follow them as best I can. But I wanted to explain the reason I will be absent so much.

Thank you, Mr. Chairman.

The Chairman. Thank you.

Dr. Weiss, are you prepared to make some comments at this time?

Dr. Weiss. Yes.

STATEMENT OF DR. MARINA WEISS, CHIEF, HEALTH COUNSEL, MAJORITY

Dr. Weiss. Mr. Chairman, you have in front of you, I believe, a document entitled, "Staff Options to Reform Medicare Catastrophic Benefits." If you will turn to pages 5 and 6 of that document, I think it will be easier for you to follow these options as I describe them.

The Chairman. I take it the pages are not numbered and we are going to have to count; is that the idea?

Dr. Weiss. The last two pages of that set of documents.

The Chairman. The one I have has five pages. It says, "Staff Options to Reform Medicare Catastrophic Benefits." Is that the one you are talking about?

Dr. Weiss. Yes, sir. If you will look at the last two pages, the document that begins on the penultimate page and goes over to the last page.

The Chairman. I think we have a problem on the pages here. What I have only has five pages.

Dr. Weiss. All right. We're sorry. Ours was put together in a different order. Then the third from the last page is where you want to begin, with Option 1.

Option 1 would increase the out-of-pocket catastrophic cap from $1370, which currently is set with the expectation that 7 percent of beneficiaries would exceed that cap or their expenses would exceed that cap. The $1370 would be moved up to $1600 in

1990. That would, therefore, benefit approximately 5.5 percent of enrolles.

The drug deductible would be increased to assure that only 16.8 percent of beneficiaries who would qualify would trip the deductible. That is consistent with what the Congress thought had been enacted early on. It turns out that with the new information that has been made available to the Department and to CBO, an approximate number of 26 or 27 percent of beneficiaries are expected to exceed that $600 cap. So that would essentially return you, that 16.8 percent, to original Congressional intent.

This Option assumes what we are terming a Part B opt out. You have heard this described on the House side as a voluntary option. But in an effort to ensure that it is absolutely clear that opting out would be tied to participation in Part B, and therefore leaving the program, choosing not to be covered with catastrophic coverage, would mean giving up Part B coverage as well. We have termed it a Part B opt out.

The Chairman. At the present time you have approximately how many that do not take -- before it became mandatory -- that did not take Part B? Approximately a million is it?

Dr. Weiss. About 990,000. Yes, sir.

Option 2 would again increase that out-of-pocket catastrophic cap that pertains to physician costs or physician expenses, as in Option 1. However, there would be a delay in

the drug benefit.

The drug benefit would begin for the intravenous drugs and the immunosupressives as scheduled in 1990 -- January 1, 1990 -- but the balance of the prescription drug coverage would be delayed by one year, from January 1, 1991 to January 1, 1992. Moreover, implementation of the utilization review portion of the drug benefit -- that is the portion that deals with identifying interactions of drugs and so forth; it is a rather sophisticated and fairly complex software package -- would be delayed yet another year.

So there would be essentially a three-stage process -- the immunosuppressives and the I.V. drugs would come into effect as scheduled -- January 1, 1990. Instead of January 1, 1991 for the beginning of the balance of prescription drugs, that would be delayed one year to January 1, 1992. The cross-match or cross-check component of what is done at the pharmacy would be delayed one more year to enable the pharmacies to have adequate start up time to get the prescription drug benefit on line.

Thirdly, there would be an increase in the drug deductible to assure that 16.8 percent qualify as under Option 1, and again a Part B opt out.

Option 3 would increase the cap, again delay the drugs. But would increase the drug deductible so that 10 percent of beneficiaries would qualify for coverage. It would approximately double the amount of the deductible from $600

projected or set in law at this time to about $1220 and again the Part B opt out.

Senator Heinz. Marina.

Dr. Weiss. Yes, Senator.

Senator Heinz. A question. When you delay the drug benefit a year, do you also delay the revenue collection for the drug benefit or not?

Dr. Weiss. Senator Heinz, because there are two different organizations involved in doing the estimates here, we asked CBO simply to focus on the spending estimates, not the revenue estimates. I would have to defer on that to my colleagues on the tax team.

Senator Heinz. What would it cost if you delayed the collections attributable to the drug benefit?

The Chairman. Let me try to get you that answer. Mr. Oglesby, do you have any comment on that?

Mr. Oglesby. I believe that that would be just separated stated, Senator. That this is just the spending side -- segment.

Senator Heinz. I understand. Can we get that information, though?

Mr. Pearlman. Yes. I think we back into these premiums. I mean, CBO gives us a number and then -- I mean that is the way the premium structure was put together. CBO gave us a number and said, this is what the cost is, now you come up with a

premium that meets the target. CBO gives us a number on the drug premium and you want us, you know, to tell you what that revenue is, we can try to do that.

Clearly the revenue was not put together from our standpoint on that basis.

(The information appears in the appendix.)

Senator Heinz. In order to be symmetrical, if you are going to delay a benefit for one reason or another, you ought to delay the payment for it a year. So we ought to develop that number.

Mr. Pearlman. I think we could do that.

Senator Heinz. All right. Thank you.

Dr. Weiss. All right.

Option 4, there would no change from current law in the out-of-pocket cap on physician costs. That is to say the cap would remain at $1370, effective January 1, 1990.

The drug benefit would be repealed, except that the immunosuppressives and intravenous drugs, sometimes known as the Mitchell drugs, would be retained and would go into effect as scheduled January 1, 1990.

And, of course, there would be a Part B opt out.

Option 5 would eliminate altogether the out-of-pocket cap on physician services, the cost of physician services. It would delay the drugs as in Option 3 by one year, and would increase the drug deductible again to assure that 16.8 percent of beneficiaries qualify, and a Part B opt out.

Option 6 would increase the out-of-pocket catastrophic cap to $1700, thereby reducing the number of beneficiaries expected to exceed that cap from 7 to 5 percent.

Again the larger drug benefit would be repealed. The Mitchell drugs -- the immunosuppressives and the I.V. therapy drugs -- would be retained. There would be created a Commission to study the best way in which to put into effect a drug benefit. That is to say, the Commission would look at the appropriate drugs that should be covered and the most appropriate methods for financing such a benefit.

Option 7, for which we do not yet have a full set of estimates, would increase the out-of-pocket cap again to $1700 and would modify eligibility for the drug benefit so that only those individuals who exceeded either the catastrophic cap -- that is to say the out-of-pocket costs on physician services cap -- would qualify for coverage.

You have a separate -- If you will take a look at your Table then, you can see year by year what you would save under each of these Options and then there is a total in the right-hand column.

Let me just draw your attention to the fact that in the early years the less expensive benefits are in effect. That is to say -- going back to Senator Packwood's comment about front loading this set of provisions -- money is collected at the beginning, very little of that money or a relatively small

amount of that money was expected to be spent at the beginning as a way of building reserves sufficient to pay for the more costly benefits that were due to take effect or are due to take effect in later years.

So cutting back the benefits does not generate a great deal of savings in the early years. Certainly not savings sufficient to reduce the supplemental premium to the extent that has been discussed earlier today.

The Chairman. Are there questions?

Senator Pryor. Mr. Chairman, if I could.

The Chairman. Yes, of course.

Senator Pryor. Dr. Weiss, on the Option 3 -- now if you would go back one more time with me and you say drugs at 10 percent delayed.

Dr. Weiss. Yes, sir.

Senator Pryor. Now that would have been moved from 16.8 to 10 percent. Now you accomplished this, I assume, by increasing the deductible and the deductible now would be $600. What would you move that to to get to the 10 percent?

Dr. Weiss. $1220.

Senator Pryor. How many -- Do you have a Table there on how many people this would affect? Because 17 percent, as I understand, of the Medicare population would fall into the category here of being protected say at $600 deductibles.

Dr. Weiss. Under current law, Senator Pryor, it turns out

that is what you thought you had enacted.

Senator Pryor. Right.

Dr. Weiss. It turns out that drug costs are higher than what was originally anticipated and utilization is greater than what was anticipated. Therefore, leaving the $600 deductible intact actually qualifies about 26 to 27 percent of beneficiaries, not what you intended, 16.8.

Senator Pryor. When this study came out -- I believe it was early in the summer or mid summer -- saying that the drug program was going to be much higher than originally thought, what was the reason that they were going to be higher? Was that more utilization by the consumer or was that the higher drug prices charged by the pharmaceutical manufacturers?

Dr. Weiss. We have both the Department here and CBO here who are prepared to comment I believe on their estimates relating to the drug benefit, if you like. It is my understanding that it is a combination of the two and that the data is simply better now. And that both CBO and the Department believe that approximately 26 to 27 percent of beneficiaries will in fact exceed that $600 deductible.

But I invite them to comment.

Mr. Olson. That is correct, Senator. We would agree with what Marina said, Senator, that we simply had better numbers this summer than we had in the past. But we would concur that it was the 26 or 27 percent.

Senator Pryor. If I might ask, what do you anticipate prescription drug prices to rise, what percentage increase per year, factored into the ultimate result of the study?

Mr. Olson. Senator, we do not have that with us. But we certainly can give you a number on what we estimate at some point.

(The information appears in the appendix.)

Senator Pryor. Well, since 1981 they have risen about 88 percent, while the general inflation rate has been about 28 percent. Do you anticipate a continuation of this spiralling increase?

Mr. Olson. Senator, I guess what I would like to do is to come back to you this afternoon with our best estimate on that.

Senator Pryor. Thank you, sir.

Senator Daschle. Mr. Chairman.

The Chairman. Yes, Senator Daschle. Oh, were you not through. I am sorry.

Senator Pryor. This gentlemen is he there now to -- Tom, if I could just ask him this final question and let him comment on it.

Senator Daschle. All right. Go ahead.

Mr. Seagrave. My name is Charles Seagrave. I am the head of the Human Resources Cost Estimates Unit at the Congressional Budget Office. You had asked, I believe, two questions. One, what caused us to change our numbers.

As you all realized at the time you passed the Catastrophic Act, we got a new data source last spring, the National Medical Expenditure Survey, which had extensive information on drug expenditures in 1987, that survey indicated that expenditures on prescription drugs by Medicare recipients were higher than we had anticipated in our previous estimate.

This caused us to change both, because the legal was higher and because the rate of growth over the period from 1980 through 1987 had been higher than we previously thought.

Senator Pryor. The rate of growth? Do you mean the rate of price increases?

Mr. Seagrave. Both price and utilization numbers were higher than we had anticipated.

Senator Pryor. And you anticipate those price increases to continue in the out years?

Mr. Seagrave. We do anticipate that prescription drug prices will rise more rapidly than the CPI; yes, sir.

Senator Pryor. Mr. Chairman, I am not going to say anymore right now.

The Chairman. All right, sir. Senator Daschle.

Senator Daschle. Mr. Seagrave, before you leave, Senator Pryor's questions triggered something that I was going to ask earlier. It may have been asked and I just was not paying close enough attention. But, obviously there have been a number of reports about the fact that this whole program may cost

substantially more than was originally estimated. We have talked a lot today about how we reduce caps and restructure premiums.

If we did nothing at all, would we have the necessary resources upon which to pay benefits beginning next year, given your new estimate of cost?

Mr. Seagrave. Across the entire program, yes, you would. The prescription drug trust fund as a separate entity would face financial problems fairly early in the game.

Senator Daschle. So these reports of unexpectedly inflated costs of the program deal almost entirely with the drug part of the benefit?

Mr. Seagrave. Yes, sir.

Senator Packwood. Tom, I did not understand your question. Did you mean, would we have enough to pay next year or do you mean during the expected life of the program?

Senator Daschle. No, I am talking about the next couple of years. Do we have adequate resources to cover the benefits that will be provided? And the answer, as I understand it, is yes, we will.

Mr. Seagrave. Yes.

Senator Packwood. Part of that is because of the front loading, though, is it not?

Mr. Seagrave. Yes, it is.

The Chairman. Are there further questions?

Senator Matsunaga. Yes, Mr. Chairman.

The Chairman. Yes, Senator Matsunaga.

Senator Matsunaga. Dr. Weiss, you have laid out seven options here. Now you heard the Administration testify this morning they want no changes at all. How did you arrive at these seven options? Were they suggestions of members of the Committee?

Dr. Weiss. A combination of sources, Senator Matsunaga. Some came from individual members of the Committee, some were generated by Staff, some were combinations that suggested themselves as we worked with these numbers.

Senator Matsunaga. But it seems to me that we are going contrary to the Administration by offering these options, are we not?

The Chairman. Let me say to that, Senator, that the Administration has not offered us any options. They have stated they are opposed to repeal.

Senator Matsunaga. Or changes.

The Chairman. And the President had previously written that he was opposed to changes. Now we heard further statements that obviously there are going to be changes. But we are not seeing proposals from the Administration. You are quite right.

I would also say, Senator, there is no -- as I stated in the very beginning -- these are Staff options, but we are not limited to these. We are not limited to these.

Dr. Weiss. Senator Bentsen, I would like to correct something I said to Senator Pryor earlier. That is, on Option 3, with a one-year delay in addition to an increase in the threshold or the deductible for drugs, that one-year delay actually increases the deductible beyond $1200. It would be $1357 in that year.

Senator Pryor. Thank you very much, Dr. Weiss.

The Chairman. Let me say, if there are no further questions, I would ask the Committee members, those who can, to meet with me informally in S-211 tomorrow at 10:00 a.m.

We will stand adjourned. Thank you.

(Whereupon, the hearing was adjourned at 12:00 p.m.)

C E R T I F I C A T E

This is to certify that the foregoing proceedings of a Executive Committee Meeting of the United States Senate Finance Committee, held on September 7, 1989, were transcribed as herein appears and that this is the original transcript thereof.

William J. Moffitt

WILLIAM J. MOFFITT
Official Court Reporter

My Commission Expires April 14, 1994.

STATEMENT BY SENATOR DAVID L. BOREN
SEPTEMBER 7, 1989
SENATE FINANCE COMMITTEE
MEDICARE CATASTROPHIC COVERAGE ACT

Mr. Chairman,

I am very appreciative to you for scheduling this mark up the very first week that Congress has returned from the August recess. This is an issue that I have prioritized this year, and one that has mobilized more of my constituents than any other issue.

I have heard from the people of Oklahoma on this issue. They feel that they have been unfairly discriminated against by an expensive program that they have no choice but to take. I am very pleased that one of the options we will consider today, one that the House has adopted, is to make this a voluntary program that will enable those who do not have other coverage and who need these benefits to enroll.

It is important to ensure the quality and affordability of this program because it is very much needed by thousands of Oklahomans who could otherwise be financially devastated by the cost of a major illness. We still need to address the problem of long-term care, but this measure is certainly a beginning in helping our elderly pay for catastrophic health care costs.

However, while we need a way to protect against the devastation caused by catastrophic illness, it is also clear there are problems with the way this current program is being financed. I have supported efforts in Congress this year to find ways to lessen the burden of financing the program. Before the most recent Congressional Budget Office estimates were released showing that the costs of certain provisions may far exceed what was originally estimated, I was hopeful that the surtax and the cost of the premium could be reduced. That is one of the most frustrating points -- that we just cannot get stable, accurate estimates for the drug reimbursment benefit, the skilled nursing facility benefit, and others. Initially, a CBO report indicated that the new law could produce almost $5 billion more in revenue than necessary to pay for the new benefits over the next five years. Now, it appears that we could be losing that much on the current program.

We must use every opportunity to try to reduce the burdens placed on the elderly. Senior citizens have come to rely greatly on both Medicare and Medicaid, and because they often live on small, fixed incomes, they are especially susceptible to inflationary and economic pressures. We must ensure that our system of health care

insurance to the elderly sufficiently meets their growing needs.

Again, Mr. Chairman, thank you for all of your work on this issue. I appreciate your efforts in developing the legislation and in educating the public of its benefits. I am hopeful that the financing can be brought in line with the benefits and we can revamp this legislation into one that will work and that our senior citizens truly want.