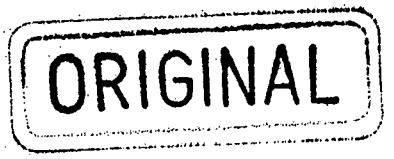
EXECUTIVE COMMITTEE MEETING

TUESDAY, JUNE 17, 1997

U.S. Senate,

Committee on Finance,

Washington, DC.



The meeting was convened, pursuant to notice, at 10:12 a.m., in room SH-216, Hart Senate Office Building, Hon. William V. Roth, Jr. (Chairman of the Committee) presiding.

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Also present: Senators Chafee, Grassley, Hatch, D'Amato, Murkowski, Nickles, Gramm, Lott, Jeffords, Mack, Moynihan, Baucus, Rockefeller, Breaux, Conrad, Graham, Moseley-Braun, Bryan and Kerrey.

Also present: Lindy L. Paull, Staff Director and Chief Counsel; Mark A. Patterson, Minority Staff Director and Chief Counsel.

Also present: Dr. Bruce Vladeck, Administrator, HCFA; Karl Scholz, Deputy Assistant Secretary (Tax Analysis), Department of Treasury; Brigitta Gulya, Tax Counsel.

Also present: Julie James, Chief Health Analyst; Dr. Alexander Vachon, Health and Social Security Analyst; Gioia Bonmartini, Dede Spitznagel, and Dennis Smith, Health Care Analysts.

OPENING STATEMENT OF THE HON. WILLIAM V. ROTH, JR., A U.S. SENATOR FROM DELAWARE, CHAIRMAN, COMMITTEE ON FINANCE

The Chairman. The committee will please be in order.

It is my intent to have Senator Moynihan and myself make opening statements. We will then call on other members of the Finance Committee panel to make their opening statement. We are asking each member to keep their comments to three minutes.

Let me start out by saying that I believe today is an historic session of the Senate Finance Committee, a mark-up to balance the budget within the next 5 years. This spending package represents a compromise, a compromise between the Congress and the White House, a compromise between Republicans and Democrats.

Pat, I doubt that anyone is entirely satisfied with it, as it is a compromise between differing political philosophies, between deeply-held views.

So, while it is not the spending package that any of us would have drafted if it were in our sole purview, it does represent, in my judgment, a major step forward. A step forward through balancing the budget can help ensure continued growth, jobs and opportunity.

In developing the Chairman's mark I have been led by two primary goals. First, to implement the budget agreement in such a manner that we not only balance the budget, but that we do so in a manner that preserves and strengthens the programs impacted.

It is not enough simply to reduce the cost of such crucial programs as Medicare and Medicaid, we must do it in a way that provides better services to beneficiaries of these important programs.

The second goal, has been to implement the budget agreement in a manner that will assure bipartisan support for the program. I believe the Chairman's mark does exactly that.

From the beginning, I have solicited the views and ideas of all members of the Finance Committee. The members, Republicans and Democrats, were asked to submit in writing their recommendations as to how the Budget Agreement should be implemented. These ideas were incorporated in our discussion draft.

Informal meetings have been held since the to seek the further advice and recommendation of members, which, in turn, have been incorporated in the final Chairman's draft.

I believe this draft has substantial support on both sides of the political aisle. So now we face the final

mark-up. I remind the committee of our responsibility. Overall during the next 5 years, we must reduce deficit spending by $100 billion, including Medicare reductions of $115 billion and net Medicaid reductions by $13.6 billion.

At the same time, we are directed to increase spending for children's health care by $16 billion, SSI support for disabled immigrants by $9.7 billion, increase spending on Welfare to Work by $3 billion.

We are further instructed to extend the solvency of the Part A trust fund for Medicare for at least 10 years, while introducing structural reforms to give beneficiaries more choice among competing health plans.

Our goal is to give the Medicare beneficiaries the same choices that Federal employees have within our Federal health program, including the traditional fee-for-service.

The Chairman's mark meets these goals and, therefore, in introducing amendments it is essential that these goals continue to be met. Amendments would be limited to those that are relevant to the Chairman's mark and the outlay reduction instructions contained in H.Con.Res.84.

Now, since the mark-up is the bipartisan product of the committee, I would hope the amendments offered would be kept to a very, very tight minimum. I realize that

over 270 amendments have been introduced, but I seriously urge members on both sides of the aisles not to offer them unless it is absolutely essential to the member.

We are working under a very tight schedule, a schedule that requires the mark-up of both spending and tax reforms to be completed this week so that floor action can take place next week. The Chairman will greatly appreciate full cooperation so that we can meet the leadership's schedule.

Pat Moynihan?

OPENING STATEMENT OF THE HON. DANIEL PATRICK MOYNIHAN, A U.S. SENATOR FROM NEW YORK

Senator Moynihan. Mr. Chairman, I would like to pledge to you, and I can speak for our side completely, that you will have that cooperation. You have earned it, sir.

I am now in my third decade on the Finance Committee and I can attest that there is no more grueling and demanding a task than that which you have just performed, to bring together a committee as diverse as ours with the unprecedented range or responsibilities and authority to produce this bipartisan proposal, a measure we have almost lost the memory of such events. You have revived it, and honorably and well.

I would like, particularly, to point, as you did, to the provisions in Medicare that will bring this 1960s program into the present age of medical insurance and medical provision of health maintenance organizations and giving choice in a very open, and I think will be productive, way.

I would like to thank you particularly for the provisions you have made for teaching hospitals which necessarily are at a disadvantage in a more competitive insurance market, and that is just a side effect of what

is otherwise a major advance in the rationalization of this sector.

I would hope that the Medicare Commission that you have very wisely included here will address this general question of medical education, as I think it can do.

The provisions for 500,000 disabled legal immigrants are surely in order and surely have the support of the entire committee.

I would just, last, say that it was a significant disappointment that the negotiations that led to the Budget Agreement could not reach accord on providing a more accurate cost of living index by which we index our various benefit programs and our revenue programs, our tax programs.

The initiative for this long-understood matter came from our committee, the Advisory Commission to Study the Consumer Price Index. We had a unanimous report from our commission and extraordinary support across the government.

Alan Greenspan, the eminent chairman of the Federal Reserve Board, said, when people complained that we were making a political interference here, "Given the state of knowledge, not to do anything is the political interference." But that is what happened. Until we do get to there, we will continuously be restrained in what

we can do and our choices will always be restricted beyond what we would hope.

I think, however, sir, that we have a sense of the Senate language on this matter. We did note that in the House of Representatives that certain prices were indexed.

On this occasion, the price deflator of the Bureau of Economic Analysis at the Department of Commerce was used, indicating what we all know, there are a half-dozen price indexes around the Federal Government and none is sacrosanct, all can be reviewed and proved, and I hope we will do this, in time, sir.

Again, thank you for the manner in which you have gone forth and the fact that you are still in good spirits. I hope this will be so on Thursday evening.

The Chairman. Thank you very much, Senator Moynihan, for those gracious remarks. I will say that I intend to work as long as necessary today, tonight, tomorrow, tomorrow night, and the weekend, if necessary, to get the job done.

We have been given a schedule. It is important that we be in a position to move to floor action next week on both the spending and tax side, and that is exactly what the Chairman intends to do.

Senator Chafee?

Senator Chafee. I have no statement, Mr. Chairman. I am just concerned about some of the standards that we do not seem to have in here for some of the Medicare beneficiaries. But that is a subject I will bring up later.

Thank you, Mr. Chairman.

The Chairman. Senator Baucus.

OPENING STATEMENT OF THE HON. MAX BAUCUS, A U.S. SENATOR FROM MONTANA

Senator Baucus. Thank you, Mr. Chairman.

Just a few words. First, to compliment you on the way you have approached this mark. I have served under six different Finance Committee Chairmen. Some are very partisan, some are very bipartisan; some are very good and easy to work with, some a little less so.

I want to compliment you very, very much, Mr. Chairman. You are certainly in the first category of Chairmen who is working hard at trying to bring us together, knowing that that will enhance the prospect of better legislation that we are all working together on. I very, very deeply thank you for that approach.

To that end, Mr. Chairman, there are several provisions you have in your mark which go a long way toward addressing some of my specific concerns, especially with respect to rural health facilities.

My State is not very highly populated, as you well know. We have a lot of seniors and a lot of low-income folks. You have made many provisions in the mark here which, while we are cutting Medicare and Medicaid, address the problems of rural States and low-income States, and I very much appreciate that.

I might say also, Mr. Chairman, that you appointed me and gave me the honor of serving on this Ad Hoc Committee on Children's Insurance, along with Senators Chafee, Gramm and Breaux. We were, as you know, unable to come up with a definitive proposal for compromise. But I think you, in your wisdom, have come up with one in the interim, and I hope that we can adopt it.

One final point. We are, in some sense, making these Medicare cuts because we want to balance the budget. There is nothing wrong with that. That is good that we do so.

But I believe that the commission you provide for in your mark is extremely important, because then the commission can make recommended adjustments to Medicare which will be not quite so budget-driven as the provisions are in this bill, and will extend the life of Medicare in an even more solid way than we have in this bill here.

But, all in all, Mr. Chairman, I want to thank you very much for what you have done.

The Chairman. Well, thank you, Senator Baucus. I share your concern about rural areas. I know that their problems are special when it comes to health care. Of course, what we are trying to do is provide provisions that treat equitably all groups, whether it is urban

areas, rural areas, or whatever. I think this draft, because of the recommendations, reflects that.

I will now call on Senator Grassley.

OPENING STATEMENT OF THE HONORABLE CHARLES E. GRASSLEY, A U.S. SENATOR FROM IOWA

Senator Grassley. I am going to follow the Chairman's admonition of not offering amendments that are important to me, because there are not any of my amendments that are important to me, all of my amendments will be important for the country.

[Laughter]

The Chairman. That goes without saying.

Senator Grassley. Mr. Chairman, you are to be congratulated. Most importantly, I know that your staff, the people at the table, and a lot of support people that are at the table deserve a lot of credit as well, because this is a good bill.

I think the Medicare portions of the bill, particularly, are going to bring very positive changes in the program. The bill calls for the necessary savings in Medicare and thereby will help put Medicare, and particularly the Medicare Hospital Trust Fund, on a sound financial footing. The bill also contains a number of innovations that I think are very important for the Medicare program.

In regard to these, first and foremost, I think the reform in Medicare managed care is at the top. From my

perspective, Mr. Chairman, I want to thank you for the inclusion of your 50/50 blend for Medicare managed care reimbursement. This is extremely important for rural America, particularly for so many States that have been very cost effective in the delivering of health care already.

I think this provision should go a long way towards giving Iowans the same kind of choices that Medicare beneficiaries in the other parts of the country have. For instance, as simple as this, Iowans would like to have access to managed care so pharmaceuticals can be included, just like Floridians or Arizonans have, as an example.

So the participation in the managed care program of additional types of health plans is also a very constructive step, and the additional types of plans should truly broaden choice for Medicare beneficiaries.

I am also pleased, Mr. Chairman, that you included numerous provisions of my bill, S. 701, dealing with consumer protections in Medicare managed care. When this legislation is enacted, Medicare beneficiaries will have considerably improved information about health plans in which they may be interested.

I also thank you for the inclusion of a number of rural health provisions. These would be exactly the same

ones that Senator Baucus just thanked you about: the Nurse Practitioner and Physician's Assistant's bill that Senator Conrad and I introduced; the Medicare-Dependent Hospital Program that I introduced; and Senator Baucus' bill on Critical Access Rural Hospitals, and Senator Rockefeller and I were close collaborators on that bill; and my Rural Referral Center and Sole Community Hospital legislation; and also for including my PACE legislation, which I introduced with Senator Inouye.

You can see here a broad array of legislation that has broad bipartisan interest. Enactment of this last bill, for instance, will be a real step forward and those who participate in that program in the coming years will have reason to be grateful to you, Mr. Chairman.

I would just say one concern I have, and that is that I am disappointed that we were not able to do more in the way of long-term Medicare reform. As Chairman of the Aging Committee, I am very concerned about Medicare lasting for baby boomers.

You did set up a commission. I would rather have had Congress wrestle with those problems and get them done right now, but I am surely going to support your commission proposal because that should produce a consensus then for us to have Medicare, which is an essential part of the social fabric of American society,

continue for baby boomers as well.

Thank you.

The Chairman. Thank you, Senator Grassley.

Senator Rockefeller.

Senator Rockefeller. Mr. Chairman, and to my Ranking Member, Senator Moynihan, I have no opening statement. We have a lot of work to do today.

I congratulate both of you. I can imagine how hard all of this must be.

The Chairman. Thank you.

Senator Nickles.

OPENING STATEMENT OF THE HON. DON NICKLES, A U.S. SENATOR FROM OKLAHOMA

Senator Nickles. Mr. Chairman, thank you very much. I compliment you and Senator Moynihan.

I do hope that we will end up with a bipartisan piece of legislation, one that will have overwhelming support in this committee. I hope to be able to support it.

I am concerned about some of the provisions, but, first, let me say from the very positive standpoint in just looking at the Chairman's mark on the first page where it talks about Medicare CHOICE, I think this has, as far as policies ---- most people, when they talk about Medicare, talk about money, and how much money are we going to save, or what are we going to reduce the outlays, or how much money are we going to spend.

And I think the money is important and the dollars are important, but I think policies are maybe even more important. I think Medicare CHOICE and the several options that we have in this proposal will be a very positive thing for seniors and give us a chance to really reform Medicare. So, I compliment you on that.

I might mention on the outlays, this is interesting. The budget that the President vetoed last Congress, the outlays for Medicare over the same 5 years is $1,249

trillion. The outlays for Medicare under this proposal for the same 5 years, $1,248 trillion. One billion dollars difference, and this happens to be less than the proposal that the President vetoed last year because it made draconian cuts in Medicare, and all this demagoguery.

So the outlays are almost identical, just for your information. There are some other differences in the packages and so on, but I find that interesting.

I do notice on the choice option that we have medical savings accounts as a trial. I think that is very positive. I would like to see that trial expanded from $500,000. You have 38 million Medicare beneficiaries.

I would like a larger trial sample, but I do think it is a very positive start, I do think it is one that seniors will like and one that, if we do give it as an option, we will be back here a couple of years from now expanding it because of popular demand. So I do think that is important.

I am concerned, Mr. Chairman, and I would just mention this. I criticized the President for what I called a shell game in transferring home health away from Part A into Part B. We do the same thing, but we do not do it at the same rate.

The President was transferring a much greater

percentage earlier, but the effect is still the same. It is a shell game, and I am not proud of it. It is part of this package. It is the only way anybody can say we are keeping Part A solvent for 10 years.

I cannot say we are keeping Part A solvent for 10 years. I just refuse to say that, because of this shell game that we are playing with home health. I am troubled by it. I am not even going to have an amendment to delete it; I know I do not have the votes. But I think it is a shell game, I do not think it is Medicare reform.

The choice portions, medical savings accounts, allowing seniors some options, those are real reforms. They are very positive. They will be very good for seniors and they will be very good for Medicare.

I have some additional comments, but I will wait until we get to the amendments. Thank you, Mr. Chairman.

The Chairman. Thank you, Senator Nickles.

I would point out that the transfer of home care, of course, is in line with the objectives and goals of the so-called Budget Agreement.

Senator Nickles. I know.

The Chairman. We have made as a primary goal of this mark-up to achieve the goals that have been set forth in the agreement reached by the President and the Congressional leadership.

At this time, it is my pleasure to call on John Breaux.

OPENING STATEMENT OF THE HON. JOHN BREAUX, A U.S. SENATOR FROM LOUISIANA

Senator Breaux. Well, thank you very much, Mr. Chairman, and thank you, Senator Moynihan, for the leadership that both of you all have shown.

We have a divided government, but we certainly do not have to have a divided committee. I think that we have a situation with a divided government that neither side can afford to say never, or no way.

We are going to have to work together on these difficult issues whether we like it or not, and I happen to think that most members of the committee, and many members of Congress, like that type of an approach. I think it ultimately results in a better product, a better piece of legislation.

I think that both political parties can stay loyal to their political principles and yet still work together in a sense of compromise, because neither side can have it just like they want.

I think that is a given and we have to approach this mark-up, and others, recognizing that in a divided government both sides are going to have to move towards reflecting the wishes of the other side. One side cannot do it by themselves, nor should they.

You have produced a package, I think, Mr. Chairman, that you are to be commended for. Your staff, working with our staff and Senator Moynihan's staff have produced a terrific starting point. That is not to say that there are not some nuances that cannot be improved upon, but in the spirit of working together I think can accomplish that.

One area that I have worked with in a bipartisan fashion in with Senator Connie Mack, and Senator Kerrey on our side, is to work in trying to improve the Medicare CHOICE program which you have laid out.

You have a demonstration program in that proposal on competitive bidding. We will offer, at an appropriate time, a more detailed demonstration program, calling on competition in the private sector based on the Federal Employees Health Benefit Plan, which I happen to think works very well.

This proposal does not, I think, go against what you have offered in the mark-up, but I think enlarges upon it, improves upon it, produces a better demonstration, with guidelines and standards which I think are very, very important.

So I would like to think that what we will be offering is an expansion and an improvement which is consistent with what you have laid out in the Chairman's

mark, and I commend both of our leaders for the work that they have produced.

The Chairman. Thank you, Senator Breaux.

It is now my pleasure to call on my good friend, Phil Gramm.

OPENING STATEMENT OF THE HON. PHIL GRAMM, A U.S. SENATOR FROM TEXAS

Senator Gramm. Mr. Chairman, let me congratulate you and our Ranking Member for putting together a mark-up document that I think everybody on this committee can say that they had some part in. I think it is a bipartisan document and I would like to just make a few comments.

First of all, this will be the only mark-up anywhere on the Senate side of the aisle, as the similar mark-up was in the House, where any program is cut. Every other committee that got a reconciliation instruction got an instruction and a mandate to spend money. The only cuts that are going to be made anywhere in this budget are going to be made right here in this committee and this mark-up.

So, Mr. Chairman, you are the only committee chairman that had to make any tough choices or do any heaving lifting in this budget.

I believe that Medicare represents a very severe problem as we look to the future. It is a critically important program. It is part of the fabric of the American system.

I do not think there is any doubt about the fact that every member of Congress and both parties are committed

to saving the system, but the cold reality we are looking at is, 25 years from today, if we do not change Medicare, the payroll tax is going to have to be at least 3 times as high as it is now.

That represents a fundamental change in the make-up of the American economy. It guarantees that you are going to have working Americans with tax rates above 50 percent and at some point you reach, under that kind of system, a situation where the economy cannot function.

I want to congratulate you for some of the reforms we have made in Medicare. In fact, I would like to predict that, of all the things we do in this budget, there are probably going to only be two things that will be remembered if we can hold on to them in the form they are in in this mark-up.

One, is we will have gone to an expanded consumer choice in Medicare and brought the forces of competition for the first time into Medicare. Second, by conforming the age of eligibility for Medicare with the retirement age and Social Security, we will have made a fundamental, long-term reform without waiting for the crisis to blow up in our face.

I know we are going to have a difficult time holding this provision on the floor of the Senate, I know we are going to have a difficult time in conference, and I know

there are going to be a lot of groups who come out against it, but I think it is fundamentally important.

We are at the point now where, if we wait another year or two, we are not going to be able to conform these two dates and we are going to lose an opportunity to make a fundamental change in Medicare.

So, while there are many things in this bill that we can debate, agree with, disagree with, I think the fundamental changes we made in Medicare, bringing in competition and in essence raising the eligibility age to conform with the retirement age under Social Security--which, by the way, we only did once the system was broke--I think if we can hold that, it will be something to be proud of.

The Chairman. Thank you, Senator Gramm.

Now it is my pleasure to call on Bob Graham.

OPENING STATEMENT OF THE HON. BOB GRAHAM, A U.S. SENATOR FROM FLORIDA

Senator Graham. Thank you, Mr. Chairman.

A short statement, first, to commend you and Senator Moynihan for the spirit in which this mark was developed. WE all have had an opportunity in an open process to be involved. I believe that we start from a very solid document, in spite of the 270 suggested improvements.

Second, speaking of fundamental changes, I am particularly pleased at the inclusion of a number of items which are intended to begin to move Medicare towards the maintenance of health rather than the waiting-until-the-crisis-has-occurred system.

The emphasis on prevention, early intervention, diagnosis, screening, I think, while difficult to put a dollar sign on today, common sense says will have a significant, long-term, positive effect on the health of the beneficiaries and on the wallet of the American taxpayer.

So, I commend you for including those provisions. Thank you, Mr. Chairman.

The Chairman. Thank you, Bob.

Jim?

OPENING STATEMENT OF THE HON. JAMES M. JEFFORDS, A U.S. SENATOR FROM VERMONT

Senator Jeffords. Thank you, Mr. Chairman. I certainly want to join the accolades on your leadership in allowing even new members of the committee to feel like they are participating. I appreciate that, and the bipartisanship manner in which you have handled this.

Also, as chairman of the Labor and Human Resources Committee, I know there are many areas of joint jurisdiction and I look forward to working with you on those, especially in the areas of health care quality and consumer protection, as we are getting involved with ERISA now and covering more and more of the business community, and we need conformity there.

I also, of course, represent I think the most rural State in the United States. In fact, we do not have anything but rural in our State.

So I am very interested in matters dealing with that, especially in Medicaid and Medicare. Also, I would be interested very much, as we all are, in increasing the protection of children.

Thank you very much, Mr. Chairman.

The Chairman. Thank you, Senator Jeffords.

Senator Moseley-Braun.

OPENING STATEMENT OF THE HON. CAROL MOSELEY-BRAUN, A U.S. SENATOR FROM ILLINOIS

Senator Moseley-Braun. Thank you very much, Mr. Chairman. I, too, want to add my thanks and congratulations to you for the work that has been done here and for the bipartisan way in which it has been achieved.

I have been delighted, as a member of this committee, to have the opportunity to work in such a bipartisan fashion, given the current climate which all too often is not bipartisan and does not seek to find common ground. You have certainly attempted to do that with this mark and I am very pleased to have been part of the process.

I want to point out, however, that I do have some concerns and I do want to raise them with regard to the distributive effects of the mark, particularly with regard to poor people in this country.

Given the changes that took place with the welfare repeal, with the welfare bill that was enacted, this bill does not, I think, adequately address the impacts and the ramifications of that.

As the administration pointed out in its letter, we failed to provide funds to ease the impact of increasing Medicare premiums on the very poor, there is no change in

terms of disproportionate share to address the impacts on the very poor, and of course we are very concerned about the issue of what happens with regard to disabled children. So the most vulnerable populations, I think, could have fared a little better in this mark.

I hope, and I do not know whether it is a matter of philosophy or not, that some of the amendments which will be filed in that regard will be taken seriously, because this is the most vulnerable population and people who have no options, and they really will need our attention to the impacts of the welfare reform on them.

Finally, Mr. Chairman, I am very concerned about the Pennington decision overrule in this mark. That decision, as you are aware, comes out of my State. It does have to do with the calculation of the unemployment insurance base period.

I think that the Federal Court in Illinois did the right thing, it was upheld on appeal, in the case of Pennington v. Doherty, but the striking of that in this mark, I think, may also cause some problems down the road.

But, overall, having said that, I just want to add my congratulations and thanks to you. You have been a wonderful Chairman to work with. My Leader, Senator Moynihan, of course, has led the way for this side of the

aisle, but at the same time I think just the tenor and the tone that you have set for this committee has been a very positive and constructive thing overall, and I am just happy to have been able to participate.

Thank you.

The Chairman. Thank you, indeed, for those very kind remarks.

It is now my pleasure to call on Senator Bryan.

OPENING STATEMENT OF THE HON. ROBERT H. BRYAN, A U.S. SENATOR FROM NEVADA

Senator Bryan. Mr. Chairman, thank you very much.

As you know, this marks my first appearance with you as part of a mark-up, and I want to commend you for the bipartisan approach that you have taken, and the Ranking Member, for his efforts in putting us where we are today.

We face a dawning public policy challenge in terms of preserving the solvency of the Medicare Hospital Trust Fund, a challenge which will be compounded in the year 2011, when the first of the baby boomers become eligible for Medicare assistance.

I believe that the mark that you and the Ranking Member have put together moves us a long way in the direction of achieving that solvency.

I would only hope, Mr. Chairman, that we might summon up additional courage to do what the Ranking Member has encouraged us to do repeatedly since I have joined this committee, and that is to press forward in adopting an accurate cost of living adjustment standard.

Second, I would hope we might also move forward, as the Centrist Coalition did in the previous Congress and as we have been working in this Congress, in taking further steps to income-relate Medicare's Part B monthly

premium.

Finally, let me note that I will heed your admonition to forbear in offering amendments to the best of my ability, but there are two that I will be offering. One, in my judgment, represents a new, unfunded mandate upon the States. That is, the extension of the Medicare Hospital Insurance tax to those employees who were hired prior to the date of the OBRA-85 agreement.

Second, I continue to have some concerns--although I would acknowledge that your staff, Mr. Chairman, has been most helpful to work with--and that is to make sure that those Medicare beneficiaries who choose a provider-sponsored organization will be entitled to the same type of consumer protections accorded under State law that other Medicare beneficiaries will enjoy.

Again, let me say that I appreciate working with you and I look forward, in a cooperative spirit, to getting a mark moved to the floor that we can all support.

The Chairman. Thank you very much, Senator Bryan.

Finally, Senator Kerrey.

OPENING STATEMENT OF THE HON. J. ROBERT KERREY, A U.S. SENATOR FROM NEBRASKA

Senator Kerrey. Thank you, Mr. Chairman. I appreciate your noting that, though I am closer to them than to you, that I am a member of the committee and not a witness.

The Chairman. You are part of the dais.

Senator Kerrey. I, too, want to congratulate both you and Senator Moynihan for the work that you have done. Our job is to produce a product that will contribute to eliminating the deficit by the year 2002, not an easy job, but an important one, made easier by growth in the economy and I think indicating to all of us that sometimes we get a little worried about what the impact is going to be on our decisions, that if we make decisions that keep the economy growing, our job and the job of the American people is going to be a lot easier.

There are a number of points that I would like to make, Mr. Chairman. One, is though we are looking at a 5-year window and, to a certain extent, a 10-year window, I think increasingly we have got to look at particularly the mandated portions of Medicare, Medicaid, and Social Security through a 20-year window.

The baby boom generation that is 77 million strong

that will start to retire in 2010 is going to consume a larger and larger share of the Nation's income in order to pay the promises that we have written into our law. In this year, it is 2.3 percent of GDP. The entire budget is 19 percent. It has not gone over 19 percent, except during the second World War and the Vietnam War. It has remained almost as constant as gravity.

In the year 2010, 4.2 percent will be the bill for just the health care portion, and it will grow to 7.2 percent in the year 2030. There is continued growth, even with the changes that we have in the law, to a point where eventually before the baby boomers are fully retired, 100 percent of the Federal budget will be consumed by the mandatory programs, that is, entitlements plus interest.

It is a fact not caused by secular humanists, or Phyllis Schafly, or liberal Democrats, or conservatives, it was not a part of the break-in at Watergate, it is a 77 million baby boom generation that will not be supported by nearly as many people following them.

Second, I do intend to make the point that States like Nebraska, that did not gain the DSH system, should not be penalized, and you have made, I think, a very good effort to see that that does not happen.

Further, again, in States like Nebraska we tend to

have lower rates of utilization in rural areas, and I also believe, as a consequence, we should not be penalized as a result of demonstrating what I consider to be relatively good behavior.

Again, you have made an effort to do that. I will try throughout the deliberations of this proposal to make the point that States like Nebraska that have done the right thing should not be penalized as a consequence.

Next, I will try to score the point that we have got to be careful that the taxpayers get their money's worth. You have got a number of provisions in here that I believe reduce the opportunity for waste, for fraud, for abuse, and I appreciate that you have done that. We have got to be vigilant.

There is a lot of money in these programs, as we all know. Where there is money there is a tendency to come in and say, it is not the money, it is the principle, and when a man tells me that, I know that it is the money.

Next, I think we have to apply a standard of fairness. I know there will be a great debate about how we are going to do that in regards to children, but I think it is a mark of this committee's effort to be fair, that we have expressed a concern for expanding coverage for children.

I believe that income-relating Part B premiums, as

well, can be a means for us to make the program not only more defensible, but also a way for us to distribute and make the program more fair. I intend to try to fight for consumers so that the consumers are getting information and have an opportunity to make choice meaningful.

Most of all, Mr. Chairman, I intend to make the point that I believe it is going to be impossible for us in the future to maintain Medicare and Medicaid as impact programs. The beauty of Medicare was that, in the law in 1965, we reduced the rates of uninsured over the age of 65 from 50 percent to zero with a single statute.

At some point I think we are going to have to revisit the entire social contract when it comes to health care and look for ways to rewrite that contract to get everyone in.

There will be 40 million Americans uninsured by the time we get done with this Balanced Budget Agreement. We are pushing, I think, in the right direction, trying to control the growth of these programs, but I think we are going to have to revisit the entire contract that we have in health care in order to be able to get it done right.

Again, I applaud, as all members have, the spirit in which you, Mr. Chairman, have worked, and you, Senator Moynihan, have worked as well. It is a tough thing to hold Republicans and Democrats together on a mark. I

appreciate the spirit in which you have done that. I think you have produced a very good mark for us to do our work.

The Chairman. Thank you very much, Senator Kerrey.

That completes the opening statements, so at this time we will turn to Julie James and the other staff members to walk us through the mark-up.

Let me start out by saying that we would not be where we are today if it had not been for the hard work and ability of the staff members on both sides of the political aisle.

But I know that has meant long, long hours, day and night, week in and week out. I just cannot be complimentary enough to tell you how much I appreciate the outstanding work the staff has provided us.

Julie?

Ms. James. Thank you, Mr. Chairman.

I am going to walk through an outline that is now being distributed. This is a slight variation from the summary that was included on the top of the mark document that was distributed last Friday.

It is titled, "Summary of Chairman's Mark," and dated June 16. There are just a few changes in this that were updated when we made some last-minute changes to the mark document.

I will also call your attention to a 7-page document that was handed out, which are modifications to the Chairman's mark that was passed out last Friday. Most of these are just further elaboration on some of the items that were discussed in a more general sense in the mark, and I think by elaborating further on some of these things we have had a number of questions, and I think those would be answered through this modification. But the major items that are in the modification, I will walk through as part of the summary.

I will begin with Medicare. The Medicare proposal achieves the budget instructions to achieve $115 billion in savings in Medicare over the next 5 years.

The proposal was crafted around the following principles. First, to preserve and protect the Medicare program for current and future beneficiaries; to establish a framework for a restructured program modeled after other successful programs such as the Federal Employees Health Benefit Plan; to provide seniors with information and allow them to choose from a variety of health plan options that meet their needs and to maintain the traditional Medicare program as one of those options; and to implement policies that slow the rate of growth in spending in Medicare; and finally, to eliminate waste, fraud and abuse in the program.

The mark establishes a new Medicare CHOICE program. This builds upon the current program we have for contracting with health maintenance organizations.

Under the new Medicare CHOICE program, beneficiaries would have a choice of a whole range of options. These range from full, unrestricted fee-for-service plans through a variety of managed care type plans, and also medical savings accounts. This is a demonstration program, capped at a participation of 500,000.

We also leave the door open for any other kinds of plans that might develop that would meet the standards outlined in this proposal. All beneficiaries enrolled in Part A and B would be eligible to make a choice, except those with end-stage renal disease.

Enrollment. There would be an annual, coordinated information and enrollment period every November. During this time, the beneficiaries would receive comprehensive information on their health plan options and they would be able to select any of those options and enroll at that time.

Plans would have to be open at that time, but they could also continue to enroll beneficiaries throughout the year. It would be their discretion as to when else throughout the year they wanted to enroll beneficiaries.

Senator Nickles. Julie, would it be possible for

somebody to switch plans midstream or mid-year?

Ms. James. Yes. This enrollment, we do follow the current law policy and allow beneficiaries to opt out of their choice and either re-enroll in traditional fee-for-service Medicare or to choose another option on a monthly basis.

Now, there is an exception for the medical savings account plan. For that plan, only during the annual open enrollment period in November do we allow change to be made for an MSA, and that is to counter some of the problems with risk selection.

Senator Grassley. Julie, for the value of the voucher for MSAs, how is that determined? In other words, if you live in New York City would you get the same amount as if you lived in Iowa?

Ms. James. Well, there is a Medicare payment amount that can be attributed to each beneficiary based on the payment amount that applies in the area, and then adjusted for certain demographic characteristics of the beneficiary, so if they are a young person they get less than if they are an older person.

And whatever the difference is between the amount of their high deductible policy and the amount that Medicare would pay for that individual can be deposited into a medical savings account.

Senator Grassley. So that amount that would be deposited would vary from State to State. For instance, in Florida it could be a lot higher dollar amount that would be deposited in an MSA as opposed to in Iowa or Minnesota.

Ms. James. Well, a lot, Senator, would depend on what the price of the high deductible policy is in the area as well. So it is difficult to determine exactly how it would vary. It could vary. It will vary by beneficiary and it could vary by area.

Plans will be able to market, but they must conform to marketing standards that have been approved by the Secretary. All plans must offer the full range of current Medicare-covered benefits, but they can include extra benefits and they can also offer supplemental benefit packages on top of their basic package, and priced separately.

As far as beneficiary protection and health plan standards, plans must provide access to care 7 days a week, 24 hours a day.

We adopt the emergency of the prudent lay person's standard for emergency services, which means that if an individual goes to an emergency room and they think that they have a serious problem, then the plans would be required to pay for getting that emergency care.

Plans must be accredited by either the Secretary or a private accrediting body approved by the Secretary, and have an ongoing external quality review program. They also must have appeals and grievance procedures. They must take all comers and they cannot discriminate based on health status.

Now, at the top of page 3, number 9, we make significant changes in the current way that Medicare reimburses for private plans. This is what is commonly referred to as the AAPCC.

We apply a number of changes to the methodology, starting with what they are getting in 1997. We then apply a blend of local and national payment rates that phases down to 50/50 over the 4-year period.

There is also a floor established in 1998 of $350. There is a minimum percent increase of 1 percent a year, so that no plan, regardless of how the other factors that are affecting their rate are concerned, will go below a 1 percent increase a year.

We do carve out of the rates the amounts of money that are attributable to graduate medical education and disproportionate share spending, and we do that over a 4-year period at 25 percent a year.

Then we allow teaching hospitals that are taking care of private plan patients to get an additional payment to

compensate for the cost of teaching and disproportionate share, just as they would when they are treating an enrollee in the traditional Medicare program.

Senator Breaux. Mr. Chairman.

The Chairman. Yes, Senator Breaux.

Senator Breaux. I would just ask Julie a question.

It is difficult for me to understand this. It is probably true for everybody. But does the proposed change affect existing fee-for-service and HMOs the same, or is there a different mechanism for determining the reimbursement rate for fee-for-service if somebody stays in that as opposed to going into a managed care type of plan?

Ms. James. Well, Senator, the payment rates that I am talking about right now would only apply to the amount of contribution that Medicare is going to make on behalf of an individual who enrolls in a private plan. It is separate----

Senator Breaux. Any kind of plan?

Ms. James. Any kind of private plan.

Senator Breaux. That is approved.

Ms. James. Right. As opposed to staying in the traditional Medicare program.

Senator Breaux. Well, suppose the person wants to stay in the traditional fee-for-service plan, how is this

proposal affecting the reimbursement rate that doctors and hospitals receive?

Ms. James. This would not affect that.

Senator Breaux. So it only affects all the plans that are listed as being approved plans to be offered, other than fee-for-service.

Ms. James. Right. This is to establish the capitated amount for the private plans.

Senator Breaux. But the amount that these other plans would be receiving would still go back to the adjusted national rate in determining how much it is going to be, but then you start blending it.

Ms. James. Right. Well, we start with the 1997 rate, Senator, which is based on actual fee-for-service spending in each area. We are trying to move away from that because of the huge variation that we have and we are making these adjustments to try to equalize these payments more across the United States.

So, at this point we are severing the link to fee-for-service. It is starting with the 1997 base year, but then it goes through and makes all these changes. Then we arrive at a base rate for each area that is going to increase at a factor that is set at per capital GDP, plus 0.5. So regardless of what is happening in fee-for-service, we now have this part of the program that is

growing at a predetermined rate.

Senator Breaux. All right.

Ms. James. So it is separate.

Senator Breaux. It is important for my colleagues to know that the proposal at this point, absent your demonstration project, is still based on HCFA's setting of fees, then you branch out, but it is still not based on competition and negotiation or bids for the right to serve Medicare patients.

Ms. James. For the formula approach. Yes, sir.

Senator Breaux. All right. Thank you.

Senator Graham. Mr. Chairman, could I ask a question?

The Chairman. Yes, Senator Graham.

Senator Graham. You say that there will be a minimum percent increase over the previous year. How does that relate to the annual inflation update, which will be GDP plus 0.5 percent?

Ms. James. Well, Senator, the carve-out, the blend, and all of these things that are going on with the rates will have various effects across the Nation on each of the individual rates.

When you get through doing all of those things, you look at what the rate is. If the rate is not at least 1 percent higher than it was the previous year, then you

adjust it so that it is, so you are assuring on the top end that you have at least a 1 percent increase.

You do the same on the other end. You look and see that the rate is at least $350 in 1998, so that you have established sort of a floor and a top end on increase, and then you have the formula working over the years to bring the rates together.

What happens at the top end is that, in the very high-paid areas right now, a lot of the reason for those payments being so high is attributable to the fact that the graduate medical education and disproportionate share payments are incorporated into the payment amount.

In some areas, when you carve that out it is a very significant amount of money, as much as 25 percent in New York City, for example.

So in order to not just pull the rug out from under those areas because now we have beneficiaries who are enrolled in these plans and are getting a lot of extra benefits, we have put in this 1 percent minimum increase to ensure that there will continue to be at least a small increase in those areas while we are moving to the system over 5 years.

Senator Graham. So that would mean that if, let us say in a particular area your fee-for-service base was $5,000, but $1,000 of that $5,000 was in disproportionate

share or graduate medical education, therefore it dropped the base to $4,000, that the HMOs in that area would still be compensated $5,000, plus 1 percent.

Ms. James. That is correct.

Senator Graham. Is the combination of that plus setting a base of $350 not going to result in HMOs receiving more reimbursement than they are today, as a group?

Ms. James. You mean, total spending on private plan enrollment?

Senator Graham. Yes.

Ms. James. No. There are savings that accrue from what we have done here because we are constraining the annual rate of growth, et cetera.

However, there is also increased enrollment as a result of this. CBO projects that, by the end of 5 years, 29 percent instead of 25 percent of beneficiaries will be enrolled in private plans. So there are those things that are going on.

To tell you the truth, I cannot tell you, with the increased enrollment, whether it would be spending less, but, per capita, we would be spending less per enrollee than we are today.

Senator Graham. One last question. The $350 minimum, that indicates that some HMO reimbursement plans

are going to be at a level above the fee-for-service in the community, is that correct?

Ms. James. That is correct.

Senator Graham. Do you have an idea of what percentage of current Medicare beneficiaries live in areas where the HMO reimbursement level will be above fee-for-service?

Ms. James. We will get that, Senator.

Senator Graham. All right. Thank you.

The Chairman. Please proceed.

Senator Nickles. I just need to ask a question. I still do not understand, and Bob mentioned this, the annual inflation update will be annual per capita GDP plus 0.5?

Ms. James. That is correct.

Senator Nickles. What does that mean?

Ms. James. It means, you take the nominal per capita GDP, which is around 3.5 to 4 percent, you add 0.5 percentage points on top of that so that you are at about 4.5 percent, and that is what the rates would increase each year.

Senator Nickles. By GDP you are talking about----

Ms. James. Gross Domestic Product.

Senator Nickles. Are you talking about an inflator?

Ms. James. No.

Senator Nickles. Are you talking about the increase in GDP?

Ms. James. Right. The growth in the Gross Domestic Product.

The Chairman. I see charts on the horizon.

[Laughter]

The Chairman. What I would like to do to expedite, but not cut off, is that we continue with the Medicare payment. Then when we start Section 12, we go on through to page 5, where we have changes to the traditional Medicare program, then open it up to those questions. But, for the moment, we will continue to take questions on the Medicare payment, because that is extremely tricky.

Senator Moseley-Braun. Thank you.

Well, I just am concerned. This issue was raised in committee before, Mr. Chairman, regarding the blended rate. And the decision in the mark to go with the 50/50 blended rate, I think, will have the effect of stifling enrollment and being a disincentive for enrollment in these managed care plans.

Looking at the numbers for State of Illinois, it not only impacts on Cook County, Illinois, which, of course, is a large county in my State, but also on Hardin County, which is a small county in southern Illinois, and really

leads to negative enrollment based on this 50/50 formula.

I just wanted to ask the staff whether you have looked at these numbers in this way, and was there actually a decision made that you do not want to see growth in the managed care areas in States such as Illinois?

The Chairman. Julie?

Ms. James. Senator, the effect of going from a 70/30 blend to a 50/50 blend, because of all the other components going on in the change in this payment formula, actually makes very little difference. The most effect it has is to bring some of the lower areas a little higher.

On the very high areas where we currently have a lot of enrollment, like Cook County, like Dade County, that are being affected by a lot of the other things in this formula, because of the 1 percent minimum update, in fact, Cook County does not change between the two options, and the same is true for a number of the areas where we have a lot of enrollment.

We now have runs that we can meet with staff and show them. I think there are some numbers around that I do not know where they came from, but we have some runs from the Congressional Research Service and we would be happy to meet with staff and go over them.

Senator Moseley-Braun. I would appreciate that, because the numbers that I have here suggest a negative 12.65 percent in Cook County, and a negative 8.07 percent in Hardin County, again, which is a small, rural county in southern Illinois.

If you have got some other numbers, obviously we would be happy to look at them, because I am very concerned that, given your preface and the statement that we are moving in the direction of trying to open this managed care as an option for these plans, this moves in absolutely the opposite direction.

Ms. James. Yes. We would be happy to meet with staff and show them those things and go over them.

Senator Moseley-Braun. Thank you.

The Chairman. I think Mr. Grassley has comments.

Senator Grassley. I do not have a question. But I would like to make a comment that supplements the discussion we have just had from the Senator from Florida and the Senator from Illinois, not to disagree with anything, but just to make the point that, in the whole effort of changing the AAPCC, we would like to have an opportunity for managed care plans in all of America the same as they have been very successful in your respective States, and a lot of different combinations can be put together to accomplish that.

But not only is our goal to get the floor up so that managed care plans would come to our respective States -- -- and, by the way, there is some question whether or not $350 is enough to do that, but I think that we ought to leave that discussion for a later period in a few hours.

But the bottom line of it is, we ought to have the same opportunity for our people to join managed care plans that constituents in your States have had over a long period of time, and not only to finally get the base up, but to get the 300 percent discrepancy between a low county like Alamakee County in Iowa where it is $252 per month per beneficiary, as compared to $768 in Miami, as an example.

It is pretty difficult for us to say to our seniors that you can have eyeglasses and pharmaceuticals if you join a managed care plan in Florida. We do not even have that opportunity to join a managed care plan in my State, and we would like to have that opportunity.

It is nobody's fault that we have this 300 discretion; it is the way medicine has been practiced in the very States. That, in and of itself, would not require us to change formulas, but the distortion that has come over several years of percentage add-ons from year to year has been a great factor in the distortion.

Senator Gramm. Mr. Chairman?

The Chairman. Phil Gramm.

Senator Gramm. Mr. Chairman, I just want to remind people, picking up where Chuck left off, that we had a proposal from the administration to reimburse HMOs at 10 percent below the average reimbursement for fee-for-service Medicare. That would have meant a 5 percentage point across-the-board cut.

The basic problem with that which staff is partially trying to deal with, is the huge disparity that exists in the HMO reimbursement rate. Many of you will remember my now-famous chart. In fact, why don't you hand me that chart.

What that chart shows is that, when HMO reimbursements are arrived at competitively by Federal employees who choose among literally hundreds of programs in many cases, that the rates are relatively uniform. That is this blue line at the bottom of this chart. That is the average monthly payment that is being made by the Federal Government under the Federal insurance program.

The green line represents the reimbursement rates under Medicare. As you can see, there is no relationship whatsoever between a competitive rice and the price at which we are reimbursing.

Basically, what we are trying to do here is achieve the savings without doing across-the-board cuts. If we

did across-the-board cuts, it would guarantee that, in the areas where you have already got relatively low cost--for example, Lacrosse, Wisconsin, Portland, Oregon, Salt Lake City, Seattle, and in rural areas--it would mean that you would decimate HMOs that are providing a relatively low price now, whereas in the high-cost areas, you would have relatively little effect.

So, by blending these rates, what we are trying to do is to eliminate some of this huge variance and protect low-cost HMOs, but at the same time achieving the savings that are mandated by the President.

Senator Moseley-Braun. Will my colleague yield?

Senator Gramm. Sure.

Senator Moseley-Braun. As I understand your now-famous chart, it compares a population of able-bodied people like the folks in this room with a population of seniors who are enrolled in Medicare. Those are two different health populations.

Senator Gramm. Well, but see, we simply adjust. To get the red line, you adjust for the average difference in the cost of fee-for-service medicine for seniors enrolled in Medicare as compared to the population as a whole.

So if you look at the red line which makes that adjustment and in essence normalizes the population, what

it shows is that we have got a totally random distribution of reimbursement under Medicare that makes no sense whatsoever.

Now, we are not going to this red line in what the committee has done, but what we are doing is trying to knock out some of these valleys and peaks so that HMOs can work in rural areas so we do not decimate them in areas where they have got big penetration and very low prices, and where we save the money.

Senator Moseley-Braun. Will my colleague yield again?

Senator Gramm. Yes.

Senator Moseley-Braun. Without taking issue with your methodology in creating your now-famous chart, the point, I think, has to be recognized that, number one, we have some debate about the methodology. Putting that aside for a moment, the issue here is not making rural areas competitive with high-cost urban areas, by any means.

In fact, in my State, Senator Grassley and I work together on a lot of stuff because most of my State is much like Iowa. I mean, outside of Chicago, outside of Cook County, I have got a rural State to be concerned about.

So the idea, I think, is to try to find balance and

to try to find common ground where nobody gets hurt, or, more to the point, where everyone is encouraged similarly to move into these more economical plans.

I guess my only point to the committee and to my colleagues is--and we should take a look at the numbers that Julie is going to make available to us--is that the blend that we have right now is likely to move in just the opposition direction and instead of having rural areas getting rid of the peaks and valleys, what you will have done is found the lowest common denominator, which will function as a disincentive for enrollment.

Senator Gramm. Mr. Chairman, let me respond very briefly and I will quit.

It has got to tell you something that Lacrosse, Wisconsin, on their competitive rate for reimbursement where Federal employees can choose from some 100 competitive plans, that when they choose an HMO, that the reimbursement rate competitively is higher than the reimbursement rate for a similar competitive price in Philadelphia, Pennsylvania, yet the HMO reimbursement for Medicare is twice in Philadelphia what it is in Lacrosse, Wisconsin. I mean, that clearly has got to tell you something.

When the competitive price for Federal employees in Lacrosse is higher than for Federal employees in

Philadelphia and yet HMOs are being reimbursed under Medicare at twice the rate in Philadelphia they are in Lacrosse, Wisconsin, that tells you something is crazy.

What the staff has simply tried to do with this blended rate is to make some adjustment for these kind of problems. There is no other way to do it if we are going to save the money. If we did the across-the-board cut, it would be far more damaging and would decimate rural American in terms of ever having these choices.

The Chairman. I do not want to shut off this debate, but I do have to point out that time is expiring rapidly this morning and we have a very, very long ways to go on this mark-up.

So what I am going to ask you to do, Julie, if you would go up to the changes to the traditional Medicare program, then we will let there be comments. But I think we are going to have to expedite things.

Ms. James. All right, Senator.

Several more comments on the Medicare payment. This blend that we are applying is adjusted for input prices so that, to the extent that wages and other costs are higher in an area, that is taken into account and that is part of the reason that mitigates that effect.

I should say that under this proposal we currently have a range between the lowest and the highest rate of

247 percent. In 2002, under this proposal, that is reduced to 111 percent. So there still is a range, but we cut it about in half.

We also apply a risk adjuster. There has been research that shows that especially the enrollees who choose to enroll in a private plan tend to be healthier. The Physician Payment Review Commission did a study that showed that, on average, the new enrollees used, in the period immediately before enrolling in a plan, 65 percent of what an average fee-for-service beneficiary would use, and that was all adjusted, et cetera, for age and sex.

So there is some concern about the fact that enrollees are healthier and, therefore, should cost less, so we have applied a risk adjustor that really is a very minimal risk adjustor.

What it does, is for new enrollees, the first year they are in a plan there is a reduction of 5 percent, the next year 4 percent, the next year 3 percent, and it phases down. It becomes effective the first time you enroll in a plan. It does not start over every time you change a plan or enroll in a new plan.

It also allows people who have been in HMOs before they turn 65 and before they age into Medicare to not have that reduction, because we assume that they have been with the plan, they have established relationships

with a physician, and they would not have the same characteristics of people who are just coming into the program. So we do have that risk adjustor.

Then we apply to the Medicare payments the same policy we have for FEHB payments in terms of prohibiting State premium taxes on the amount of the Medicare payment.

In terms of financial and contracting requirements, all plans must be licensed by the State. They must assume full risk for the Medicare benefits. They must meet solvency requirements and minimum enrollment requirements.

Now, because we have allowed for provide sponsored organizations, we have special rules for a few years to enable these organizations to meet some of these requirements.

For the first three years, through the year 2000, provider sponsored organizations will be able to go directly to the Federal Government and apply to be certified as a Medicare plan. They will not have to be licensed by the State.

The States, however, once they adopt solvency standards that are equal to those of the Federal Government and the Secretary certifies that they are the same, then at that point a provider sponsored

organization will have to go through the State.

But until that time the Secretary will develop solvency standards and certify the PSOs, and their certification will sunset at the end of the year 2000. The solvency standards that the Secretary develops will be determined through a negotiated rule-making process.

We also require that, as part of the contract that the Secretary enters into with the plan, one of the contracting requirements will be that the PSO comply with all State beneficiary protections so that they are on a level playing field in terms of all of the other non-solvency standards, if you will, in the State.

We also have a tax clarification that nonprofit hospitals do not lose that status when they join a PSO, regardless of the tax status of the provider sponsored organization.

We make several changes to policies regarding Medicare Supplemental Insurance. We allow guarantee issue, or portability, so that beneficiaries who opt to enroll in a private plan have up to one year, if they decide to disenroll, they can be assured of getting their Medigap coverage back without having to go medical underwriting.

We also eliminate pre-existing condition exclusions that are now allowed under the Federal standards. When

beneficiaries currently have a 6-month guaranteed issue period upon turning age 65, Federal law now does allow pre-existing condition exclusions to be applied, and we eliminate those.

We also authorize a new high-deductible Medigap option to be offered in the States, and this would have an annual deductible of $1,500 before the policy kicked in and began paying the cost sharing.

We provide permanent status for the PACE program.

Senator Chafee. Julie, on those disabled under 65, what do they have under the Medigap? They are not guaranteed to be able to----

Ms. James. When they become 65 they have----

Senator Chafee. No, just take the----

Ms. James. Right. They have the same----

Senator Chafee. The under 65.

Ms. James. We have made no changes to the provisions for the under-65.

Senator Chafee. Thank you.

Ms. James. Then we have a number of demonstration projects. I mentioned earlier the Medicare medical savings account demonstration. We also provide for a competitive pricing demonstration and a Medicare enrollment demonstration to allow the Secretary to experiment with competitive approaches to determining the

payment rates for private health plans.

We extend the Social Health Maintenance Organizations, or the SHMOs, through the year 2000, and the Community Nursing Organization demonstrations are extended for two years.

Senator Baucus. Mr. Chairman, are there any limits on the number of enrollees in these demonstration projects, other than the 500,000 for medical savings accounts?

Ms. James. The Social HMOs have limits on enrollment, and we have increased those limits from 12,000 to 36,000 for those sites.

Senator Baucus. Yes, I see that right here.

Ms. James. But the other ones do not.

Senator Bryan. Mr. Chairman, could I ask a procedure question?

The Chairman. Yes.

Senator Bryan. I understood you asked us to forbear on the asking of any questions until after we deal with Item 15. I do not want to waive my right to ask questions on this.

The Chairman. What were you going to say, Julie?

Ms. James. I just have the commissions, then I am done with this section.

The Chairman. Why do we not go through the

commissions, then we will recognize you.

Senator Bryan. No problem.

Ms. James. The proposal includes two commissions. The first, is the bipartisan commission on the future of Medicare. This is a commission that will meet for one year and develop recommendations for Congress on the changes that are necessary for the long-term health of the program, and will also address the issue of financing for graduate medical education.

The second, is a change in the current commissions that we have that advise Congress on all these various payment policies. We combine ProPAC and PPRC into one new commission called the Medicare Payment Review Commission. So that concludes the CHOICE section.

The Chairman. Senator Bryan.

Senator Bryan. Mr. Chairman, I thank you very much. If I might ask Julie some questions with respect to Item 12 on page 3. The first question is, during the period of pendency in which the Federal regulations are to be developed for solvency standards would any Federal waivers be issued during that period of time?

Ms. James. No. PSOs could not be contracted with the Secretary until the standards had been developed and the Secretary determined that they met the standards.

Senator Bryan. Thank you. That answers one

question.

The next question I have, and I have no problem with the concept that you have advanced that the financial standards be developed at the Federal level, is a follow-on. Would there be a reasonable period of time before those new Federal solvency standards go into effect for the States to comply, for example, a period of, say, 6 months, or a comparable period?

Ms. James. Senator, we do not provide any special period of time. I should mention that we call for the Secretary to issue interim standards and then to enter into a negotiated rule-making to adopt the final standards.

We do not provide for any gap between the time that the standards are developed to allow the States time to act, so during that 3-year window, once the State acts and has met those solvency requirements, they would be able to go forward, but also the Federal Government could go forward to contract with the PSOs until then.

Senator Bryan. I appreciate your response.

Mr. Chairman, I know you are trying to move it along. My concern, and I have discussed this with staff, is that I believe that a Medicare beneficiary, irrespective of the choice he or she makes--and I do not have a problem with the provider sponsored approach that you are taking-

-is that every Medicare beneficiary would be provided with the same consumer protection provisions that are allowed under State law.

My concern is that, if you do not have that, then you leave some who choose a PSO to, in effect, go through a Federal process which would be much more difficult, and I would respectfully suggest that that engenders a lot of confusion, potential confusion, among beneficiaries.

If some reasonable period were allowed--and I am talking about a reasonable period of time after the Federal standards for solvency are established--for the States to comply, then in effect you would get the States to certify immediately and you would obviate the problem, still being able to establish the financial standards for solvency at the Federal level that you seek to accomplish.

We will be discussing that in an amendment, I know, but I just wanted to make that concern known.

Senator Baucus. Mr. Chairman.

The Chairman. Senator Baucus.

Senator Baucus. Mr. Chairman, I want to ask on Item 16, the commissions, particularly the National Bipartisan Commission on the Future of Medicare.

How does that differ from the so-called National Bipartisan Commission on Social Security that I think was

established in 1983?

Senator Moynihan. 1982, I believe.

Senator Baucus. 1982. Thank you, Senator Moynihan, which you served on.

I am asking because, as I recall, and Senator Moynihan will know much more than I, I believe there were not only public sector, but there were private sector members on that commission.

Senator Moynihan. There were.

Senator Baucus. It is my belief, frankly, that that commission did a great job. That is, there were public and private sector people on that commission, bipartisan.

My concern is, looking at the composition of this commission, that it looks like it is not necessarily private sector people. In fact, it could well be no private sector people.

Ms. James. Well, the Social Security Commission was established by executive order in 1981 by President Reagan. Of the actual appointments to the commission, half of them were appointed by Congress, the others by the President.

I believe that there was actually a private sector appointee at that time, you are right, by Congress. This would allow that same flexibility in appointment, it would just be left to Congress to decide who could

actually be appointed. The mission of this commission is modeled after the 1981, 1982, 1983 commission. It concluded in 1983.

Senator Baucus. Was that a one-year commission, too?

Ms. James. At that time the executive order did establish a 12-month period. They received two extensions, actually, and that is why they completed in January of 1983.

Senator Baucus. I just believe there should be some indication here that there should be a significant number of private sector people on this commission in addition to members of the House and the Senate.

Ms. James. We attempted to leave flexibility for the leadership and not to overly direct the President in who his appointees may be, or Congress, in that regard.

Senator Baucus. I see that.

Ms. James. That is obviously left to them.

Senator Baucus. As I read it, all 15 members could be members of Congress.

Ms. James. That was actually a concern during the Social Security Commission, too.

Senator Baucus. It is my concern, too.

Ms. James. I think Mr. Sweeney was appointed by the Senate, along with, I think, Senator Moynihan at that

time.

Senator Baucus. Again, Mr. Chairman, I just think we should find some language some way to make sure that there is significant private sector participation.

The Chairman. Well, we will be happy to work with you on that.

Senator Baucus. Thank you.

The Chairman. I would point out that the bill language does provide for that.

Senator Baucus. Well, it allows it, but does not require it, at least in the description here.

Senator Moynihan. Could I say to my friend, Mr. Chairman, I think we should presume it and that we have a legislative record here that says that.

Senator Baucus. Right. Right.

The Chairman. Very good.

Shall we proceed?

Ms. James. All right. We are going to proceed with changes to the traditional Medicare system on page 5. The first section relates to PPS hospitals. This is the bulk of hospital payments under Medicare.

First, we establish a calendar year basis for hospital payments, moving from the current fiscal year basis, and then we adjust the update for 1998 by minus 2.5 percentage points, and then set it at minus one

percentage points for the rest of the 5-year budget window.

We reduce hospital payments for inpatient capital by 10 percent, and we provide that an adjustment be made for reimbursements for property taxes.

We amend current capital payments for capital asset sales to reflect sales price equal to book value. This is a provision that the administration suggested.

We apply the hospital transfer policy that applies when a patient is transferred from one hospital to another hospital to transfers to PPS-exempt hospitals, skilled nursing facilities, and home health facilities.

We adjust the disproportionate share payments to hospitals, we change the formula to better reflect actual uncompensated care being provided by hospitals, and we phase down the payments over the 5 years by about 4 percent a year.

We eliminate graduate medical education and disproportionate share add-on payments to outliers. These are the very expensive cases for which hospitals receive payment above the PPS amount.

We reduce bad debt payments to providers, Medicare reimbursement for bad debt, to 75 percent in 1998, 60 percent in 1999, and 50 percent in future years.

We increase payments for Puerto Rico's hospitals.

They have a different formula for payment and we make an adjustment to that formula.

We establish a permanent payment for hemophilia clotting factor so that that is paid separately from the PPS payment to a hospital when they treat a hemophilia patient.

Are there questions on the PPS hospital policies?

[No response]

The Chairman. If not, please proceed.

Ms. James. All right. On PPS-exempt hospitals, these are the hospitals that are currently reimbursed on a cost basis, subject to certain limits. There are a number of different types of hospitals, including rehabilitation, psychiatric, long-term care, cancer hospitals, and children's hospitals.

We call for the establishment of a PPS system--PPS means prospective payment--for rehabilitation hospitals, beginning in fiscal year 2001, and we also call for the necessary data to be collected so that the PPS system for long-term hospitals can be implemented.

We reduce the annual update for PPS-exempt hospitals by 1.5 percent points on average, although we give a higher update to the lower-reimbursed hospitals and a lower update to the higher-reimbursed facilities.

We reduce the incentive payments that currently are

given to PPS-exempt hospitals. Currently, to the extent that they come in under their target amounts, it is split 50/50 with the program, and we reduce that to 10 percent.

We change relief payments that are targeted to those facilities who have very, very low cost basis and, because of that, have trouble keeping their costs below their targets.

We reduce hospital capital payments for rehabilitation, long-term care, and psychiatric hospitals by 15 percent.

Then we make some changes in the cost limits for existing rehabilitation, long-term care, and psychiatric hospitals. We establish a floor of 50 percent of the national average and a maximum amount of the 90th percentile for each category.

Then we establish new payment criteria for establishing the basis for new facilities and we limit that so they do not exceed 130 percent of the national average.

Then we grandfather certain long-term care hospitals that were established prior to September 30, 1995 that were established within a hospital.

The Chairman. Any questions?

[No response]

The Chairman. If not, please proceed.

Ms. James. For graduate medical education payments, Medicare makes an additional payment to hospitals for each of the patients they treat for indirect medical education.

We slowly phase that amount down over 5 years and we establish, for direct medical education, which is the amount that Medicare reimburses per resident in a teaching hospital, a cap on the number of residents that qualify for direct medical education payments.

Then we have the payback of the amount of money that has been carved out from the payment rates to the private plans so that, again, when a teaching hospital treats a Medicare private plan patient, the amount that the teaching hospital gets paid for caring for the patient is negotiated with the plan, but there is an additional amount that Medicare will pay to compensate for the additional cost of medical education and disproportionate share.

Senator Breaux. Mr. Chairman?

The Chairman. Yes, Senator Breaux.

Senator Breaux. Is all this under the definition of micromanagement?

Senator Moynihan. Mr. Chairman, may I offer a suggestion?

The Chairman. Yes.

Senator Moynihan. As we bring HMOs into the Medicare system more and more, we would have to make provision for teaching hospitals because HMOs do not do that on their own.

Senator Breaux. Well, I agree with that.

The Chairman. Please proceed.

Ms. James. For hospital outpatient departments, we currently have a problem in the reimbursement for hospital outpatient department services where there is a flaw in the formula for determining reimbursement and, therefore, Medicare does not get offset, dollar for dollar, the amount that the beneficiary pays. This also has led to an increase in the percentage that the beneficiary actually pays in cost sharing.

We call for the establishment of a prospective payment system beginning in fiscal year 1999, and we also phase down that percentage that the beneficiaries pay for cost sharing.

At the top of page 8, hospice services. We make a number of improvements in the hospice program. Skilled nursing facilities. The proposal calls for the establishment of a prospective payment system for skilled nursing facilities.

This is something that the administration has worked with the industry on for a long time and this is ready to

begin to be transitioned in over a 4-year period, and it will be a per diem prospective payment system for skilled nursing facilities, so there will be a set amount paid per patient, per day.

On home health care, home health care has been growing since 1988 at an average annual rate of 37 percent. It is one of the, if not the, fastest-growing areas in Medicare. It is an open-ended benefit. It provides valuable services to beneficiaries, but the cost of the home health services has been escalating.

We have included a number of payment reforms here to try to stem that growth. We establish an interim payment system that was recommended by the administration for the period until the year 2000, and then call for a full prospective payment system for home health services to be implemented in the year 2000.

Senator Moseley-Braun. Mr. Chairman, may I?

The Chairman. Yes.

Senator Moseley-Braun. Ms. James, is it not a fact, though, that the home health care, even though the payments have escalated, is still a cost savings, particularly with regard to the long-term disabled, because those people then do not have to be institutionalized. Institutionalization costs are higher still than the amount that is being spent or paid for by

home health care.

Ms. James. I think there is no question that, to the extent that home health care can replace institutionalization, there is a savings.

Senator Moseley-Braun. Thank you. I just think that is important to say, as you talk about how fast the costs have been growing in this area.

Ms. James. Right.

We make a number of technical changes, such as requiring that payment be based on where the person resides and the services are delivered as opposed to where the agency is, so that if an urban agency is delivering services in a rural area, then the rural rate applies.

We eliminate periodic interim payments which were designed to improve the cash flow to agencies and we eliminate those with the establishment of the prospective payment system.

We also clarify the benefit and ask the Secretary to study and recommend appropriate home-bound criteria, for the definition of home-bound, which is what is required to get home health services.

Then, beginning in 1998, we define a Part A home health benefit, as well as a Part B home health benefit. For Part A, it will be home health visits up to 100

visits that follow a hospitalization. All other home health visits will be in Part B.

We phase this transition in over a 7-year period so that the benefits that are being shifted over to Part B are slowly being paid for by Part B over a 7-year period.

Then consistent with other Part B services, for the Part B benefits we establish a beneficiary cost sharing of $5 per visit. Agencies can bill this on a monthly basis, and it is capped at the amount of the annual hospital deductible.

So, in Part A, the patient has gone into the hospital, paid a deductible, and then gone home and can get up to 100 visits. On the Part B side, the patient has usually not been hospitalized so, to sort of even out both sides, we establish the out-of-pocket limit on the Part B side at the amount of the annual hospital deductible.

Then we also require that beneficiaries receive a Medicare explanation of benefits so they see the amount of services that they have received on home health.

Senator Nickles. Julie, we have the $5 co-pay or cost sharing for home health, which would be new, and I am assuming that right now you have a Federal program that is 100 percent paid for by the Federal Government, with no limits on visits, so you have a program that has

exploded in costs. I think in 1990 it was $4 billion, and now it is, what, $20 billion, in that neighborhood.

So did the committee consider, say, for home health visits for persons with incomes above 100 percent of poverty a 20 percent co-pay?

Ms. James. No, Senator, we did not consider any difference in cost sharing based on income.

Senator Nickles. I think it is something we should look at. I know it may not be the most popular, and correct me if I am wrong, but I believe this is the fastest-growing component of any entitlement program, certainly of Medicare, with the Federal Government paying 100 percent of it, no matter what the income level of an individual might be. The committee has courageously added the $5 co-pay, and it would have some impact, so I think that is to be commended.

But I think if you are really going to reform the system at some point, and I mention individuals with incomes above 100 percent of poverty. I am pulling that out, there may be a better level, but at some point we should have a co-pay.

Some people think that would be on the premium. I do not think so. I do not think charging people more premiums will impact the behavior. I think if you had a 20 percent co-payment for the benefit received, it would

have, possibly, a significant change in behavior.

So I mention that. Could maybe at least the committee or staff give me some information on what that would mean, dollar-wise?

Ms. James. We can try to find that out, yes.

Senator Nickles. Also make it possible for me to receive a lot of phone calls in the next 24 hours.

Ms. James. All right.

The Chairman. All right. Do you want to proceed, Julie?

Ms. James. Yes.

The Chairman's mark includes three new categories of preventive benefits for coverage under Medicare. The first, is to expand mammography screening to allow payment for annual mammograms for women over the age of 40; the second is to allow payment for colo-rectal cancer screening, and we leave the decisions as to what procedures and the frequency, et cetera, of those procedures to the Secretary, in consultation with experts in the field.

Senator Moseley-Braun. With regard to the mammography screening, we had raised the issue that there is a co-payment associated with that which will just impact negatively on those at the bottom of the income scale. If Senator Nickles' point is well taken regarding

having the ability to pay factor in this, I am afraid that the proposal, without having some waiver on that co-payment, is just going to make it less likely that poor women will get mammographies. I do not think that is the direction in which we want to head.

Ms. James. Yes. For all of these services, for the lowest income, of course, Medicaid will pay the cost sharing for those people, for the cost sharing on these preventive services for those that are under 100 percent of poverty and are qualified Medicare beneficiaries in the Medicaid program. So the lowest income are taken care of in terms of the co-pays.

Senator Moseley-Braun. But the working poor would have to come up with----

Ms. James. Above 100 percent of poverty, the co-pay would apply. But 90 percent of people, however, would have supplemental coverage that covers those.

Senator Moseley-Braun. Again, I think that, if anything, we ought to take a look at that. For those people, for the working poor women who need mammographies, this is the group that is most at risk.

I just think we ought to be able to do a little better in terms of not requiring people who cannot afford it to have to make the co-payment in this case.

The Chairman. Please proceed.

Ms. James. All right.

The third is a new diabetes self-management benefit that would provide payment for self-management education for diabetics, as well as pay for certain equipment that they need.

On physicians and other health professionals, we implement a single conversion factor for the physician fee schedule known as the RBRVS fee schedule.

There are currently three different conversion factors, which is the determinant of how much you get paid for a procedure. We combine those into one, beginning in January 1998, and we also revised the formula for determining how much of an update----

The Chairman. I ask that the room be in order. Julie is entitled to be heard.

Ms. James. We revised the system for determining the update each year that physicians will receive on their Medicare payments.

Then we provide for a 4-year transition period for the issue known as the practice expense component of the fee schedule. This is to determine the overhead costs, if you will, that are incorporated into the fees that are paid to physicians.

This is to go into effect in January of 1998, 100 percent into effect, under current law. Because of the

size of the impact, especially on some types of specialties, we allow for a 4-year transition to mitigate the impact of the changes.

Senator Nickles. Julie, you do not change the recommendations on reimbursement, say, for specialties, you just delayed the impact or phased the impact in over 4 years.

Ms. James. That is correct. But we begin with a very small step of just taking 10 percent of the amount of money that would be reallocated and do that in January of 1998 so that there is time to further refine the information that is available in terms of this. We have called for a GAO study of this.

Dr. Vachon. There is a requirement for a very thorough GAO study of the entire methodology and the data that is used to underlie the administration's proposed revision of practice expenses. That will be done within 6 months.

Senator Nickles. I have not quite understood. So we have time for additional study, we are asking GAO to study it? Some of the reallocation, I guess, or some of the changes on specialties were very significant.

Dr. Vachon. In the first year they are very modest and we have data simulations done by HCFA, and we can provide those to your staff.

Senator Nickles. No. My question is, are you planning on phasing it in as the proposal was, or are we going to have a chance to revise the proposal for, say, heart surgeons, neurosurgeons, and some of those? Some of the changes were pretty draconian.

Dr. Vachon. By doing a special rule for 1998, doing 10 percent of the redistribution, that effectively gives us a year or year and a half to thoroughly study this matter and revisit it before any major revisions are effected.

Senator Nickles. All right. So in this bill we are now moving down a path that automatically assumes that we are going to do everything in the original proposal.

Dr. Vachon. No, sir.

Senator Nickles. So you are saying 10 percent, then we will have a chance to have an additional study on it.

Dr. Vachon. The bill specifically calls for a thorough GAO study, as well as required consultation by the Secretary with physician organizations.

Senator Nickles. And we are not marching down a path that is irrevocable, accepting the recommendation of a year ago that a lot of people was on not very good data.

Dr. Vachon. Not at all, sir.

The Chairman. You want to proceed, Julie?

Ms. James. We also include a provision that has been reported out of this committee many times to provide expanded direct reimbursement for nurse practitioners and physician assistants.

On laboratories, we reduced the annual updates by 2 percentage points and slightly reduced the cap on the payment amounts. We also called for specialized carriers to process laboratory claims similar to what has been done for durable medical equipment.

On durable medical equipment, we also reduced the annual inflation update by 2 percent points each year for the 5 years and we reduced the payments for home oxygen by 25 percent in 1998, and an additional 12.5 percent in 1999. This conforms to information that we received from a study by GAO.

Senator Graham. Mr. Chairman.

The Chairman. Bob.

Senator Graham. I just want to state again, as I said during the workshop session, I think that these recommendations on durable medical equipment, in light of the facts that we have before us, are extremely timid.

The reality is that the General Accounting Office, others who have looked at this issue as recently as last weekend, a major national television program, have focused on the gross overpayment by Medicare in this

category.

Just to say that our response is to reduce the inflation rate by 2 percentage points I think is woefully deficient, and refocuses the fact that we, Congress, are the ones responsible for these egregious overpayments.

So I would hope that when we come back to the amendment section, that we will have some more aggressive proposals to make in this area, which is a significant area of overpayment and abuse.

Senator Baucus. Mr. Chairman?

The Chairman. Senator Baucus.

Senator Baucus. Mr. Chairman, I have some of the same views as the Senator from Florida. I might ask the staff how they arrived at this figure. Obviously the staff was aware of these charges, that these suppliers had been overcharging Medicare, and I am just curious how the staff dealt with those charges, how much they looked into the charges, and how the staff came up with this 2 percent figure.

Dr. Vachon. On the 2 percent figure, the Health Care Financing Administration has an ongoing study, whose results we are waiting, on charges for durable medical equipment. They call it in here a reasonable study. I believe they may want to address that question directly. They have been looking at the top 100 items for DME.

Specifically, some of the issues in the 20/20 piece you are referring to, Senator, I understand have been resolved, for example, the wound care situation. But, clearly, there is a serious issue regarding how Medicare can be a prudent payor, can more accurately get prices, and be a more flexible purchaser. That is something that will require further recommendations.

Senator Baucus. I see Dr. Vladeck is here. I might ask what HCFA is doing on this ongoing study.

Dr. Vladeck. Well, we are trying to determine appropriate market prices, sir, for approximately 100 high-volume items of durable medical equipment and supplies, and the preliminary findings are, frankly, that our payments, as set by statutory formula, are all over the lot.

In almost no instance are they below market value, but in many instances they are relatively close to what a competitive market might provide. In other instances, they are as much as 2 or 3 times as much as another purchaser could purchase on a wholesale basis.

We are still refining some of that information. But, again, each of those items currently has a price set by statutory formula.

The Chairman. When do you expect that study to be completed?

Dr. Vladeck. I think the next 60 to 90 days.

Senator Baucus. I would think we would take advantage of this study somehow, because I think Senator Graham is onto something here. I think it would be foolish for us not to take advantage of this opportunity to try to address it.

Dr. Vachon. Senator, may I make the point also that in the Chairman's mark there is a provision to give the administration some additional flexibility in adjusting prices where there is evidence either of grossly deficient payments of grossly excessive payments, and we think that will address the issue, in light of the kind of data that HCFA is now collecting as well.

Senator Graham. The trouble with that is, that treats as if this were an aberration, that every once in a while there is a gross overpayment. The fact is, this is not an aberration, this is a consistent, systemic issue and a license to receive payments at above the market rate because we have arbitrarily set that to be the price list.

I think that we need to aggressively pursue this area and do it now while we have the matter before us, rather than wait for another 5 years when we will be back at this again with billions of excessive payments having been made in the interim.

The Chairman. Well, I would suggest that staff, with you, Bruce, and representatives of yours, get together and see if any further recommendations can be made on this matter.

Senator Kerrey. Mr. Chairman?

The Chairman. Yes.

Senator Kerrey. May I just make the point here that I really think this underscores the need for the amendment that I know Senator Breaux and others are going to offer later to establish in law an office of competition in HCFA, authorizing HCFA as well to use a much more competitive bidding process to determine what the price is going to be.

It is going to be awfully difficult, it seems to me, if we maintain a price list of goods and services that we are willing to pay out, for us to come in and make a determination with GAO and other sorts of studies evaluating it.

I mean, can you imagine if we were building our highway system with a price for every single thing and we were paying out contractors throughout the country?

The Chairman. I have to say that I agree that price and wage controls are not very effective.

But we will proceed. Ms. James?

Ms. James. Yes. We also do a similar policy for

ambulance services and ambulatory surgical centers. Then we provide new payment rules for the few outpatient drugs that Medicare covers. The Part B premium is extended at 25 percent. The 25 percent level is due to expire in 1999.

Then we have a rural package that has policies that support sole community hospitals. We reinstate Medicare-dependent hospitals. We expand the ICRCH program for critical access facilities. We grandfather rural referral centers and apply certain policies to help them.

We reform payments to rural health clinics and we establish reimbursement for telemedicine or telehealth services in rural areas that are designated as health professional shortage areas.

Other proposals include permanently extending the secondary payor authority, where Medicare pays secondary to private coverage for beneficiaries who have private group coverage, and we increase the length of time for secondary payor for end-stage renal disease patients to 30 months.

We clarify certain policies regarding the time and filing limits for going back and trying to reconcile the secondary payor issues. We include a number of anti-fraud and abuse provisions, including additional authority for exclusion and civil monetary penalties, and

improvements in program integrity, including requiring surety bonds, requiring the provision of identification numbers, et cetera.

Then we also require that skilled nursing facilities submit all bills for Part B Medicare services for patients that are in those facilities.

Finally, we have two provisions that are intended to address the long-term problems of the Medicare trust fund. The first, is to conform the eligibility age for Medicare to that for Social Security, which slowly phases up to age 67 in the year 2027.

We extend the Medicare Hospital Insurance tax to all State and local employees. Those hired before April 1986, at the discretion of the local or State government, may be exempt from that tax. About 98 or 99 percent of those people do end up qualifying for Medicare coverage.

Mr. Chairman, that concludes the Medicare portion.

The Chairman. All right. We will proceed, then, with Medicaid.

Senator Moynihan. Well done.

The Chairman. She is not off the hook yet.

[Laughter]

Senator Nickles. Mr. Chairman, do we have two votes right now?

The Chairman. Oh, we do right now?

Senator Nickles. I think we do.

Senator Moynihan. Yes, we do.

Senator Nickles. We have two votes, I believe, starting at 12:00, just for your information.

The Chairman. Well, this may be a good time to break then. Then we are going to have the caucuses on both sides of the aisle. So come back here, I would like to say, at 2:00. For how long do the caucuses go on?

Senator Nickles. Until 2:00, and I think the Democrats go until 2:15.

The Chairman. 2:15. All right. Well, we will come back here at 2:15 then. The committee is in recess.

[Whereupon, at 12:05 p.m., the meeting was recessed.]

AFTERNOON SESSION

[Time noted: 2:40 p.m.]

The Chairman. The committee will please be in order. Julie, I would ask you now to proceed with the Medicaid provisions.

Ms. James. We are now on page 13 of the summary document, the June 16 summary document.

The Medicaid program, the instructions to the committee are to achieve $13.6 billion in savings over the five-year period, and his package does meet those requirements. The Medicaid package has been put together around the following principals: First, to enhance the ability of State and the Federal Government to meet the health care needs of vulnerable populations, to slow the growth of spending on Medicaid, to improvement management of the program, and coupled with the child health initiative to increase access to health care coverage for children by building on existing relationships between the States and the Federal Government.

There is a package of flexibility reforms for the Medicaid program. The first is to allow mandatory managed care without waivers as part of this. This is for all but the dual eligible population, those that are eligible for both Medicare and Medicaid.

Many of the requirements that are currently barriers to managed care for Medicaid would be removed, such as the 75/25 provision that requires a certain amount of commercial enrollment, et cetera.

The threshold for Federal review of contracts has changed from $100,000 to a million dollars. States would be allowed to use primary care case management without a waiver. And there are certain quality standards related to managed care that are included in the mark.

Second is repeal of the Boren amendment that relates to provide payment rates. These provider payment issues will now be determined by the States and there will be no Federal right of action for providers. And States must provide public notice of their payment rates and the methods used to achieve those rates in their State plan.

Senator Rockefeller. Mr. Chairman, just a question to Julie. In the last question you were talking about mandatory managed care without waivers. At one point in this process there were not protections for consumers. It seemed to me that you mentioned it just now. Has that just been put in.

Ms. James. There are consumer protections.

Senator Rockefeller. There are protections as

you just --

Ms. James. Yes, and they are outlined in more detail in the modification document that was handed out today.

Senator Rockefeller. All right.

Ms. James. All right.

Senator Rockefeller. Thank you.

Ms. James. The third flexibility provision is to allow Medicaid rates to apply as far as cost sharing requirements for those people who are eligible for both Medicaid and Medicare. And those are referred to as the qualified Medicare beneficiaries. So that Medicaid rates could be considered payment in full.

Fourth is that States could enter into selective contracts with providers without the need for a waiver.

Now the bulk of the savings in the Medicaid package come from changes in the allotments for disproportionate share payments to hospitals. We make a number of changes by imposing freezes, making some gradual reductions and reducing the amount of dish money that's claimed for mental health services. And we also restrict payments for institutes for mental disease.

On expansion of Medicaid eligibility, the states would have the option, I'm sorry, to allow disabled SSI

beneficiaries with incomes up to 250 percent of the Federal poverty level to buy into Medicaid on a sliding-scale basis.

We also include in the Medicaid package the option for the pace program. This is the program that addresses the needs of the frail elderly which was also described in the Medicare section. So this is a program that tries to coordinate care under both Medicare and Medicaid for frail elderly beneficiaries.

Items 8, 9, 10, and 11 are administrative simplifications of requirements in the Medicaid program that have not proven to be effective. And these were all suggested by the Administration.

And then item number 12 on page 15 relates to cost sharing. States would be permitted to establish cost-sharing amounts for benefits for those populations who are not required to be covered under Federal law. So for the mandatory populations the populations that are required to be covered under current law, there would be no cost sharing, but it would be allowed for those populations that are covered at the States' option.

Senator Nickles. Julie, that is just current law as it exists today? Some proposals are to expand Medicaid coverage with this, for example, on children?

Ms. James. Correct. Cost sharing would be

allowed unless it is one of the populations that is mandated to be covered under Medicaid.

Senator Nickles. Under present law?

Ms. James. Correct.

Senator Nickles. But if that present law was expanded, that coverage would --

Ms. James. This would conform to that, yes. If it was going to be expanded as a mandatory population.

Senator Nickles. Is there a limit on the cost sharing?

Ms. James. Yes, there are limits.

Senator Nickles. Limits of a percentage?

Ms. James. As far as the percentage of income.

Senator Nickles. No, is there a limit on the cost sharing?

Ms. James. There is a total annual limit on the amount of cost sharing that a family would have to bear.

Senator Nickles. Is there a percentage?

Mr. Smith. Senator, there would be a limit of 3 percent of the family income for those, I believe, up to 150 percent of poverty and a limit to 5 percent of total income --

Senator Nickles. What about as far as percentage of the cost?

Ms. James. It is up to the State.

Mr. Smith. That would be an annual limit.

Senator Nickles. I understand that, but the State could set a cost sharing of 20 percent --

Ms. James. The State would determine --

Senator Nickles. -- or up to 25 percent?

Ms. James. Exactly. The State would determine how to set those cost sharing.

Senator Nickles. Up to 50 percent the State would have that option.

Ms. James. As long as they did not exceed the limits for a family, yes.

Senator Nickles. I understand. Thank you.

Ms. James. Number 13 amends a provision that was in the Health Insurance Portability and Accountability Act last year that relates to criminal penalties for asset divestiture in order to qualify for Medicaid. This clarifies that that provision was intended to address those individuals who assist people in divesting of their assets solely to qualify for Medicaid.

Senator Chafee. What about the people themselves who do it? Who do the divesting?

Ms. James. There are already procedures on the books for people who divest their assets and then

report to the State.

Senator Chafee. They would be ineligible for --

Ms. James. Right. Right. So they are ineligible for a period of time.

Senator Chafee. Thank you.

Ms. James. And number 14 is a study on early periodic screening, diagnosis, and treatment. Services, this is an area where there have been some concerns expressed about this is implemented and we've called on the secretary you consult with other interested parties and study what the effects of this provision have been.

Senator Rockefeller. Julie, there is some -- Mr. Chairman, I apologize. There are some governors that would like to see this happen so that in fact, you know, that program will disappear the EPSDT. And this is just simply a benign study; is that what it is?

Ms. James. Yes, Senator.

Senator Rockefeller. It has nothing behind it?

Ms. James. No, it's simply a study.

The Chairman. Please proceed.

Ms. James. Number 15 is increasing the Federal matching percentage for the District of Columbia. That percent is currently 50 percent. This increases it to 60 percent for a period of three years, through fiscal

year 2000.

Number 16 there are currently caps on the amount of Medicaid spending for the territories and this provision raises those caps.

Senator Kerrey. Can you explain this Federal matching for the District, is that essentially an Administration proposal? Is that rationalization? We have a distressed area here and there is a need to increase the Federal match as a consequence; is that the rationalization being used?

Mr. Smith. Yes. Senator, the Administration originally proposed a 70-percent Federal match through the five-year period of time. This does not go that far, but the rationale is that the District is facing financial constraints and it is a way of --

Senator Kerrey. So let us say a recession hits one part of the country or a community is particularly ravaged by some natural disaster or some sort of thing and they experience prolonged difficulty with their budget, does this establish a precedent for us to be doing similar sorts of things in the future for other communities? Or is this just something that were going to do because we've got an unusual situation with the District?

I mean, do we establish any kind of thing in this

proposal that enables us to defend against doing this across the board for other communities that are distressed?

Dr. Vladeck. Senator, if I can speak to that because of the Administration proposal. Under current law States which participate in the Medicaid program may require county or local governments to share the cost of the State's share, but in no instance may they require a municipality or a county or locality to pay more than 60 percent of the State's share. Thus any other city in the United States would only be required to pay up to 30 percent of the Medicaid costs for its residents.

The District of Columbia--because of its special status--is the only city in the United States that is required from city-derived revenue to pay more than 30 percent of--under current law--its Medicaid costs in the city and that was the logic by which the President's budget recommending reducing the District's share to 30 percent.

Senator Kerrey. But you understand what I am asking. I mean, there could be other communities outside the District that could come now and make a special case that they, as well, are suffering financial problems and ask for additional match, is

that yes or no?

Dr. Vladeck. Well, again, the underlying logic is not connected to the particular short-term financial distress of the District that we proposed it as a permanent change. But rather to the fact that its unique status as a city which is a State for purposes of the Medicaid program requires it to bear a higher share of Medicaid costs than any other city government in the United States, and that is how the 70/30 match was arrived at.

Senator Nickles. If I might follow up on that, the same question. The District's Federal share right now is what?

Dr. Vladeck. It is 50 percent.

Senator Nickles. And if it was treated like a State would it be 50 percent?

Dr. Vladeck. Yes, it would.

Senator Nickles. Under eligibility standards? So this is basically a gift to the District of Columbia of $300 million over five years?

Dr. Vladeck. Well, again, it is a recognition, we believe, of the unique status of the District of Columbia as both a city and a quasi-State for purposes of portions of the Social Security Act.

Senator Nickles. Thank you.

The Chairman. Please proceed.

Ms. James. That concludes the Medicaid section and we now move on to the child health initiative and there are obviously overlaps here. And beginning on page 16 the budget resolution calls for $16 billion to be invested in expanding coverage for children.

We have two provisions that relate to Medicaid that would affect the spending towards $16 billion. The first is to allow States to have full, continuous 12-month coverage so that when somebody is enrolled, say, in an HMO they are just automatically covered for 12 months.

The second is the increase in Medicaid enrollment that would occur as a result of outreach activities. And those two together are about $1.4 billion.

Then as far as this child health initiative there would be a condition, first of all, that for States to participate in this initiative they would have to cover the current older children who are being phased in under current law. So that would be a condition of participation.

And then States would have the option to choose between two different ways to tap this money. The first would be they could choose a capped grant that they could use, and the second would be to use through

an enhanced Federal match to expand their Medicaid program.

Each State would be allocated an amount of money that would be based on the number of children in the State under 200 percent of poverty in relation to the nation. Both options would have the identical State matching requirement.

In the Chairman's mark proposes the current Federal Medicaid match plus 15 percentage points. So that if the current Federal match were 50 percent for this program the States would get 65 percent Federal match. If the current State match were 72 percent the enhanced match would be 87 percent and there is a limit of 90 percent.

Senator Nickles. Could we go through that again? Previously the enhanced--as it was discussed, I guess, a few days ago--was 30 percent enhanced?

Ms. James. It was 30 percent of your Federal amount so that, if you had 50 percent, an additional 30 percent would put you at 65.

Senator Nickles. And now you are proposing?

Ms. James. Well, now we are proposing just 15 percentage points be added onto what your Federal match is, instead of the 30 percent.

Senator Nickles. And so I am not wanting to

debate it, I am wanting to understand it. So you are saying for Medicaid population, if it is 50 percent for those kids, for those families, it would still be 50 percent. But for the eligibility we are trying to encourage, it would be 50 percent plus 15?

Ms. James. Correct.

Senator Nickles. Or 70 percent would be 85?

Ms. James. Correct.

Senator Nickles. So we want a more generous Federal match for families that make more money than Medicaid eligible?

Ms. James. Senator, since these are optional programs, under current law, States can already expand. So this is a way to provide an incentive. That is the rationale behind it.

Senator Nickles. Thank you.

Ms. James. On use of funds the States, if the States choose the capped, block-grant approach they would have to provide coverage to children that is equivalent in terms of health insurance coverage to a level equal to the Federal Employees' Health Benefit package that is available in the State. And that would be certified by the Secretary to meet those levels.

Senator Moynihan. Julie, you are now on this provision just out and that is option one of your --

Ms. James. That is correct, Senator.

And if the State chooses the Medicaid option they would get the enhanced match and get the enhanced match for an expansion of their Medicaid up to the amount that would meet their allotment.

Now, both programs also called that one percent of the funds be set aside for outreach activities.

Senator Chafee. Julie, I have a couple of questions, if I might, Mr. Chairman.

The Chairman. Yes, go ahead.

Senator Chafee. I do not seen in here that there is a limitation as far as poverty level for assistance to take under the use of the funds, understand number six here, using the cap grant. Is there a poverty requirement of any type?

Ms. James. No, Senator, because each State would have to -- if they chose to do the Medicaid expansion, they would have to negotiate with the Secretary how much they could expand within their allotment.

Senator Chafee. Yes, that is the Medicaid expansion.

Ms. James. Correct.

Senator Chafee. But suppose they go the block grant route?

Ms. James. Oh, I am sorry, Senator. Then they

could provide coverage for children up to 200 percent of poverty.

Senator Chafee. Well, you do not say that. Are you sure you are right on that? You talk about the allotment of 200, that is how you figure the allotment, but you do not say that it has got to cover -- that is just in the calculation.

Ms. James. I apologize, Senator. If you look at the modification that we handed out today on page 6, it says, about two-thirds of the way down the page, "that States choosing the block grant option will receive their allotment in the form of a block grant to be used for health insurance coverage for children up to 200 percent of poverty. And lower-income children must be served first.'''

Senator Chafee. Now, what about the benefit package for the low-income children? You mentioned that it is all right if they do the FEHPB, but that has a whole series of deductibles and co-payments.

Ms. James. Well, it would have to be equal in value to what is offered. We left it flexible enough so that the States could construct a package that would suit the needs of the population that they are trying to reach. So the State would have some flexibility. But within what is called the actuarial value of the

package in terms of the comprehensiveness and the amount of cost sharing, that would have to be consistent with what is a typical FEHBP package.

Senator Chafee. And I appreciate that, but I do not want to beat this to death, but I just want to get an answer so that I understand it.

If the state uses the cap grant or the grant approach they can provide -- if they have a level of benefits equal to the FEHBP that is all right. Is it? Or is it not?

Ms. James. It is subject to approval by the Secretary.

Senator Chafee. Well, I do not see that here that it is subject to approval of the Secretary. So you could well have substantial deductibles and co-payments if the governor so wanted?

Ms. James. I am sorry, Senator, on the bottom of page 6, again, it says, "The Secretary will certify that the coverage meets this test.'''

Senator Chafee. You have too many sheets of paper for me, Julie.

Ms. James. I know, it was late.

Senator Chafee. At least I got you working nights, though.

[Laughter.]

Senator Gramm. Mr. Chairman?

The Chairman. Yes, sir.

Senator Gramm. Mr. Chairman?

The Chairman. Yes, Senator Gramm.

Senator Gramm. Mr. Chairman, I would like to remind my colleagues that the Governors have asked for the ability to use co-payments. And what we have done here in raising -- in dealing with concerns such as Senator Graham of Florida raised is that we have set out an objective criterion for what has to be covered, the equivalent of the package available to Federal employees, one of the best and most generous health care packages available to people who actually purchase their health insurance.

We have set out a provision now where the Secretary has to certify that the money is used for the purpose that we set it out to be used for, that it meets the standards that they have set out, that it provides the benefit package consistent with the test, and we are now down to a point where we have a defined benefit package defined by standards of people who are currently using health care in these income categories, 50 percent of the people between 150 percent and 200 percent of poverty are buying private health insurance. So this benefit will be at least as good as what they

are getting.

And so it seems to me, Mr. Chairman, that your final proposal here basically answers each of the questions that have been raised while preserving the ability of States who believe that Medicaid can do it better to do it through Medicaid. And if they believe as the State of Tennessee did, when it withdrew from Medicaid, that they could do it better, then we have these guidelines to guarantee that the money as Senator Breaux said is not going to be used to buy vans, that it is for insurance coverage, not building or maintaining hospitals or health clinics. So I think you have done an excellent job.

I would just like to get clarification on one thing, Julie, because either I do not understand or Senator Nickles and I heard it differently. Under the original proposal by Senator Chafee, there was a 30 percent enhancement of the Federal share to induce people to induce States to provide this coverage. We have now lowered that to a 15 percent enhancement.

Ms. James. No, Senator.

Senator Gramm. All right.

Ms. James. We have changed it from a percentage of your Federal match to just say whatever your current Federal match is, you add 15 percentage points so that

it is equal to 30 percent if you are at the 50 percent match level. It would be less than 30 percent as you go up.

So that if you are at 80 percent right -- I am sorry, 70 percent right now, your Federal match level, then the match would be 85 percent under the enhanced match.

Senator Gramm. All right. Thank you.

Senator Rockefeller. Mr. Chairman, I just have one question.

The Chairman. Senator Rockefeller.

Senator Rockefeller. I was just going to follow along with what Senator Chafee was saying to Julie. The block, as I understand it, the block grant as opposed to the Medicaid approach and they are still split, you go one way, or you go the other. You have a $200-a-year deductible for in-patient, 200 out-patient surgery and tests, 200 out-patient therapies, 2,000 annual limit on all co-insurance combined, and I am trying to figure in my head if that is an average family at 133 percent of poverty, that is 10 percent of their entire income.

Ms. James. Well, again, Senator, we have left flexibility to the Governors to be able, depending on the target population that they need to reach in their

state to devise a package that is in general actuarially equivalent. It does not mean they have to have exactly the same cost-sharing amounts, and it also depends on how they structure it as to whether or not you are in a HMO where you would have very little cost sharing versus whether they have it in a more open maybe PPO or something else where there could be greater cost sharing.

So the flexibility is left to the Governors, but they do have to correspond in the average value of the package in comprehensiveness --

Senator Rockefeller. That I understand.

Ms. James. -- to be consistent with the Federal package.

Senator Rockefeller. It is the point that Senator Chafee was raising about the deductibles, that part, that I was also pursuing because it is fairly specific, I think written down here. It is potentially $2,600.

Ms. James. But I'm not quite sure, are you quoting --

Senator Rockefeller. In the FEHPB.

Ms. James. -- what one of the FEHBP plan --

Senator Rockefeller. Right. Right.

Ms. James. -- cost sharing is?

Senator Rockefeller. Right. That is if there is just one child sick.

Senator Gramm. Yes, but it is the average --

Ms. James. Right. But we are not -- there is no -- Governors do not have to do that. I mean, they could choose to use HMOs to enroll all of their populations and have an equivalent package to an FEHBP package that has very little cost sharing.

I mean, there are Federal packages now with very small cost sharing. An it is, again, the Secretary has the ultimate authority to determine whether or not this is a reasonable package that corresponds to what FEHBP coverage would be to reach the target population in the State.

Senator Rockefeller. Thank you.

The Chairman. Senator Breaux.

Senator Breaux. Sorry I was late, Mr. Chairman. I would just like to ask Julie some questions. I think that for many of us who strongly support the Rockefeller-Chafee concept of trying to insure more children and at the same time to do it in a way that makes sense were concerned that a complete block grant to the States for $16 billion, we are talking about a significant amount of money. And the budget agreement says that it is to provide more health insurance for

children who do not have health insurance.

The concern that I have had is how do we do that with the States and yet at the same time guarantee that that is what it is going to be spent for. And my concern, as Senator Gramm pointed out, is I do not want this money to go to the States to allow them gain the system and to use it for purposes other than taking care of children who do not have health insurance.

And so what I am trying to understand is the option that is in the mark now. It seems to be significantly changed in a sense that the Secretary, I assume HHS Secretary, would have to take a look at what the State is proposing to do with that money in order to be able to certify that these criteria are being met. And I have a couple of questions, I guess.

The question is, is it the intent of the draft to require that certification? Suppose the Secretary gets this plan from Florida, or from Louisiana, or from West Virginia, and says this does not meet the criteria. Does not guarantee that more children will be receiving health insurance and I am not going to certify it, and she does not certify it because it does not meet that criteria, I would presume that that means what?

Ms. James. The proposal does require that the Secretary certify it. So the Secretary would have to

continue working with the State until they could work out that the standards were indeed met.

Senator Breaux. But until the Secretary certifies it --

Ms. James. There is no money.

Senator Breaux. -- the block grant cannot go forward?

Ms. James. That is correct.

Senator Breaux. Now, Senator Rockefeller was raising the question again of the Federal employees' health benefit plan and I know this is not statutory language, it is just a concept, so it is not hard to figure out exactly what we mean. Does it mean that they have to enact a plan that is the same standards of the Federal employees' health benefit plan? Or what do we mean when we say consistent with? I mean, how consistent with?

I mean, I think Senator Rockefeller raised some good questions about the premiums and everything else. It has to be exactly like that or is it patterned after that? What do we mean by that language?

Ms. James. It is more in the concept of actuarial equivalence in that you have a set of benefits that is similarly comprehensive to what is offered under a Federal plan.

It does not have to be exactly, and because these will be plans that are targeted to children they may very well have a little bit different benefit structure than you might have for a plan under FEHBP that serves a whole population and all ages.

Senator Breaux. How much of the directive will be in the actual statutory language that will be instructions to the State that these new monies would be used for children for health insurance for children?

Ms. James. Well, Senator there will be language that specifies that. I do not know how much further I can say right now about how specific it would be.

Under both options -- under both the block grant option the money must be spent for coverage for children. And under the Medicaid option the additional funds flowing to the State, if a State has already covered children up to 133 percent of poverty and they would now be getting an enhanced match, that money has to be used for additional coverage for children.

So there are requirements the money is being used to cover children.

Senator Breaux. My final question is, will the language that will be submitted when it is statutory language be strong enough to prevent that States would not be able to use the new funds that would be coming

to them to substitute other spending programs unrelated to children's health or to be used as part of their matching fund perhaps to get other monies from the Medicaid program?

Ms. James. That is the intent, that it not be used for anything else.

Senator Breaux. But I mean -- and I presume that you are saying the language will be there that will -- when a Governor gets that pot of money that he is not going to be able to use it to substitute or to make up his matches to get his Federal share.

Ms. James. That is right.

Senator Breaux. Okay. I thank the staff.

The Chairman. There is a vote going on, so I think we better recess for that purpose. I ask the members to please return directly because I intend to continue as quickly as possible.

[Recess at 3:10 p.m. to vote.]

AFTER RECESS [Time noted: 3:34 p.m.]

The Chairman. The committee will please be in order.

Julie, will you please proceed.

Ms. James. We were answering questions on the

child health care.

The Chairman. That is right. Yes, that is correct. Yes.

Do we have any more questions on children's health care?

Senator Breaux. Mr. Chairman, I think from our side I think Senator Gramm is coming back and he wanted to ask some questions. Yes, Senator Gramm had mentioned he wanted to ask some questions.

The Chairman. Why do we not continue with the review of the markup and as soon as he comes in then we will reopen it for his --

Senator Nickles. Mr. Chairman?

The Chairman. Yes.

Senator Bryan. Mr. Chairman, would it be appropriate to -- I would yield to Senator Nickles if he had a --

Senator Nickles. No, go ahead.

Senator Bryan. I was going to ask a question relevant to what we were discussing right before the break if that is appropriate at this time.

My question simply dealt with which of the two options that we are considering provides additional coverage for those who are currently uninsured? If that answer has already been given, I will get it from

the record. If it has not been asked, it seems to me that it is an appropriate question.

Senator Rockefeller. I would be happy to answer that question.

[Laughter.]

Senator Bryan. Could I get the staff first? I always want to hear it --

The Chairman. Julie, do you want to comment?

Senator Bryan. -- from my friend from West Virginia.

Ms. James. Senator we do not have estimates on either proposal as far as the coverage is concerned.

Senator Bryan. Will those estimates be available before the crucial time that we have the make a decision, or is that something that is over the horizon?

Ms. James. We have been working with CBO. I cannot guarantee you that we would have them.

Senator Moynihan. Well, may I ask Julie, Mr. Chairman? We know now what the average Medicaid expenditure per youth is, and we know how much money we are allocating to this new program, so we have some range of estimate about how many persons $1,000 into 16 billion equals something in that mode, Mr. Vladeck?

Dr. Vladeck. That is the way we have done some

of our estimates, yes, sir. About a thousand bucks a kid per year, total expense.

Senator Moynihan. How much, sir?

Dr. Vladeck. Except for very seriously ill kids --

Senator Moynihan. Yeah.

Dr. Vladeck. -- an insurance premium of about $1,000 --

Senator Moynihan. About $1,000.

Dr. Vladeck. -- per year buys a pretty good policy.

Senator Moynihan. And you have 16, so that gives you 1.6 million people?

Dr. Vladeck. That is a five-year number, so it is about $3 billion a year. And if it was 100 percent Federal dollars.

Senator Moynihan. Three billion would be three million.

Dr. Vladeck. Pardon?

Senator Moynihan. Three billion would get you three million at a thousand each. So you may be somewhere -- I do not want to confuse this, but maybe three million persons is what -- is a range, would you agree?

Dr. Vladeck. Again, part of the issue -- there

are two issues, one is how much is contributed by the States or by the families as premium or co-payments. But second what has concerned CBO is depending on what arrangement you undertake how many folks who now have private health insurance would end up being covered under the new program without a net increase in the number of kids being served and that is what all the argument is about estimates from these proposals are coming from.

The Chairman. Julie, do you want to --

Ms. James. Well, that is the point that I was going the make. Number one, this is an option, so certain assumptions have to be made about which states will choose to participate. And then it is not simply coverage for kids who are currently uninsured, but there is a certain amount of overlap that needs to be taken into account.

Senator Chafee. I might say, the CBO in doing the House provision says that a block grant will only provide insurance to about 380,000 new children. So that is what they say -- the CBO says about the House version of a block grant, 380,000.

The Chairman. Well, I do not think you can have a figure --

Ms. James. Senator, just if I may, I had a brief

conversation with CBO earlier about this. The way the block grant is structured on the House side, the money can be used to provide health care services, as well as coverage to children, and that affected their score in terms of how much would be spent on actual insurance coverage and so they cautioned about -- they cautioned me about looking at that figure.

Our proposal is different than the block grant proposal on the House side because we do not allow the funds to be expended for just providing services. It needs to be coverage -- insurance coverage.

Senator Chafee. It is the only score we have got.

Ms. James. Senator, I understand that.

The Chairman. Senator Nickles?

Senator Nickles. Mr. Chairman, just to note, just to let Senator Chafee know the Commerce Committee was saying that they were totalling new kids brought into their program, two and a half million Medicaid. Well, added altogether they say 3.775, almost 3.8 million kids. But I have a couple of other questions. I do not want to debate that. This came from the Commerce Committee, not me.

Let me ask you a question, Julie. Of the Chairman's proposal, these monies with enhanced match,

would they reimburse States that are already covering these kids, or are we going to have a greater Federal share going to cover kids that are already covered?

Ms. James. Well, there is the possibility that States could be -- if they have already covered -- expanded their Medicaid coverage that they could be getting enhanced match for children that are already covered. However, the amount of the enhanced match that they get we do require be spent on additional coverage.

Senator Nickles. Well, let me try and decipher through that. You have 32 states that now provide for coverage over and above what the law mandates, I believe, and you also have 39 states that have a program that helps cover kids through services or something else, State programs. And they are doing that with either State money, private money, local money, some kind of combination.

A lot of this money, correct me if I am wrong, but a lot of this money from the enhanced match -- or answer my question, can that be used to just help the States pay for kids that they are already covering? In other words, it will help the States financially, but a lot of those kids already have insurance or already have health care coverage; is that not correct?

Ms. James. Correct.

Senator Nickles. Dennis, you can add something in.

My concern, Mr. Chairman, and I have this concern with Senator Chafee's proposal, I believe it is applicable as well, is that, yes, we will have an enhanced Federal match which as you know, Mr. Chairman, I do not care for. I do not think it makes sense for us to have the Federal Government paying 15 percent more, in other words, going from 75 percent to 90 percent, or 50 percent to 65 percent so a greater Federal match for kids that are already being covered. And I think we do that under both proposals; is that correct?

Ms. James. Correct.

Senator Nickles. So, Mr. Chairman, I hope -- I know this is going to take some time to get all this worked through, the enhanced match. And I thought when I heard that the proposal went to 15 percent, I thought you cut the enhancement back in half, but that is not the case. There is almost no difference in most States. There is very little difference.

I would be less opposed if it was 15 percent increase of the Federal share. That would be saving billions of dollars.

This proposal you add 15 percent so the Federal Government is going from 50 percent to 65 percent for kids that make more money than the Medicaid population. I hope my colleagues understand that. We are helping the not-so-poor kids more than we are helping the poorest of kids on Federal share. That is not good policy. We ought to be making good policy, not just trying to figure out how to spend $16 billion.

And I do not see how it is wise to be saying we are going to be helping families of four with higher incomes. We are going to give them a higher Federal match and in many cases they already have -- they are already covered.

I think, Mr. Chairman, we want to do good policy and I do not think this enhanced match is a good policy. We should figure out ways--and maybe staff could help me come up with a way--to give the States some incentives without having a higher Federal match for families that have higher incomes than Medicaid.

I think Senator Moseley-Braun and others that have talked about being fair to low income, I think this is upside down. And not to mention the fact that, Mr. Chairman, when you end up having this distorted of a Federal match, the Federal match being as high as it is, it is already greater Federal than it is State in

most cases.

What is the average Federal share, 60 percent?

Ms. James. Fifty-seven percent.

Senator Nickles. Fifty-seven percent. Well, a lot of States, my State is 70 percent. So my State goes to 85 percent Federal, and a lot of other States do. And to me it is not very sound.

Plus, Mr. Chairman, just to take an example. The State of Washington, they cover kids up to 200 percent. So they are already covering these individuals. There will not be any additional kids covered under this program, as I can see it, correct me if I am wrong. And what are we doing? All we are doing is changing their match from 50 percent to 65 percent.

So the Federal government is going to pay more to cover the same kids. There is not going to be additional kids covered.

Senator Rockefeller. Mr. Chairman?

The Chairman. Have you finished?

Senator Nickles. I will finish my comment. Mr. Chairman, and Senator Rockefeller, I know that you share that concern with me. So let us think together and see if we cannot come up with incentives to get States to do more to help cover additional kids. Not kids that are already being covered either by private

or by Medicaid, let us come up with additional, but not come up with a higher share to cover those that are already covered.

The Chairman. Senator Rockefeller?

Senator Rockefeller. Mr. Chairman, I just wanted to ask a question of procedure of the Chairman. And that is, I am ready to engage in full-scale debate on this issue if that is what the Chairman wants. And I am not clear whether the Chairman wants to sort of go ahead and complete the explanation or to engage in debate now.

Because what makes it very difficult for those of us who are kind of holding back when other members come in and put things which are disadvantageous and then we are kind of being quiet about it. I do not want to be quiet, but I would rather have the Chairman tell me what our direction is on this.

The Chairman. Well, I would like to proceed with the review of the markup and we will, of course, be debating this once that is completed. So I think the point is well taken and I do have two people that have asked to be recognized. I will recognize those two then I am going to have Julie proceed. Bob, do you want to --

Senator Graham. Thank you, Mr. Chairman. I have

a short list of questions. First, as to the allotment among the States, let me state what I understand the allotment is and correct me if I am in error.

If let us say a particular State had 1 percent of the nation's population of children under 200 percent of poverty then that State would get 1 percent of whatever the pool was to be distributed in that particular year, approximately $3 billion; is that correct?

Ms. James. Yes, sir.

Senator Graham. Then second, in order to receive that 1 percent that State would have to come up with a State match which was the remainder of the formula current State match plus 15 percent from 100 percent; is that right?

Ms. James. That is right. That is correct.

Senator Graham. Number two, I heard Mr. Vladeck make a statement as I was coming back in the room that I think was saying that you could buy a children's insurance policy that would be compatible with this standard of terms of the Federal employees' health benefit programs for approximately $1,000.

Dr. Vladeck. That is a very rough estimate across, but that is the number we have been using for estimation purposes.

Senator Graham. And what is the estimate of covering per child under the Medicaid standards?

Dr. Vladeck. Well, our current costs under Medicaid nationally are probably about $1300, but that is very heavily skewed by all the disabled kids in the Medicaid program.

Senator Graham. Yes.

Senator Rockefeller. And it is actually less than that. I think it is short of 1200.

Senator Graham. What is it for a random selection of population of children who are the target of this proposal? Is it 1200?

Dr. Vladeck. We have used our actuaries in estimating the President's budget used a figure of about approximately $1,000 per kid.

Senator Graham. So you are saying that the relative cost per child covered is about the same whether you do it through Medicaid or do it through an available health insurance policy?

Dr. Vladeck. We are a little bit with apples and oranges, Senator Graham, but all other things being equal the Medicaid benefit package has been more generous than that in most of the private packages we have been talking about.

Senator Graham. Well, I am asking -- I recognize

we may have apples and oranges. I am trying to put a price tag on the apple which is the private health insurance which is the price tag you suggest is $1,000; now the orange of the Medicaid package, what is that going to cost?

Dr. Vladeck. Well, we have been -- you can find in some of the State-operated programs a reasonably good private health insurance packages for kids in the range of $800 per kid per year. Those are less comprehensive benefit packages than the Medicaid package which we estimate for expansion populations for relatively healthy kids for a more generous set of benefits to be on the order of $1,000 a year, but they are very, very close if you compare the same policy.

The Chairman. Bob, we are trying to proceed with the review of the markup. I would ask --

Senator Graham. I have just got two more questions which are --

The Chairman. But then we have Orrin Hatch and he is going to have --

Senator Graham. All right.

The Chairman. Thirty seconds more.

Senator Graham. Well, does this plan allow a State which wants to have some form of family participation on a means-tested basis to do so?

Ms. James. Yes.

Senator Graham. Is there a maintenance of effort requirement for States before they can insure other children? Do they have to maintain the coverage of their existing children's population and use this above or can it be as Senator Nickles was suggesting, a displacement.

Ms. James. Well, there can be a certain amount of displacement, but they are to be using the funds for increased coverage of children.

Senator Graham. Is there some standard of how much displacement is allowed and how much has to be used for increased coverage?

Ms. James. Well, it is difficult. You have displacement of both the Medicaid population and you have displacement of current employer-provided insurance. So I do not know how to answer that.

The Chairman. Yeah, go ahead.

Ms. James. We do, though, require before you could -- a State could participate in either option that they do have to cover the current older children who are being phased in over the next four years.

So they would have to at least pick up those children if they hadn't already in order to participate.

The Chairman. Orrin, I would ask you to --

Senator Hatch. Yes, let me just make this very quick. Senator Nickles, I think, Mr. Vladeck was concerned that there may not be a need for an enhanced match. But is it not true under Section 1902R, as I recall, that the States already have the right to increase their eligibility, but they just will not do it because it is too expensive for them?

Dr. Vladeck. Well, without attributing motive almost no States are at the maximum permissible levels of eligibility that they could reach --

Senator Hatch. But the point I am making is they could increase if they wanted to. And what Senator Chafee is trying to do is give them an enhanced reason for increasing eligibility because they will not do it under current circumstances.

Dr. Vladeck. Yes, sir.

Senator Hatch. All right.

The Chairman. Julie, will you proceed, please?

Ms. James. We are now on page 17 with the income security provisions.

SSI eligibility will be maintained for all legal non-citizens who are in the United States and receiving SSI benefits as of August 22nd, 1996. Also legal non-citizens who are in the U.S. on that date will be

eligible to qualify for SSI benefits if they apply on or before September 1997.

SSI eligibility of refugees, asylees, and Cuban, and Haitian entrants will be extended from five years to seven years.

Certain permanent resident aliens who are members of an Indian tribe will be exempt.

Senator Breaux. Julie, what page are we on?

Ms. James. I am sorry, page 17.

The Chairman. Seventeen.

Ms. James. And we are on number four. Certain permanent resident aliens who are members of an Indian tribe will be exempt from the SSI restriction and the SSI restrictions will not apply for certain SSI recipients if they had an application filed before January 1st, 1979. These last two are to pick up a few small issues that arose.

The mark also includes the establishment of a welfare-to-work program. There will be $3 billion in funds for States to assist them in their welfare-to-work initiatives. Seventy-five percent of the funds will be provided through formula grants to the States and the remaining 25 percent will be awarded by the Secretary of HHS on a competitive basis. And the grants will be administered through the State Taft

program.

There will also be $100 million of funds reserved to be distributed based on performance in terms of increasing the earnings of long-term welfare recipients.

Senator Chafee. Mr. Chairman, could I say a word?

The Chairman. Senator Chafee?

Senator Chafee. Mr. Chairman, in going back to the SSI eligibility for non-citizens. Mr. Chairman, I would like to thank you very much for what you have done here. And what you have done is grandfather legal immigrants who are in the U.S. and receiving benefits as of last August or August '96, and I think that is a very fair thing what you did.

I am also pleased that the mark clarifies that those very old individuals who have been on SSI since 1979, but whose documentation in some case is lost that they are going to continue to be covered under the Chairman's mark. So I want to thank you for that, too.

And, finally, under the Chairman's mark, as I understand it, the refugee exemption is expanded from five to seven years; is that correct?

Ms. James. Correct.

Senator Chafee. So that covers a group of

refugees. Well, thank you very much, Mr. Chairman.

The Chairman. Thank you, Senator Chafee.

Julie?

Ms. James. Okay. Now, going on, on page 18. The Secretary is authorized to approve up to 10 State projects to integrate the eligibility and enrollment determination functions for Federal and State health and human service programs.

Senator Moynihan. Julie, could I ask, did you mean to skip the welfare-to-work program?

Ms. James. Oh, I am sorry. I described it and then I forgot to enumerate. I am sorry.

At the top of page 18 these are the use of the grant funds for the welfare-to-work program. These funds are to be used by the States to assist in moving people off of welfare into work and that can be done through job creation, on-the-job training, contracts with job placement companies or public job placement programs, job vouchers, or job retention or support services if those services are not otherwise available.

I apologize.

And we will move on then to the demonstration for integrated enrollment. I described number eight.

So number nine is the integrated enrollment service system that was submitted to the Department of

Health and Human Services and the Department of Agriculture will be deemed approved and eligible for Federal financial participation. Each project will be required to provide an evaluation as to the effectiveness of the project in improving client services.

Senator Moynihan. Thank you.

Ms. James. We then include in this mark the Welfare Reform Technical Corrections Act. All of these provisions related to Title 2 of the Social Security Act are deleted because of budget reasons. And there is a correction to the sanction for failure of States to meet minimum participation rates.

Senator Moynihan. Mr. Chairman, could I ask Senator --

The Chairman. Senator Moynihan.

Senator Moynihan. -- Senator Moseley-Braun had some concerns on that participation rates. Has that been worked out?

Ms. James. That is exactly the provision we presented earlier, Senator.

Senator Moynihan. I see. Thank you.

Senator Nickles. Julie, on the --

The Chairman. Senator Nickles.

Senator Nickles. -- on the sanctions, we had

some sanctions in the welfare bill that -- or at least we allowed the States to have sanctions if they didn't have welfare families, for example, enroll their kids or make sure their kids attended school and so on. There is minimum wage provisions and so on that put a lot of those sanctions in jeopardy. Does this keep those sanctions in?

Mr. Smith. Senator, we had not addressed the sanction issue in the mark. There is an issue in the application of the Fair Labor Standards Act how that would affect the welfare programs in the States. That is an issue, we have not addressed it.

Senator Nickles. I may have an amendment. I want to protect the rights to have that. So I may be addressing that soon.

Also there was a letter, I think, by Senator Thompson from Wisconsin who has done a lot on welfare reform that was concerned about some of the welfare reform moves that were moving in the House.

Senator Moynihan. Is that Governor Thompson?

Senator Nickles. Governor Thompson. Did I say Governor Thompson?

Senator Moynihan. Senator.

The Chairman. Senator, you said.

Senator Nickles. Excuse me. Are we making some

of those -- from his viewpoint are we making some of those same mistakes, I think, concerning displacement and other provisions?

Mr. Smith. Senator, I would describe it as we have a leaner package than the House has in terms of things that were added in committee.

Senator Nickles. I will work with you. I want to make sure we maintain the States' rights to have sanctions to ensure that the kids are immunized or make sure the kids are in school and so on. I do not want those to be jeopardized by the Administration's regs dealing with minimum wage requirements or Fair Labor Standards requirements.

Mr. Smith. Yes, sir.

The Chairman. All right. Please proceed.

Ms. James. Again, on page 18, number 12, these are the unemployment insurance provisions. The mark increases the Federal unemployment account ceiling from .25 percent to .5 percent of covered wages and it clarifies that States have full discretion in setting their own unemployment insurance base periods for the purpose of determining eligibility for unemployment insurance benefits.

And, finally, that inmates of penal institutions who participate in prison work programs will not be

eligible for coverage under the Federal Unemployment Tax Act for work performed in prison.

Senator Grassley. Mr. Chairman, can I ask a question at this point?

The Chairman. Yes.

Senator Grassley. Remember in our other work last week I brought up about prisons and not allowing prisons to get -- prisoners to get disability insurance and there was some technical reason that I could not bring that up because it was subject to a point of order. Has that been worked out now? Because I see here that you have got something here that prisoners cannot collect unemployment compensation.

Mr. Smith. They are different issues, Senator. This issue deals with unemployment. The other affects the Social Security Act in itself which provides a burden of problems.

Senator Grassley. So anything you do to the Social Security Act --

Mr. Smith. That is the problem. Not --

Senator Grassley. -- triggers in?

Mr. Smith. That is the problem.

Senator Grassley. Okay. So, on that issue we were not able to work anything out on that, I assume. It still raises a point of order; is that right?

Mr. Smith. In dealing with the Social Security Act it still raises a point of order, yes, sir.

Senator Grassley. All right. Thank you.

Ms. James. Now, again on page 19 we have three provisions related to the earned income credit. All of these were contained in the Administration's package of provisions released earlier this year and they are intended to reduce fraud in the earned income credit program.

Senator Breaux. Could I ask a question on that? On the EITC?

The Chairman. Yes.

Senator Breaux. What is the relationship in that Chairman's mark with the EITC and the $500 per child tax credit?

Ms. James. I need some help answering that question.

Ms. Gulya. Senator, it is addressed in the Chairman's mark that combines the packages by using your earned income credit first before you get the benefit of the $500 child credit.

Senator Nickles. You do not get both.

Ms. Gulya. You can get both.

Senator Nickles. You can get both?

Senator Kerrey. You could get both?

Ms. Gulya. You can get both.

Senator Kerrey. But if your income is $25,000 a year, you are likely to take the EITC. If you take the EITC first you would not have enough to get the $500 --

Ms. Gulya. That is correct. You get the credit --

Senator Breaux. You would not have any tax liability.

Senator Kerrey. Whereas, if you did the $500 tax credit first you would always get the EITC on top of that?

Ms. Gulya. In certain circumstances the ordering would change.

Senator Nickles. Mr. Chairman?

The Chairman. Senator Nickles.

Senator Breaux. Just one last question.

The Chairman. Go ahead, Senator Breaux.

Senator Breaux. As I remember in the House mark there was reduction for the dependent child care for mothers if they got that $500 tax credit, and all of this is related to income security. How does the Chairman's mark deal with the dependent child are for mothers?

Ms. Gulya. We do not address it as the house identification.

Senator Breaux. There is no change?

Ms. Gulya. No, no change.

Senator Breaux. They could still get the dependent child care?

Ms. Gulya. Yes.

Senator Breaux. All right. Thank you.

The Chairman. Senator Nickles?

Senator Nickles. Mr. Chairman, some of us have done a little homework on the EIC and have found very significant problems, and correct me it I am wrong, but I think the agreement was that we would not take up significant reforms of EIC in this package but would still have the opportunity to do EIC in a separate package; is that correct?

The Chairman. Is that correct? I do not know.

Ms. Gulya. It is my understanding that these proposals that are included in this package were designed to specifically address some of the fraud items that have come up through this study that the Treasury has released. But they were not overwhelmingly broad proposals.

Senator Nickles. Well, these are -- the say they are not overwhelmingly broad is an understatement. Correct me if I am wrong, but I think the study showed that this is maybe the most fraudulent program in

Government and some of us would like to reform it significantly.

But I think, Mr. Chairman, and I am pretty sure I am correct on this, that the package with the President said that we would take up EIC separately and significant reforms other than these.

Ms. Gulya. I think that is correct.

Senator Nickles. I just wanted to make that point, Mr. Chairman. I hope that this committee will have some oversight hearings, do some homework and try and reform this program. We should not be looking at program that has an error rate of what was the last study that said --

The Chairman. Twenty percent.

Ms. Gulya. Approximately 20 percent.

Senator Nickles. Twenty-four percent, I think. Something like that. We should not have a program like that on the books without us at least making an effort to reform it. So I mention that to inform all my colleagues. I am not going to try and do it in this package, but it is my hope that this year we will take up the EIC program and try to -- try to fix it.

The Chairman. I would say to the distinguished Senator that thee has been these recent reports that show the problem as quite deep rooted. I might point

out that in PSI of the Government Affairs Committee two years ago that the same thing happened so that I am sympathetic to the problem you have raised.

As a matter of fact, I would suggest it might be appropriate in the subcommittee on taxation to take a look at this matter.

Senator Nickles. I will be happy to do that, Mr. Chairman. Thank you.

Senator Moseley-Braun. Mr. Chairman? Mr. Chairman?

The Chairman. Senator Moseley-Braun?

Senator Moseley-Braun. Thank you very much, Mr. Chairman. We got to the EITC kind of skipping over the unemployment insurance provision and I would like to raise a question in regard to that. Specifically on page 18, number 13, clarify that States have full discretion in setting their own unemployment insurance based periods for determining eligibility for unemployment insurance benefits.

Now, the Social Security Act under Section 303 calls for the unemployment insurance laws to provide for methods that are (quote) "reasonably calculated to ensure full payment of unemployment compensation when due."

In Illinois the Court and then later the Court of

Appeals ruled that the "when due" provision meant that those people who work irregular hours or in construction or really the low-income and periodic workers that those eligibility requirements, the base period calculation had to be consistent with the "when due" language of the Social Security Act. And so that is an issue that obviously is very important in my State. And the concern, of course, is that we would see that people who are ineligible for unemployment insurance would go up if this change were put into the -- this change in the mark were adopted.

And I am really concerned about it and I wanted to ask the question if it was the intention -- I mean, I do not understand how it is that we are, you know, overruling a Court of Appeals decision in this mark without any -- I mean, I do not see the motivation here for this to be in the mark.

Mr. Smith. Senator, the "when due" issue as you have mentioned has recently been litigated in one State, it is pending in three other States, it has the potential to spread across many other States as well. The issue is whether or not the States -- the States historically have had the authority and discretion to define points such as "when due". The ruling has gone contrary to what the history of the program has been.

So the intent is to clarify that the States have the authority in those types of administrative decisions about how the program is run.

Senator Moseley-Braun. Again, I mean, we all, I think, support the notion of the States having some flexibility in regards to their programs, but at the same time the effect of this change in the mark would mean that a lot of low-income workers will be ruled ineligible for benefits or could have their benefits denied. That was certainly the situation in my State.

And I guess with all the other changes that are taking place in this mark to have yet another hit at, you know, the working poor, it seems to me just to go in the absolute wrong direction. And, I do not know, I just hope that I will have -- probably have to have an amendment on this, but I hope you will take another look at this provision because I think that it mitigates in a very negative way against people who really -- again, the working poor and people who work in construction and periodic employment. It really mitigates negatively and it is not something that has to be done at this time it seems to me.

The Chairman. Anything further?

Senator Kerrey. Yes, Mr. Chairman?

The Chairman. Yes, sir.

Senator Kerrey. I'm down here with the witness.

The Chairman. Oh, Senator Kerrey. You are a long ways away.

Senator Kerrey. Yes, in more ways than one.

Can you --

[Laughter.]

Senator Kerrey. Julie, can you tell me the provision on earned income tax, we say that a taxpayer who fraudulently claims EIC would be ineligible to claim the credit for a period of 10 years. Now, is that a standard that we are applying in other areas of these programs?

I mean, earlier we dealt with a change that clarified that somebody who is advising people on asset declarations having to do with long-term care that the person advising the sanction will fall, and the other individual become ineligible. How long are they ineligible? And does a doctor or hospital who fraudulently engages in activities are they in ineligible for ten years? Is this a standard that we pulled here that is consistent with standards that we impose on other people who engage in fraudulent activity?

Ms. Gulya. I would recommend that maybe the Administration would like to answer this since it is

their proposal.

Senator Kerrey. Yes, I wonder how they come up with ten years ineligibility in the EITC program and, you know, you are basically saying that they are -- I presume the definition of "fraud" is anybody who over reports their income; is that --

Mr. Scholz. No, it is intended to be a higher standard than simply the sort of overreporting that could come from not understanding the rules. But it is closer to a legal definition of fraud. And the motivation for the penalty was with legal -- with the earned income tax recipient who has received overpayment through fraudulent means fines are not a very effective deterrent for the family because there is little money to be gotten from the taxpayer through the fines. And, indeed, a fine may encourage the taxpayer to --

Senator Kerrey. Well --

Mr. Scholz. -- noncompliance in the future.

Senator Kerrey. We do not have a means test on traffic fines because we do not think it is going to deter somebody because their income is low. I mean, what is the basis for saying that a fine is not an effective deterrent in an EITC claim?

Mr. Scholz. Because in subsequent years with a

fine the taxpayer would actually have an incentive to over report income in order to collect the earned income tax credit, inappropriately high earned income tax credit in the future. So by denying eligibility for a period of time in the future for fraudulent behavior, one, the Internal Revenue Service does not have to investigate the claim for a period of time in the future.

Second, you remove this incentive for a taxpayer to engage in non-compliant behavior in subsequent years in order to pay this fine that is levied.

Ms. Gulya. In addition, this is designed to get at individuals who have intentionally disregarded the way the program should work. So it is not as if it was just an accident or carelessness. It is an intentional disregard of the rules.

Senator Kerrey. Again, do other people who intentionally disregard rules suffer a ten-year ineligibility as a consequence of intentionally disregarding the rules?

Mr. Scholz. The other analog is that there is a comparable -- I am not certain about the length of time, but I could find out for you. But for paid preparers who inappropriately prepare returns for clients are denied the ability to prepare returns.

Senator Kerrey. To boil out all the excess adverbs and adjectives that I have thrown at you, I mean, I am trying to determine, have you done a comparative analysis to enable us to say that we are not going after EITC fraud in a fashion that is more aggressive than we are going after fraud that might generate greater losses to taxpayers than this.

Ms. Gulya. Under certain code provisions you can go to jail for that kind of fraudulent act. So there are other standards in the code that are even more severe.

Senator Kerrey. Again, that reference is helpful for other questions that I might have. But the question I am trying to get an answer to, and you do not need to answer it now, later will be fine, as to whether or not there is a comparative analysis that you all have done to determine whether or not this imposition of penalty is consistent with penalties that we impose upon other people that are considering fraudulent activity against the taxpayers.

Mr. Scholz. We will address that for you.

The Chairman. All right. Anything further?

Ms. James. Senator, there are two more provisions. One is that the mark includes the sense of the Senate resolution that all cost of living

adjustment required by statute should accurately reflect the best available estimate of changes in the cost of living.

Senator Moynihan. And it does say that that best available was pointed out by the commission appointed by the Finance Committee?

Ms. James. Correct.

Senator Moynihan. Oh, come one, we cannot do that --

[Laughter.]

Ms. James. Report.

And finally the debt limit is raised -- the ceiling is raised from $5.5 trillion to $5.95 trillion. I practiced that.

Senator Moynihan. And that does mean that we will -- the debt will grow by half a trillion dollars in the next four years?

Ms. James. Right.

Senator Moynihan. Could I just say, Mr. Chairman, that these rates of growth are unprecedented. I mean, we are in good shape and yet we are going to add half a trillion dollars worth of debt. In 1981 we had a total debt of $800 million, now in four years we are at 500.

I am just trying to say, there is something to,

you know, Senator Kerrey has a point.

Senator Kerrey. Mr. Chairman, I wonder if it would be possible to get for our use--and perhaps I am the only one that has an interest in it--but, a summary document? This entire package saves $115 billion over five years. Yes, is that --

Ms. James. No. That is the Medicare number.

Senator Kerrey. That is just Medicare?

Ms. James. Right. And then we also had instructions to save -- the overall instructions are to save, when you consider the new spending for children's health are to save $100 billion, roughly.

Senator Kerrey. Let me ask for two things then. One, some kind of a summary -- I have actually pulled it myself, but I do not trust my capacity to extrapolate off of your documents -- listing out the various negatives and the subtractions and adds. I mean, Medicare choice, for example, saves $24.9 billion. Payback of graduate medical education is plus 7.3. I've done it all to come up with $115 billion. And then in addition to that we have other things that we are adding and other things that we are subtracting in the package.

Ms. James. And you do have the CBO tables for the -- they are really packaged in three separate

tables. One is Medicare, one is Medicaid, and one are the welfare and income security provisions. We do not have any score, as I said, on the children's health proposal. And we are trying to get CBO to come up with sort of a bottom line. But right now we have these three separate packages and each one of them meets our target; 115 billion in Medicare, 13.6 billion savings in Medicaid, and whatever the targets were, I am sorry. We are spending money in the welfare and income security provision.

Senator Kerrey. Thank you.

The Chairman. Carole?

Senator Moseley-Braun. Mr. Chairman, this may be asking the obvious question and it may -- may should not ask it at all. However, can we do this package? Is it possibly done without raising the debt limit? I mean, do we have to do this?

[Laughter.]

Senator Moseley-Braun. And if so, what can we do to fix this so we do not have to raise the debt limit.

[Laughter.]

Senator Moseley-Braun. I said it was the obvious question.

Senator Moynihan. We were having a good hearing --

Senator Moseley-Braun. Pardon?

Senator Moynihan. We were having a good hearing until this question.

Senator Moseley-Braun. I am sorry to be the one to talk about the emperor's new clothes, but I mean, I just -- you know, we are raising the debt limit again, and we are supposed to be balancing the budget. I mean, is there any way we can do any of this without this last --

Senator Breaux. Yes, bankruptcy.

Senator Moseley-Braun. Oh, okay. Thank you.

The Chairman. I would point out to our distinguished Senator from Illinois that under the budget agreement we are instructed to --

Senator Moseley-Braun. To do that.

The Chairman. -- to do that. And I think it is important that we move in good faith to meet the goals and objectives of the budget agreement.

Senator Moseley-Braun. Well, Mr. Chairman, I mean -- and I understand that. And I know you -- and, again, this is asking the obvious question, and I do not mean to embarrass anybody, but at the same time it just seems to me that if we are giving away a chicken in every pot here we ought to at least think about the ramifications and whether or not we absolutely have to

move in this direction increasing the debt limit and all. I am sorry.

The Chairman. I would just point out that the budget resolution sets forth in page 16 on the Committee on Finance, Part B, to increase the -- the Senate Committee on Finance shall report changes in laws within its jurisdiction, (b) to increase the statutory limit on the public debt to not more than 5 trillion, 950 billion dollars, and that is exactly what we are doing.

Senator Rockefeller. Mr. Chairman?

The Chairman. Yes.

Senator Rockefeller. Can I just ask one point of information to --

The Chairman. Senator Rockefeller.

Senator Rockefeller. -- Julie James. You are doing an incredible job.

Senator Moseley-Braun. Yes, she is doing a great job.

Senator Rockefeller. You are.

Senator Chafee. Thank you.

Senator Rockefeller. I thought that in the budget agreement that we discussed this the other day on the so-called "Slim B" thing the low-income Medicaid beneficiary and when you are moving the home health

benefit and all of that, that there was a $1.5 billion set aside to make sure that citizens of Medicaid of very low income would not have to pay that.

Ms. James. That is correct, Senator. In the budget resolution it calls for some premium assistance to the amount of $1.5 billion.

We do not have anything in the package right now for that. We were waiting to get our final numbers and to be able to look and see what the premium impact was on beneficiaries as a result of this package, and we are prepared to discuss that with members so that they can have that information before deciding what do to about that.

Senator Rockefeller. Thank you.

Senator Chafee. Are we making a mark-up decision before we have got a score? We will have a complete score from CB --

Ms. James. Yes. I mean, each of these pieces can be put together. It is just difficult to try to account for all the interactions, and that is what we are asking them to produce for us. But we know that since each package meets the target that the total meets the target.

Because the interactions are accounted for on each table. There are Medicare interactions on the Medicaid

table that we have accounted for and we have done the same on the Medicare table, we have accounted for Medicaid interactions. So we have accounted for them all, we just can not display them clearly yet because we have not gotten the combined table.

Senator Chafee. And I point out, and this, again, is my first markup of either a Medicaid or Medicare, or tax package, but particularly on the entitlement side we have not done a very good job of forecasting the expenditures, have we? I mean, we have gotten previous marks either with decisions to expand or change the underlying statute? I mean, have we not usually --

Ms. James. Historically, is that what you are asking?

Senator Chafee. Yes. I mean, there have been previous moments when --

Ms. James. Yes, spending has exceeded what the estimates were.

Senator Chafee. Spending exceeds what the estimates were.

Ms. James. It has in the past, yes.

Senator Chafee. So it is good as I am talking about this thing to put an asterisk on it and show down at the bottom, do not expect my forecast to be -- not

yours, but mine -- because I am the one that is going to have to vote on this thing, right. I should not actually count on the forecast being what we are forecasting.

If anything I need to acknowledge that there is a possibility with interactions and changes in behavior and everybody is going to be trying to get as much as they possibly can that it is likely that we are going to spend more than we are forecasting.

Ms. James. Well, I mean, given the current assumptions CBO has tried to take all of that into account. But it is based on the best information that they have today and it may prove to not be in fact what happens in the future.

Senator Kerrey. Thank you.

Senator Moynihan. Now it is clear, right?

Senator Breaux. Clear.

Senator Kerrey. It is clear.

The Chairman. This completes the review of the spending side.

I, too, want to thank the staff, Julie in particular, but all the members for a job well done.

[Applause.]

Ms. James. Thank you.

Senator Kerrey. Now that you have confessed we

are going to turn the lights on.

The Chairman. At this time I would like to recess for a short period to have an informal meeting of the committee. At this meeting I will forewarn you, I would like to discuss amendments as well as the children's health. So we will -- yes, we will be in 215, our Finance Committee Hearing Room.

Senator Chafee. Bill, could I just ask one question before Julie goes. A quick one on the --

The Chairman. Sure. Go right ahead.

Senator Chafee. On the disabled, Julie, we do not cover the disabled who were not -- I am talking about the legal immigrants. We do not cover those who were -- other than those who were collecting a year ago. However, there was a suggestion that they might be possible under the Chairman's mark to cover those for a limited period of time. And there was a question of how long that would be, but there was something about the immigrants --

Senator Moynihan. May we have order?

Senator Chafee. There was a question that the immigrants would be able the apply until September 30th of this year. I just did not understand what that meant to them?

Ms. James. Well, that was the date that in our

discussions with CBO, that was the date that we arrived at in order -- within the restrictions that we had in terms of the money that was available.

Senator Chafee. But they have to apply and then they might be carried on indefinitely?

Ms. James. Yes.

Senator Chafee. We have enough money --

Ms. James. If they apply, yes.

Senator Chafee. -- for them?

I see. All right. Fine. Thank you.

Senator Murkowski. Mr. Chairman, I wonder if you could start with -- do you intend to start with the children's health when you go back in as opposed to the amendments?

Senator Chafee. No, I am not stating that. It is a matter for us to discuss back in the committee room

Senator Murkowski. I just thought maybe from the standpoint of your agenda because I have got a short meeting at 4:30, and I will probably be gone for 15 minutes, and I wanted to make sure I got back for the amendments.

The Chairman. Good. Good.

Senator Murkowski. Good, yes. Thanks for the assurance.

The Chairman. The committee is in recess.

[Recess at 4:22 p.m.]

EVENING SESSION

[9:33 p.m.]

The Chairman. The committee will please be in order.

I have had the Finance Committee staff go through the amendments that have been proposed by members of the committee. Each member of the Finance Committee has a page with a list of these amendments. These amendments will be accepted, if there is no objection.

Senator Moynihan. I so move, Mr. Chairman.

The Chairman. Those in favor, signify by saying aye.

[Chorus of ayes]

The Chairman. Opposed, nay.

[No response]

The Chairman. The ayes have it. The amendments are adopted.

There has been today a considerable discussion about the Child Health Initiative under the Budget Agreement. The Finance Committee has been instructed to provide $16 billion to expand health coverage for children.

Under the proposal contained in the Chairman's mark, States will have an option as to how they choose to participate in the Child's Health Initiative. Each State may choose to spend its allotment through a cap grant or

through an enhanced Federal match to expand its Medicaid program.

There are two modifications to this initiative. These two modifications are being made by the Chairman to the Chairman's mark.

With that, the Chair will recognize Senator Chafee for four minutes.

Senator Chafee. Thank you very much, Mr. Chairman.

The amendment that I have submitted, on behalf of myself and 12 members of this committee, provides the following.

First of all, the States do not have to do anything if they do not want to. If they want to access the enhanced funding, then they have to do two things. First, they have to cover the 14- to 18-year-olds who are currently not covered, who are at zero coverage. That is the current situation. Those 14- to 18-year-olds have no Medicaid coverage.

Under this program, those children would have to be covered up to 100 percent of the poverty level. That is the first step. The second step, is that those children who are on Medicaid would be entitled to remain on Medicaid for a year, even though their family's fortunes might change.

Now, once the State has done that the State can go up

to 133 percent of poverty and receive the enhanced dollars.

Can we have silence here, please?

The Chairman. The Senator is entitled to be heard.

Senator Chafee. Once the State has reached covering those children up to 133 percent of poverty, then they can choose one of two routes. They have got a choice. They can stay in the Medicaid area and cover the children up to 150 percent of poverty, again, with the enhancement.

If they do not want to do that, then they can go the so-called block grant route, which gives the governors considerable latitude. Indeed, you are liable to end up with 50 different programs.

Now, let me just say, Mr. Chairman, what are we trying to do here, what is this all about? What we are trying to do, is several things. First, provide health insurance for poor children with a set of decent benefits, with a program that will cover as many children as we can reach.

That is the so-called entitlement program. That is what our Medicaid program is. Our program takes care of every one of those. It is a proven program that is currently in effect in 50 States. All 50 States have a Medicaid program, so you are not setting up a new

mechanism to take care of these increased numbers of children.

We provide that the funds that go out through the enhancement will encourage the States to increase their coverage. If a State is already doing that coverage, then they must maintain their effort with continued efforts in connection with child health care.

Now, Mr. Chairman, what about the so-called block grant approach which seems to me has evolved, frankly, into a cut and paste operation? It is continually changing, but the latest version for the package for the children is modeled after the Federal Employees Health Benefit package. That, of course, has deductibles and co-payments in that, hardly the kind of program for very, very low-income people.

Now, the suggestion is that it will be sent then to the Secretary of HHS and then presumably he or she will make some changes to it. I find that entire program very, very vague.

It seems to me that the currently existing Medicaid package is a good package for children, and that is the package we should be trying to adhere to.

So, for those reasons, Mr. Chairman, because I believe that we adhere to the objectives, health insurance for poor children, our program is aimed at poor

children, it is not up to 150 percent of poverty, it is for the lowest-income children, with a set of decent, prescribed benefits as set forth in the Medicaid package and its entitlement program. It is going to cover all the children that we can bring into the program.

So, for those reasons I strongly support our program, which provides, from the $16 billion, $12 billion will be devoted to the Medicaid portion of it, with $4 billion for the block grant for those governors who want to add something on top of it.

The Chairman. Senator Gramm.

Senator Gramm. Well, Mr. Chairman, let me, first, say that I do not have anything negative to say about Senator Chafee's plan. I think it is a testament to the wisdom of the bipartisan proposal you put together, that if State governments are convinced that Senator Chafee is right, under the compromise that is before us in the bill, each State could opt to do exactly what Senator Chafee wants to do.

What your bipartisan compromise does that I am proud to support, is that it gives a choice. It requires that all children up to 18 be covered immediately by Medicaid, an expansion in a Medicaid benefit.

It requires that States submit an implementation plan to the Secretary. It requires that they have a benefit

package roughly equivalent to the health insurance that is available to government employees.

It sets out a procedure where we can guarantee, to the best of our ability, using procedures we have learned from the failures of Medicaid, that we protect from waste, fraud and abuse, from the use of provisions like provider taxes.

It sets out a matching rate that is identical so no State will game the system and choose to have its own program as compared to Medicaid because it saves them money.

Basically, your proposal lets them choose with a defined benefit in both cases, but it gives States the ability to set up their own program. Senator Chafee is alarmed that we might have 50 different plans. Those who support the Chairman's mark rejoice that we might have 50 different plans, because States can learn from each other.

We will have innovation, as we have in TenCare, as we have in Florida, as we are now building in States around the country, 15 States that have gone to their own plan. Yet, we have got protection through the approval system that you have set up.

So, basically, the compromise that is built into the bill allows the State to do exactly what Senator Chafee

wants them to do if they believe it is best for them. If New York believes that Medicaid works best for them, they can choose it. If they believe they can set up their programs within these real guidelines and safety precautions we have erected, they can choose to set up their own program.

It is basically a choice that we present, believing that not all wisdom is in Washington, but since part of the money is coming from Washington we want some guarantees.

We have had 6 members of this committee that have contributed to this compromise in the last day and a half. It is a bipartisan compromise; I hope it will get a bipartisan vote.

If you want the Chafee plan, vote for the compromise before us because it lets States have it. But it also lets States, if they choose to, within our guidelines set up their own program. That is the genius of it. I think it is an excellent proposal.

The Chairman. Well, the vote will be on the Chafee amendment.

Senator Kerrey. Mr. Chairman, is there going to be further public discussion of this before we vote?

The Chairman. Bob.

Senator Kerrey. Mr. Chairman, first of all, I

regret that the Hatch 43 cent cigarette tax is not germane. That would be a wonderful compromise, in my view. We could do John Chafee's Medicaid expansion and Orrin Hatch's block grant, and we would have a done deal and be over it. I understand it takes 14 votes to get that done, and we have got 12 votes to do it, and that is not possible.

I do appreciate, Mr. Chairman, that you have moved a considerable distance. I, myself, have not--and probably will not until a roll call is issued here--decided exactly whether I am going to support your position or not.

I am a co-sponsor of the proposal that Senator Rockefeller and Senator Chafee have put up. I like what it does. It does push the Medicaid program out and it does seem to me to provide States some options.

But I am impressed by how far you have gone towards acknowledging that there is a need to create a level playing field, that there is a need to protect so the block grants cannot be abused.

I have a question, particularly for those who are advocating the block grant proposal. I would appreciate it if one of you could, perhaps, answer it. Under the block grant proposal, you are saying that the States would have to offer comparable to the FEHB, the Federal

Employee Health Benefit program.

But there is a difference between FEHB and Medicaid. The difference is, with FEHB there is a $200 a year deductible for inpatient care, $200 a year deductible for outpatient surgery, $200 a year for outpatient therapy, and a $2,000 annual limit on co-insurance.

Now, for somebody that is at 133 percent of poverty or below, this could be a substantial amount of out-of-pocket money, and I wonder how you all have addressed that. I am sure this has been raised in the last day and a half by opponents of the block grant, and I am sure you have got a pithy, intelligent, and persuasive response.

The Chairman. Senator Gramm.

Senator Gramm. Mr. Chairman, let me say that Senator Kerrey has outlined one of over 100 options that are available under the Federal insurance system, and that is the high deductible option. Also under that system you have got Blue Cross/Blue Shield, you have HMO options.

You will have under the new provisions that we have adopted in this bill many other options that are available. The effort to try to take the Federal employee package and find the mean point, you have taken one extreme, but the no-deductible HMO would be another extreme.

Senator Kerrey. It may be that I read off the extreme, but I asked for the standard FEHB. I have asked for the mid-point, not the extreme.

Senator Gramm. The point we are trying to reach here, without forcing people into one sort of pigeonhole of the Medicaid package, which is the most generous package anywhere, is to simply take a standard that everybody knows something about because it is held up as a standard for private insurance, and that is the range of options that are available under the Federal system.

Basically, what we are saying is, looking at that whole system and finding a mean point, that is what we want to set out as a standard. Now, obviously, we are requiring that the States cover the poorest children first.

Senator Kerrey. Well, Senator, I am looking at a Blue Cross/Blue Shield, This is Not a Bill/Explanation of Benefit form, for a routine ear infection, what we owe. The beneficiary owes $99.38 out of a bill of $132.50, and $33.12 is what the individual has to pay. That is the co-payment on a standard. There are deductibles of $200 and $400. I mean, this is a standard plan.

Again, I appreciate that you are trying to say that the States have to have some standard, but the question is whether or not the FEHB midpoint is a standard that is

high enough, given that we are going to be trying to help lower-income working families out there acquire not only health insurance, but the capacity to take care of their children.

Senator Gramm. If I might respond, Mr. Chairman. Basically, we have a spectrum of plans from HMOs that have no deductibles to high deductible plans available to Federal employees.

What we were seeking to do was to pick something that everybody understood, but that had some variance in it, but we are doing something that we had never done before in our previous proposals, and that is, we were setting a generally expected benefit package to give assurance to people who were concerned that States were not going to provide insurance coverage. The governors and the legislatures have a mandate, under our bill, to cover the poorest children, first.

Obviously, what they will do in terms of what the cover will depend on the amount of money they have relative to the number of children they cover, just as in TenCare they were able, by dropping out of the Medicaid system, to cover an additional 340,000 children.

When they made the decision to do it, they basically concluded, and I quote the director of their health department, "The uncontrollable growth in the cost of

Medicaid threatens the financial stability of State government." What they did, is they set up their own program that did not have as generous a package, but it covered 340,000 additional people. So, it is that kind of flexibility we want to give the States.

But to anybody who is worried about there not being a definition of what the minimum is, by setting the mean point of the spectrum for Federal employees, I think we have defined a mean point that is meaningful.

Senator Hatch. Well, Mr. Chairman, if I could just add something here. You see, one of the reasons why the Chafee plan is so important to some of us with regard to children is because the early and periodic screening, diagnosis, and treatment, the EPSDT, is designed to help children. That is not part of the Federal Employee Health Benefit program, nor is it going to be part of it.

This means eyeglasses, it means hearing/audiology tests, it means dental work for these poor kids that otherwise are not going to get it and are going to be well behind their peers as they go through school. So you cannot really compare the two things.

And let us face it, if you were governor you would love to be able to not have to provide those services, or some other aspect of services that you would normally provide.

This particular program, EPSDT, has been part of the Medicaid program virtually since its inception. From the beginning, EPSDT recognized that children have unique medical needs and cannot be treated as "little adults."

The original EPSDT regulations required State Medicaid programs to cover screenings to detect children's medical problems, necessary treatment of those problems to the extent the State covered such treatment for adults, and necessary dental, vision, and hearing care, regardless of whether adults were covered for such services.

Now, I imagine most of us on this committee have suffered from some sort of hearing, sight, or dental problem during our lifetimes. Now, the Blue Cross/Blue Shield standard plan exemplifies the FEHB plans that enroll the most workers.

This plan denies coverage for certain preventive services that children need, such as general eye exams and eyeglasses, which many children need to see the blackboard and learn in school. These kids will not get that, otherwise.

Children also cannot receive hearing exams and hearing aids, even though many children have repeated ear infections. My own grandchildren, one of them, has had just one operation after another to try to help him with

his ears.

Similarly, when you stop and think about it, some of them can suffer permanent hearing loss and other developmental delays associated with hearing problems.

Now, the plan also imposes across the board treatment limits, the Blue Cross/Blue Shield standard plan, that deny essential care to children with special health needs. For example, only 25 speech therapy visits per year are covered, even for children who need more in order to learn to speak and develop into healthy, productive adulthood.

Now, that limit may work for adults, but it is not going to work for children. You are talking about, similarly, only 25 outpatient mental health visits a year are covered, even for a child who was badly sexually abused and needs considerably more care.

So in 1989, Congress, on a bipartisan basis, expanded Medicaid coverage for children by providing that when a health screen shows that a child has a problem the State must cover medically necessary treatment for the child, even if the State does not ordinarily cover that treatment for adults.

It does involve drugs, dental care, vision and hearing care, speech and physical therapy, respiratory care, and many other services that are not provided by

the Federal Employee Health Benefit program.

I admit that it is more expensive to do it the Chafee way, but there is a reason for that. This EPSDT is the reason. I think you cannot ignore that here. That is one reason why I am going to support Senator Chafee on this matter.

The Chairman. I have Jay Rockefeller on the list next, then Don Nickles.

Senator Conrad. Mr. Chairman, might I get on your list as well?

The Chairman. Yes. But we do want to proceed if we can, so I would ask each of you to keep your comments to three minutes.

Senator Rockefeller. Mr. Chairman, I hope I can proceed as the previous speaker, as I am the original co-sponsor to the Chafee-Rockefeller bill, and I have not had a chance to talk virtually at all.

First of all, let me say that what has not been discussed in all of this is children. We have not referred to them in our discussion behind closed doors which went on for hours, and out here we are not going to do it. The Families USA report, 89 percent of these folks that we are talking about, the head of the household worked either all the time or most of the time over a 24-month period.

John Chafee and I, I thought, made a very good compromise with those on the other side, the block grants. The House has done the block grants. The House has made the governors very happy. Then there is our side. We are called the Senate. I think we were meant to do what we want, then we confer.

But John Chafee and I said, all right, we will not require that all $16 billion go to Medicaid, we will say $12 billion will go to Medicaid and $4 billion will go to block grants. In so saying that, we were kind of dismissed.

But I need to report to my colleagues and those who may be interested, that the $4 billion that is allocated for block grants is 5 times more than is currently being spent under a block grant or State approach by all 50 States added up together.

If you took all 50 States that are sort of doing stuff on their own, it would come up to one-fifth of the $4 billion, which we allocate to something called a block grant.

During the course of our previous discussions, standards were rather vague. Bob Kerrey has mentioned already the extraordinary deductibles that are associated with FEHB and that, therefore, would be associated with the block grants because those have been merged now and

that would take a substantial part of the income of poor people.

It used to be a common thought that one of the reasons that we did Medicaid and that we did larger programs is because they had volume purchasing power. You could get a better deal for your dollar.

Now, you take 50 States doing 50 different things, and I warn you that the States will take the block grant. Remember, there is no choice in the Roth plan. I say that with respect.

But there is no choice. You either go block grant or you go Medicaid, you cannot mix the two. You go one way or the other. I predict to you that the States will go the way of the block grant, at least for the first few years, because that is what the governors want.

There have been an amazing number of governors calling, as one of our Senators said, governors who had never evidenced an interest in children are all of a sudden calling all day today and yesterday to talk about the need for block grants. Well, there is a reason for that: they get money, they like that.

The leverage is not there. You have to duplicate administrative facilities of Medicaid and the block grant. Medicaid is ongoing. Of the 38 States that have expanded coverage for health care in this country, so far

33 have done it through Medicaid. They find that satisfactory. Why? Because it is a 30-year-old program that works. Everybody knows what it is. Families know what to expect, so does the State.

So why the compelling reason to create the block grant in the name of something called State flexibility? Well, we do that. We do that, $4 billion, 5 times more than the entire country is doing right now. That seems to me a bipartisan compromise.

It strikes me as a fair deal. What it particularly strikes me as is a better deal for the children of America. We are here for one purpose only, and that is to provide health insurance for up to as many of the 5 million we can possibly do, and more if possible, and to do it in the most efficient, humane way. The Chairman's mark does not lead us in that direction. I regret that.

The Chairman. Don Nickles.

Senator Nickles. Mr. Chairman, first, I want to compliment you because I think the approach that you have taken, one, can have strong bipartisan support in this committee and on the floor, and I think that is important.

Two, I would just take a little, maybe, difference of opinion with Senator Rockefeller. I think States do care. The facts are, there are 39 States that do more

than Medicaid mandates today. 39 States. 32 States have programs outside of Medicaid. So States are already moving, and that is very positive. We want to encourage that.

Mr. Chairman, in your proposal you allow the States to have Medicaid expansion or block grant, and they can choose. I think the States will choose what they believe will be in the best interest of helping kids.

A couple of reasons. I want to compliment John Chafee and the sponsors of his proposal, but I disagree with it for a couple, three reasons. First, I have to ask you a question. Is your enhance matched 30 percent?

Senator Chafee. It is 25 percent.

Senator Nickles. 25 percent. All right. I thought it was 30 percent.

Well, let me just mention a couple of things. One, under his proposal I am afraid you could be paying for a lot of kids that already have this coverage. And I compliment Rhode Island, they cover kids up to 250 percent; Hawaii covers kids up to 300 percent of poverty. Some States have really reached out and done a lot.

Well, we are not going to be covering any additional kids under that proposal, what we are going to be doing is having a higher Federal match. We are going to have a 25 percent increased Federal share.

That means a State that was contributing 50 percent is going to be contributing 25 percent more than that. It will be 62.5 percent. A greater Federal share for paying for the same kids. That is substituting Federal dollars for State dollars, but it does not insure any more kids.

Senator Chafee. Well, if that is a question, the answer is that under our program we require that the money be continued to be spent for health care for children.

Senator Nickles. Well, I do not quite of think of it in the form of a question. I asked this question earlier today. I believe you could have significant substitution where you would have greater Federal dollars paying for the kids in Rhode Island, for example, that the State already covers above the Medicaid mandate that right now is paid for by a smaller share.

In Rhode Island, for example, today it is 53.9 percent. If it is a 30 percent enhanced match, that would be 70 percent. Now it is 25, so it would be closer to 67 percent.

So the Federal Government was paying 53, now is going to be paying something like 67 percent. The Federal Government is going to pay more, but you are not going to insure more kids. I do not think that is a good

solution.

So, Mr. Chairman, I think you have come up with a good approach. States are doing a good job. I do not think we should be increasing a brand-new entitlement program, making it so attractive that States are going to receive 65, 75, 80 percent, 90 percent of this program financed by the Federal Government. I do not think that is a wise idea.

Senator Conrad. Mr. Chairman.

The Chairman. Kent Conrad.

Senator Conrad. Thank you, Mr. Chairman.

Let me just say, about what Senator Nickles just indicated, in terms of States doing more, New Hampshire is covering 39 additional children, Utah 99. We are talking about, some of these add-ons are very, very limited.

But let us go to the heart of the issue. What is the purpose that we are gathered here to address? The purpose is covering 5 million additional children in this country. If we are going to accomplish that goal we need to do it in the most cost-effective way possible.

The most cost-effective program that we know of is Medicaid. It has got the lowest overhead of any of the proposals, I think, before us. It is tested. It provides a benefit package specifically tailored to

children.

Let me go to the problems that I see with the Chairman's mark. And I would acknowledge the Chairman has made a good faith effort to improve his offering. But I am afraid we are still left with a package that will allow State gaming.

We have seen it with the DSH program, we have seen it with other State operations, that take money that is intended for one purpose and uses it for another. We have seen it repeatedly.

I think this is open to that occurring again, that instead of getting additional children covered, what we will find is the States take the money and subsidize other State programs not covering children.

Finally, Chafee-Rockefeller provides seamless coverage for children of a family. In the Chairman's mark, a child under 6 would get Medicaid, but his 7-year-old sister might get a completely different health package, leading to complexity and confusion.

Mr. Chairman, I really do think you have made a good faith effort, but I think Chafee-Rockefeller have a superior proposal for covering children.

The Chairman. Next, we have Senator Moseley-Braun.

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

I am glad that Senator Rockefeller mentioned that we cannot lose sight of why this exercise exists. We are talking about, how do we provide coverage for children?

Just to put a reality check on some of the conversation, when we talk about poverty levels, what constitutes 100 percent of poverty. For a single mother and a child, the poverty level in 1997 was $10,610 a year. $10,610 a year to cover all life expenses for that single mother and that child.

It seems to me that if we do anything to make it more difficult for people at that level of the income scale to provide health care for children, we will have committed a grievous harm to the most vulnerable population in this country.

The Chafee-Rockefeller proposal calls for coverage of 100 percent of poverty, again, the $10,000 that I mentioned for that single mother and child, and provides for enhanced coverage up to 150 percent of poverty. Again, we are not talking about people who have a lot of disposable income or who have an awful lot of options.

Senator Hatch made an interesting point, and I would call my colleagues' attention to it, having to do with the extent of coverage for these vulnerable populations of poor children.

He mentioned the EPSDT, which is the early, periodic

screening, diagnostic, and treatment. It is a range of services, particularly for children, that have to do with prevention, early intervention, to catch the eyesight problem that might impede learning or the hearing problem that might impede a child's development.

Well, if we move away from the direction of that level of coverage, again, we will have just aggravated the difficulties that these poor children will face. So, my time is running out.

I just want to say that, while the rhetoric about the States, and this, that, and the other may have popular appeal, and I do not castigate any of my colleagues for referring to it, at the same time, at the end of the day, in the final analysis, we really are talking about the poorest, most vulnerable children in this country and the level and range of health care that will be made available to them.

It seems to me that those children should not be left to an accident of geography, what State they might live in. They are all American children and we ought to make certain that they receive a level of health care that befits our entire country.

The Chairman. I have two more on my list, then I would like to call for the vote. Max Baucus and John Breaux.

Senator Baucus. Thank you, Mr. Chairman.

Mr. Chairman, I think this is a fairly important vote, and let me explain why. When the President's health care plan failed several years ago, I think it left kind of mixed emotions in the minds of all of us. On the one hand, the plan was too big and it fell of its own weight.

On the other hand, I think most of us realized we had to figure out what next we were going to do with health care. We did pass the Kassebaum-Kennedy bill, which did give additional coverage in the sense of portability.

In addition, we denied insurance companies the right to deny coverage on the basis of pre-existing conditions. That was a Federal bill. We did not give States the option to deny because of a pre-existing condition or States the option to provide for portability coverage or not, instead we took a Federal approach.

My concern, frankly, with the mark and the reason why I prefer the bipartisan alternative, is essentially because if we ask ourselves the fundamental question, under which proposal are more low-income kids going to get covered. the answer is quite clear: it is under the bipartisan Chafee-Rockefeller proposal.

This is the reason why. Under the bipartisan Chafee-Rockefeller provision, we are extending a known program,

Medicaid, designed for low-income people. It is an entitlement program, but it is capped, so it is more likely that more low-income kids are going to get covered.

Compare that with the mark. The mark says, all right, States, you get a block grant. Some States are going to do a good job. I can tell you from experience that some States, some States' governors and some States' legislatures are not going to do a good job. They are going to take the block grant money and, as pointed out by Senator Conrad, they are going to game it. They are going to use it for other purposes. It is just going to happen.

In addition to that, the Federal Health Benefit program is quite varied. It includes deductibles and co-pays. I do not think we want a low-income insurance program that has deductibles and co-pays. Under the provision before us, not the amendment, at least in the mark, that is entirely possible. That could happen, and that would be disaster for low-income kids.

In addition, I might remind Senators that already there is a lot of State flexibility. Many States, through waivers of Medicaid, have all kinds of flexible programs and some have opted out because of waivers. Currently today there is a lot of flexibility.

But the bottom line question is, are more kids going to get covered under expanding Medicaid or are more low-income kids going to get covered under a block grant for States?

I submit, almost by asking the question, the answer is clear: that more kids are going to get covered under Medicaid, expansion of Medicaid, than they will of block grants. If that is what this debate is all about, if we are out to cover more kids, it just seems it is pretty clear to me that we should adopt the Chafee-Rockefeller amendment.

The Chairman. John Breaux.

Senator Breaux. Mr. Chairman and my colleagues, I think that it is fair to say, at least in my opinion, that ultimately we will end up with something that will be, I think, fairly pleasing to both sides. The question is, how do we get there?

I think the goals are the same for both arguments, and that is to insure more children. The question truly is, what do we go to conference with in order to ensure that that goal is met?

It is an interesting argument that some make that, well, if we let the States have a block grant they are going to somehow game the system, as if they had not gamed the Medicaid system since it has been in existence.

My State, and many other States, have become experts at gaming Medicaid.

So what we really ought to do is to try and devise a system that puts enough assurances that when we send the program down to the States we can be guaranteed that they will follow the law as we intended to do that.

I think the compromise does that. I was a sponsor of the Chafee-Rockefeller. I commend them. Their original goal was to insure more children, and I agree with that 100 percent.

The question is, how do we do it in the best and fairest way? To suggest that the States should not have the ability to be innovative and to come up with other ideas about how best to do it suggests that we know best in all areas of health care, and I think that is not correct.

I think it is important, finally, that when we look at what this option provides we ought to recognize how tightly it is drawn. A lot of the arguments I think that were made this afternoon and this evening on this do not reflect what is in the Chairman's option.

Option 1 says, yes, they get a block grant if they want to, but the block grant must be used for health insurance coverage for children, not for vans, not for other services, not for material things, not for pay

increases for State employees, but that block grant must be used for health insurance coverage for children up to 200 percent of poverty. I think we all agree with that as a goal. The fact that lower-income children must be covered first is a very positive addition.

The other part that I think is so important to recognize, is that it says that it is to provide health care for children that is consistent with the Federal Employees Health Benefit plan.

That does not mean they have to have the same premiums, the same charges, the same deductibles. It says the coverage. When you are talking about coverage you mean what is covered by the plan, not how much it costs, not what the deductibles are, but it must have the same coverage that is consistent with the Federal Employees Benefit Plan.

Finally, the ultimate protection is that we have to say to every State that they have to submit a plan to the Secretary, and the Secretary must certify that all of these things in this option are being met before that Secretary can approve it, regardless of which Secretary and which administration it happens to be. I think that this is a fair compromise and, ultimately, my colleagues, I think, are going to come up with most of us can agree with, it is just how we get there.

The Chairman. I believe the time has finally come for a vote. We have had a full and extended debate.

Senator D'Amato. Mr. Chairman.

The Chairman. Yes, Senator D'Amato.

Senator D'Amato. Thank you, Mr. Chairman.

Mr. Chairman, it is important for us to ascertain those States that do have an effort not mandated by Medicaid to be sure we are not going to be placed in a situation where we lose certain benefits. Let me be more specific.

New York now has a plan that has been in operation since 1990 and has been expanded quite a bit called Child Health Plus. Now, it spends $110 million a year. It basically is managed care.

As a result of pooling and a number of insurers coming in, it provides insurance for 130,000 children. That is roughly a cost of $84 a month, and it comes to a little more than $1,000 a year. Let me assure you that it covers up to age 19, and up to 220 percent of poverty.

Now, why do I bring that up? It covers the whole array of doctor's visits, inpatient lab tests, diagnostic, emergency room, prescription drugs, radiation, kidney dialysis, et cetera. It is the goal of the State to continue to expand that.

I bring this up for several reasons because, yes,

there may be some States that have not and do not provide, but I believe that to characterize all of the States and their efforts in that manner is certainly not accurate. Can we do better? I think, certainly. Are States doing better? I think many are, and many will.

I am a co-sponsor of the legislation by my good friend, John Chafee and Senator Rockefeller. Having said that, the block grant does provide a flexibility that our governor seeks.

I have to ask one question, because we provide these services by use of a provider tax. I have to get two things. Number one, can we use our current spending on our children, that $110 million, that health insurance program, as part of our State match if we were to support, or if the Chairman's plan were to be adopted?

Mr. Smith. Senator, I think the intent is that the States be recognized for the additional coverage that they have already covered, and we certainly do not want to penalize States who have already done more.

Senator D'Amato. That is very important to us, so that we are not penalized or lose the ability, if we are purchasing this insurance, that we could not use it as a match.

Second, there will be no prohibition against using that provider tax?

Mr. Smith. The same rules of Medicaid that are already there would apply to the new program.

Senator D'Amato. So we could still continue the use of that tax.

Mr. Smith. Provider taxes and donations are allowed, to some extent, under current law.

Senator D'Amato. Mr. Chairman, I thank the Chairman. Now, that is a very important element, and I have had our State health people and budget people working with Senator Moynihan and I frantically to ascertain that. Under those conditions, I can support the Chairman's mark.

Senator Rockefeller. Would the Senator from New York yield?

Senator D'Amato. Certainly.

Senator Rockefeller. Just to the observation that, under the Chairman's mark, whereas it is true that New York has covered about 90,000 children, it has, I think, about 900,000-some uninsured children yet to go.

Senator D'Amato. We are up to 130,000, and I think that is a pretty good effort, and an effort that is intended to expand to some 200,000 in the next two years.

Senator Rockefeller. If I could just make my point, sir.

Senator D'Amato. Certainly.

Senator Rockefeller. You will not be able to get a whole lot higher because what has not been pointed out yet, the Medicaid in the Chairman's mark is capped. You cannot spend, for uninsured children, beyond a certain amount. I think it would be impossible for New York to cover its 500,000 that the Senator himself refers to.

The Chairman. I think the time has come for the vote. Let me point out, an aye vote will be for the Chafee Medicaid amendment, a nay vote will be opposed to that amendment.

The Clerk will call the roll.

The Clerk. Mr. Chafee?

Senator Chafee. Aye.

The Clerk. Mr. Grassley?

Senator Grassley. No.

The Clerk. Mr. Hatch?

Senator Hatch. Aye.

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. Gramm.

Senator Gramm. No.

The Clerk. Mr. Lott?
Senator Lott. No.
The Clerk. Mr. Jeffords?
Senator Jeffords. Aye.
The Clerk. Mr. Mack?
Senator Mack. No.
The Clerk. Mr. Moynihan?
Senator Moynihan. Pass.
The Clerk. Mr. Baucus?
Senator Baucus. Aye.
The Clerk. Mr. Rockefeller?
Senator Rockefeller. Aye.
The Clerk. Mr. Breaux?
Senator Breaux. No.
The Clerk. Mr. Conrad?
Senator Conrad. Aye.
The Clerk. Mr. Graham?
Senator Graham. No.
The Clerk. Ms. Moseley-Braun?
Senator Moseley-Braun. Aye.
The Clerk. Mr. Bryan.
Senator Bryan. No.
The Clerk. Mr. Kerrey?
Senator Kerrey. Aye.
The Clerk. Mr. Chairman?

The Chairman. No.

Senator Moynihan. Moynihan, aye.

The Clerk. The votes are 9 yeas, 11 nays.

The Chairman. The Chafee amendment does not carry.

Senator Hatch?

Senator Hatch. Thank you, Mr. Chairman.

The amendment I am offering on children's health.

Senator Gramm. I thought we were going to do the Kerrey amendment.

Senator Hatch. Well, they asked me to go next. I am happy to wait until the Kerrey amendment.

The Chairman. No, we will proceed. Senator Hatch, please.

Senator Hatch. All right.

The amendment that I am offering on children's health is based on the bipartisan Hatch-Kennedy child legislation. The essence of this legislation is to increase the tobacco tax 43 cents in order to finance voluntary State children's health insurance programs and to provide for deficit reduction.

Now, some might make complicated arguments that my amendment would violate the Budget Agreement. Some will contend that an amendment that actually reduces the debt by $10 billion over 5 years is somehow antithetical to a balanced budget deal.

Now, I would just raise in advance, why should this amendment be considered as out of order in a legislative package that makes an adjustment to the Tax Code, such as, for example, the proposed adjustment to the HI Trust Fund?

Now, the American people support this proposal. An April 26 Wall Street Journal/NBC News poll asked a simple question: "Two Senators, a Republican and a Democrat, have proposed increasing cigarette taxes by 43 cents a pack and giving much of the money to help States provide health insurance for uninsured children. Based on this description, do you favor or oppose this plan?"

Seventy-two percent of Americans agree with our plan, and this support cuts across almost every demographic category that you can think of. For example, more than 50 percent of smokers agree with the Hatch-Kennedy plan.

Now, experts believe that tobacco costs society $100 billion annually, including $50 billion in direct health care costs. Of this $50 billion, there are $10 billion in annual costs to Medicare, $5 billion in Medicaid, $4.75 billion to other Federal programs, and $17 billion in increased insurance premiums.

So the case against tobacco, and for a tobacco user's tax increase, is strong. As a conservative, I carry a strong presumption against all tax increases, but in this

case I believe the burden has been met.

There is an equally strong case to increase resources for children's health insurance. Ten million American children without health insurance is simply too many. My amendment, taken in concert with the $16 billion already in the Budget Agreement for children's health, will go a substantial way toward addressing this problem.

But the simple fact is, $16 billion is not enough to get the job done. The Federal share of Medicaid is about $860 per child this year. According to the Employee Benefit Research Institute, there are about 4.7 million uninsured children in families with incomes less than 125 percent of poverty. That is about $19,500 for a family of four.

To cover these children will cost $4 billion this year, and that is almost $1 billion more than is in this Budget Agreement. As a matter of fact, if we use the same calculation on the total of 8.3 million uninsured children that live in families under 240 percent of the poverty level, it would cost $7.14 billion this year to cover these children.

My amendment, if we combined the $16 billion already in the budget agreement, would raise $7.2 billion on a 5-year annualized basis. This sum, of course, would not be sufficient to cover those 2.2 million uninsured children

in families over 240 percent of the Federal poverty level, nor does this calculation take into account the impact of health care inflation over the 5 years that will shrink the actual purchasing powers of these grant dollars.

Also, this simple calculation does not take into account the enhanced Federal match rates which serve as an incentive to get States to participate in children's programs.

What these simple calculations do prove, though, is that $16 billion alone is not anywhere near sufficient. Only if $16 billion is combined with the Hatch-Kennedy child bill can we make substantial progress on this problem.

Now, with regard to the health benefit package, I have always said to the governors I will be flexible on it, and we will. But I think it is important that we vote for this tonight, and I would ask that we vote for it in committee.

Senator Gramm. Mr. Chairman.

The Chairman. Yes, Senator Gramm.

Senator Gramm. Mr. Chairman, let me say that we have just decided, on a bipartisan vote, to go forward with a major new innovation, spending $16 billion and giving States the ability to opt for Medicaid or to

develop their own plans within strict guidelines.

What Senator Hatch is proposing is that we take a system which we just decided at the committee level to start two and a half minutes ago, and add another $20 billion to it.

If you take the 5 million children that we have all targeted that we want to cover, and if we are funding it over 5 years, and you take the amount of money that would be provided by the Hatch proposal, we would be providing $1,444 per child, which is more than twice the amount that anybody estimates that this program would cost us to put into place. That is with no State match whatsoever.

So I think what we are seeing here is a good idea gone crazy. Why should we buy every child two insurance policies when we can buy them one insurance policy?

Now, I know how people feel on the tobacco tax, but let me just remind my colleagues that this is not just a vote on the tobacco tax, this is a vote to raise taxes on tobacco and to spend the money on a purpose that we have already provided $16 billion for on a bipartisan basis.

So I believe, Mr. Chairman, that the committee has spoken on this issue. We have set up a program providing $16 billion. Coming back now and adding another $20 billion to that program, providing more than twice the amount of money needed to insure every one of the 5

million children that we are targeting, makes absolutely no sense.

If someone is just overcome by the desire to tax cigarettes, I ask that they consider that if one decided to do that, and I am not for it, I would want to remind them that they could spend the money for something else other than force-feeding a program that provides more than twice the amount of money that is required to do the job.

So I think we ought to reject this amendment. I think we ought to object it on a big vote and get on with providing a program that the President supports at $16 billion, that our conferees negotiated at $16 billion, and which we just provided at $16 billion.

Senator Hatch. Mr. Chairman, could I answer?

The Chairman. Well, the Chair wants to point out that this proposal is in addition to the $16 billion contained in the Budget Resolution.

The Chair, on its own motion, holds that the amendment is non-germane, under Committee Rule 2-A, for two reasons. One, the amendment embraces S. 525, a proposal within the jurisdiction of the Labor and Human Resources Committee, and two, the amendment embraces a tobacco tax. Now, this is not a tax bill and that provision is not germane to this spending reconciliation

legislation.

Senator Hatch. Well, Mr. Chairman, if I could respond to that.

The Chairman. The Senator from Utah.

Senator Hatch. First of all, let me respond to my friend from Texas. We learned earlier today from Bruce Vladeck that the House Commerce block grant may be scored as reaching only 380,000 uninsured children.

Now, I understand that this is a complicated matter, because some funds will be used for direct services and not to purchase insurance, but it just shows you that this whole area is not cheap.

We heard earlier today from Bruce Vladeck that it costs about $1,000 or so for a good, solid insurance policy. We also know that the Federal share of Medicaid this year averages about $860 per child.

In the first year of the child program there would be an even 50/50 split between health care and deficit reduction so that $3 billion will be used for program costs. In year 5, this program component will grow to $5 billion.

Using these numbers as a guide, it seems reasonable to expect that, depending a great deal on how States choose to implement this program, that our bill will be able to cover about 3.5 million or so children in the

early years of the children, and about 5 million children in the fifth year.

Now, there are many variables, such as which States choose to participate, what their State matching requirement is, and what co-insurance and co-payments they require, and so on. We must also take into account inflation, which will erode the purchasing power of the yearly allocation.

Now, there is another way to look at the problem to see how many children the $16 billion in the Budget Agreement would cover. This $16 billion amounts to an average of $3.2 billion per year. If we used all of this money to buy Medicaid coverage at $860 per child, it would only cover 3.7 million children.

Now, this would still leave 1 million children under 125 percent of poverty with no health insurance at all. As I said earlier, we think that, together, the $16 billion with the $20 billion of Hatch-Kennedy's child funds, would cover these 8.3 million children that live in families under 240 percent of the poverty level.

This represents about 80 percent of the Nation's uninsured, poor, working families' children. Ninety percent of these kids live in families where one parent is working.

Now, with regard to the Chairman's ruling that this

amendment is non-germane, I would just ask the Chairman to reconsider that because ours is an integrated, self-financed children's health initiative.

During the conceptual discussion of the spending bill last Thursday, it was indicated that the Chairman's mark itself might include at least one tax provision, which I mentioned before, extending hospital insurance payroll taxes to State employees.

In the past, I know the Chairman has exercised his discretion to allow consideration of tax items during mark-ups on spending bills. For example, during the consideration of the Reconciliation bill in 1995, Chairman Roth allowed consideration of an amendment by Senator Moynihan that would have paid for scaling back the Medicare cuts by scaling back tax cuts.

So I would hope you would reconsider. If not, I would have to appeal the ruling of the Chair and ask for a roll call vote.

The Chairman. The Senator from Utah has asked for a roll call vote. I would point out that the Senator, in the past, has made the point of order that legislation proposed by, I think it was Senator Pryor, on drugs was not germane----

Senator Hatch. That is true.

The Chairman. [Continued]. Because it was not

within the jurisdiction of the Finance Committee.

Senator Hatch. That was not nearly as important as this.

[Laughter]

The Chairman. So I must rule that the proposed amendment is non-germane and I would call for a vote. I would point out that an aye vote would be to overturn the Chairman's ruling, a nay vote would be to sustain the appeal.

The Clerk will call the roll.

The Clerk. Mr. Chafee?

Senator Chafee. Aye.

The Clerk. Mr. Grassley?

Senator Grassley. No.

The Clerk. Mr. Hatch?

Senator Hatch. Aye.

The Clerk. Mr. D'Amato.

Senator D'Amato. Aye.

The Clerk. Mr. Murkowski?

Senator Murkowski. No.

The Clerk. Mr. Nickles.

Senator Nickles. No.

The Clerk. Mr. Gramm.

Senator Gramm. No.

The Clerk. Mr. Lott?

Senator Lott. No.
The Clerk. Mr. Jeffords?
Senator Jeffords. Aye.
The Clerk. Mr. Mack?
Senator Mack. No.
The Clerk. Mr. Moynihan?
Senator Moynihan. No.
The Clerk. Mr. Baucus?
Senator Baucus. Aye.
The Clerk. Mr. Rockefeller?
Senator Rockefeller. Aye.
The Clerk. Mr. Breaux?
Senator Breaux. No.
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. Bryan.
Senator Bryan. Aye.
The Clerk. Mr. Kerrey?
The Chairman. We want you to vote.
Senator Kerrey. Aye.
Senator Nickles. But not that way.

[Laughter]

The Clerk. Mr. Chairman?

The Chairman. Nay.

The Clerk. The votes are 10 yeas, 10 nays.

Senator Hatch. No. It is 11 yeas, 9 nays.

The Chairman. It takes two-thirds of a vote to overturn the Chairman, so the Chairman is sustained by the vote.

We are open to further amendments. Senator Kerrey?

Senator Kerrey. Back by popular demand.

Mr. Chairman, this amendment that I have offered we have discussed before. It is an amendment that establishes in law in the Medicare program an income-related premium for Part B.

As we all know, the Part B premiums are currently calculated to cover 25 percent of program costs through 1998, with the remainder of Part B expenses financed through general revenues. It has been often discussed---

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Senator Moynihan. Can we have order, Mr. Chairman?

Senator Kerrey. [Continued]. That some kind of an income-related test needs to be applied. I have originally offered an amendment that adjusted the premiums with income and with Senator Gramm's collaboration.

The current language of the amendment reads as follows: it establishes monthly premiums for individual beneficiaries with incomes below $50,000, and couples with income below $75,000 at the current level of 25 percent, and after that level of income there is a straight-line, sliding scale phase-out for beneficiaries with incomes above $50,000 and $75,000, with the subsidy ending at $100,000 per year annual income for individuals, $125,000 a year for couples, with the subsidy phase out applied to the Part B deductible.

Mr. Chairman, again, this has been amply discussed. Senator Chafee, I understand, is still co-sponsoring the amendment, and Senator Gramm is as well.

I would have preferred, and Senator Moynihan, as well, would have preferred, frankly, to have the income test a bit lower, but I think this does get us started and it is defensible on the floor. It is defensible, I think, in almost every imaginable way. I am hopeful that it can be adopted by the committee.

Senator Gramm. Mr. Chairman.

The Chairman. Senator Moynihan, I think.

Senator Moynihan. May I just say, Mr. Chairman, and remind the Senators, who know this, that when the Medicare program was begun, the matching rate for the Part B insurance provision was 50 percent. We were

holding on there at 25 percent, but now for the first time we return to something like the original intent of this legislation in the interest of maintaining the integrity of the program.

The Chairman. Senator Gramm.

Senator Gramm. Mr. Chairman, I am very proud to be a co-sponsor of this amendment. I think this represents a major reform. It indexes the equivalent of the Part B premium.

This will now become a deductible for high-income individuals, so we will not only save the money but we will also change their behavior by the fact that they will have to pay this amount of money before they qualify for a benefit, something that is supported across the whole political spectrum, in order to try to provide incentives for people to be cost-conscious.

I think that this reform, together with conforming the retirement age of Social Security with the eligibility for Medicaid, represents by far and away the most dramatic reform of Medicare in the history of this country.

There is no doubt about the fact that if this amendment is adopted and sustained, together with what we have done to conform the retirement age under Social Security with eligibility for Medicaid, we will have done

more in one mark-up to save Medicare than all the talk that has occurred in this country for the last 35 years.

The Chairman. Next, is Senator Chafee.

Senator Chafee. Mr. Chairman, I just want to briefly say that we had this in the Centrist Coalition budget a year ago, so I have been a supporter of it for a long time.

Some people are under the misconception that Part B funds result from a payment into some kind of a trust fund, then the premium monies are paid to the government from that that trust fund. Not at all.

Under the present system, the individual pays 25 percent of the cost of the premium and 75 percent, three-quarters, comes from the General Treasury of the United States of America.

So you have the bizarre situation of low-income people working away, paying their taxes, and their taxes going to pay some multi-millionaire's physician's bills, which is the Part B.

So this is a very, very worthwhile proposal and I just want to congratulate everybody who has had a hand in it.

Senator Nickles. Mr. Chairman.

The Chairman. Senator Nickles?

Senator Nickles. Mr. Chairman, I compliment

everyone who has spoken. I concur. I would mention, I think we suggested that all of these savings or additional revenues to be generated from this would go into Part A, is that agreeable?

Senator Kerrey. That is an agreeable change for me.

Senator Nickles. Mr. Chairman, I would appreciate it, and I think my colleague from Nebraska, that that further ensures that, yes, there will be some additional costs for upper income people. We are saying we will take 100 percent of these costs and put that into Part A, which does have significant solvency problems in the future.

Senator Conrad. Would the Senator accept a co-sponsor on that?

Senator Nickles. I would be happy to.

Senator Baucus. Mr. Chairman?

The Chairman. Senator Baucus.

Senator Baucus. I would like to ask the sponsor of the amendment, is the point of this to phase out Part B premiums only, or also hospital deductibles?

Senator Kerrey. Just Part B. It only affects Part B. As I said, for individuals under $50,000 and couples under $75,000, they would continue at the current rate, which is 25 percent.

Senator Baucus. Right. But it only affects Part B

premiums.

Senator Kerrey. It only affects Part B premiums.

Senator Baucus. Thank you.

The Chairman. Is there any further comment?

[No response]

The Chairman. A roll call vote has been requested.

The Clerk will call the roll.

The Clerk. Mr. Chafee?

Senator Chafee. Aye.

The Clerk. Mr. Grassley?

Senator Grassley. Aye.

The Clerk. Mr. Hatch?

Senator Hatch. Aye.

The Clerk. Mr. Murkowski?

Senator Murkowski. Aye.

The Clerk. Mr. Nickles.

Senator Nickles. Aye.

The Clerk. Mr. Gramm.

Senator Gramm. Aye.

The Clerk. Mr. Lott?

Senator Lott. Aye.

The Clerk. Mr. Jeffords?

Senator Jeffords. Aye.

The Clerk. Mr. Mack?

Senator Mack. Aye.

The Clerk. Mr. Moynihan?
Senator Moynihan. Aye.
The Clerk. Mr. Baucus?
Senator Baucus. Aye.
The Clerk. Mr. Rockefeller?
Senator Rockefeller. I think not.
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. No.
The Clerk. Mr. Bryan.
Senator Bryan. Aye.
The Clerk. Mr. Kerrey?
Senator Kerrey. Aye.
The Clerk. Mr. D'Amato?
Senator D'Amato. Aye.
The Clerk. Mr. Chairman?
The Chairman. Aye.
The Clerk. The votes are 18 yeas, 2 nays.
The Chairman. The Kerrey amendment is carried.
The Chairman. The legislation is open to amendment.

Any further amendments?

Senator Moseley-Braun. Thank you, Mr. Chairman.

The Chairman. Senator Moseley-Braun.

Senator Moseley-Braun. Thank you.

Mr. Chairman, I propose my amendment number 6. It has to do, really, with the language of the mark pertaining to cost sharing requirements. It seems to me that, at a time when we are seeking to address the problem of children lacking health care coverage, that it is counterproductive to adopt a rule that would allow States to charge premiums that would discourage many families with children from participating in Medicaid.

The cost sharing proposal in the mark threatens to reduce access for care for many of the children, elderly, and disabled who rely on the Medicaid program, even though there was no evidence that there was any need to really change the amount that is being charged for co-pay.

Given that the States are likely to have greater flexibility to reduce reimbursement rates for hospitals, nursing homes, and HMOs, not to mention the impact of the welfare reform, I believe it is particularly important that we not rush to judgment in changing the cost sharing requirement language in ways that would mitigate negatively against access to health care by these

vulnerable populations.

To explain the issue specifically, under Medicaid the States are allowed to impose nominal cost sharing requirements, which has been interpreted to mean abut $2 to $3, but they are not allowed to charge right now under the HMOs and managed care.

Well, certainly it makes sense to have the same nominal cost sharing requirement applied to both Medicaid and HMOs, but the mark sets up a new formula altogether. The new formula can go as high as 5 percent for those who are between 150 and 200 percent of poverty. Earlier we were talking about what those numbers are. You are talking about people that do not have a lot of money.

Essentially, for a single working mother with a child, that could be, under the new formula, as much as $1,000 on an annual basis. Certainly for those who use the services, the disabled, the elderly, the chronically ill and cumulative users of the system, this formula would not only impose a burden on the individual, but I believe also would be difficult for the States to monitor because the States would have to keep track of how many times each individual beneficiary made use of services, the size of the co-payment he or she was charged for the services in order to enforce the caps on cost sharing that is proposed in the mark.

So the administrative difficulties, as well as the impact on individuals, suggest that just using the word nominal as opposed to this new formula would achieve the ends that this committee has set out to achieve.

I had hoped that this would be something that we could work out and it would not have to be voted on, it would be something that could be just accepted or looked at because, again, it really comes down to whether or not we are going to use the existing formula that allows for a nominal co-payment charge, which makes sense to extend that to HMOs, or if we are going to go to a brand-new formula that, again, can have the untoward impacts of closing access for these vulnerable populations.

I would encourage the Chairman to consider the amendment, if it can be accepted. Again, given the administrative difficulties, as well as the individual impact, as well as the negative impact on access to necessary primary care, that this part of the mark needs to be amended.

I would point out, further, that in light of the fact that this new formula and co-payments can be applied to pregnancy-related care, including prenatal care, it can be applied to immunization and other preventive care for children, it can be applied to prescription drugs.

It probably makes more sense to just stick with

nominal, the language that currently is in the law, as opposed to going to a new formula that opens up all of these difficulties that I have mentioned.

The Chairman. Dennis, would you comment on this proposal?

Mr. Smith. Yes, Mr. Chairman. First, in terms of current law and those families that are required to be covered by Medicaid, basically this is not a change for them.

Senator Moseley-Braun. Yes.

Mr. Smith. These are for the new populations then-----

Senator Moseley-Braun. For HMOs. Right.

Mr. Smith. [Continued]. As we extend into coverage.

Senator Moseley-Braun. Right.

Mr. Smith. There are co-payments allowed under current law. There are co-payments allowed under waivers, et cetera. So what we were trying to do is, as Medicaid gets expanded into higher levels of income, to have a cost sharing amount for them, but also still capped.

Again, there is cost sharing already in the Medicaid program for families in transition, up to 3 percent of poverty, less child expenses. So we are building on what

is in current law.

For those families moving up above 150 percent, we would have a 5 percent limit on them. So we are trying to maintain the structure there, but to continue to allow cost sharing as Medicaid gets expanded into new populations.

Families at 150 percent of poverty, about half of children in these families are insured with private insurance. At that level in private insurance, a family is bearing about a third of the total cost of its private insurance, when you add up all the premiums, deductibles, co-payments, et cetera. So keeping that lid on total co-payments down to 3 percent seems to be a reasonable level, in terms of what is already allowed in the Medicaid.

Senator Moseley-Braun. Mr. Chairman.

The Chairman. Senator Gramm.

Senator Gramm. Well, if Carol wanted to respond to that, then I would like to be heard, Mr. Chairman.

The Chairman. Carol?

Senator Moseley-Braun. Well, I just wanted to make the point that I do not know that Mr. Smith, in terms of responding, again, we are talking about, you are right, it is correct that the current law says nominal co-pay.

My argument is not with co-payments, it is just that

you have got a new formula that nobody is going to be able to understand or administer, given that you have got to track income, you have got to track co-payments as to each visit, and it will apply, again, to these vulnerable populations.

We are not talking about the top end of the scale, but rather the bottom end of the income scale, up to 150 percent of poverty. So I do not know that the response was actually responsive to the issue being raised here.

Mr. Smith. I apologize, Senator, if I was not responsive. You are absolutely correct, there would be administrative costs associated with doing this, and the States would choose whether or not they would want to take on those new burdens. CBO did not score this as costing or saving any money.

The Chairman. Senator Gramm?

Senator Gramm. Well, Mr. Chairman, first of all, let me point out that this simply allows States to do what States have asked us to allow them to do, and that is to begin to use co-payments.

Let me explain why, in the provision where we are expanding coverage to higher-income people, this is critically important. When you get to 150 percent of poverty, 50 percent of all families already have private health insurance.

So for every two children that you are reaching in this category, one of them is already covered by private health insurance. One of the biggest problems we have in trying to help children is this problem called crowding out, where we expanded Medicaid benefits in 1987, and what happened is, as Medicaid benefits expanded, people dropped private health insurance.

So, remarkably, even though we spent billions of dollars of additional money, we did not cover, in the aggregate, one new child, we simply substituted public money for private money.

Some of you will remember, and since we have our illustrious Majority Leader on my left I am not going to cover up his profile with my chart, the chart that I showed where, as Medicaid went up starting in 1987, private health insurance went down as people dropped their private health insurance.

What this provision will do, is simply allow States to try to coordinate the coverage so that we do not drive people out of private health insurance, and in the process destroy the fact that 50 percent of the children we are trying to reach have already got private health insurance.

As Dennis said, where these private health insurance policies do have some small co-payments and small

deductibles, if the States, in trying to prevent crowding out, want to try to homogenize, or harmonize is a better word, the private insurance with a public alternative, they can do it without driving people out of private health insurance. You can imagine----

Senator Rockefeller. Would the Senator yield?

Senator Gramm. Let me finish my point. Let us say that I am 150 percent of poverty and I have got a private health insurance policy. If the coverage is being provided by Medicaid and there are no deductibles and no co-payments and the Federal Government is going to pay for all of it, why should I keep my private health insurance policy? Why not drop it and pick up Medicaid?

The point is, millions of families have already done that between 1987 and the present. Why I see the Chairman's provision as being important is we are not forcing States to do co-payments.

We are limiting the level of co-payment, but we are simply giving them the flexibility of harmonizing some of these provisions for higher-income families that have already got 50 percent insurance coverage so that we do not end up trying to cover 5 million children, only to find that 5 million other children that had private health insurance dropped it, so we did not end up covering anybody and so, $16 billion later, all we have

done is gotten people out of Blue Cross/Blue Shield or HMOs into Medicaid.

So this is something the governors asked for. It is totally flexible. There is a limit on the aggregate amount that you can do. But co-payments, even at very low levels, are very important things, which is why the States want them.

Senator Rockefeller. Would the Senator yield?

Senator Gramm. I would be happy to yield.

Senator Rockefeller. Senator Gramm, number one, the children that we are talking about basically, at 150 percent below poverty, if you reach the Congressional Research Service or a plethora of other studies, these are not the kids that are going to be crowding out private insurance into public insurance, these are the people whose families who do not have----

Senator Gramm. I am sorry, but that is not right. In fact, the crowding out occurred below 100 percent of poverty. We are going to have a lot more crowding out here, and 50 percent of the children have already got private health insurance. Fifty percent of these low-income families, sometimes with their employer, sometimes in a partnership with their employer, sometimes on their own, 50 percent of them are actually paying for private health insurance right now.

The point is, we do not want to crowd them out of private health insurance and get them to opt for Medicaid. If, by having the flexibility which the governors want, to try to have some modest co-payments we induce people not to do that, I cannot understand why we would not want to do it.

Again, this is not for people that are below the poverty line, this is for people at higher incomes where we have got 50 percent of them that already have private health insurance.

Senator Moseley-Braun. If the Senator will yield. The point is not against co-payments. This is accepting that we would have co-payments. The question is, are you are going to have co-payments that are fixed or are we going to go to a brand-new formula that nobody will be able to administer? That is the issue here, not the larger issue that you raised about crowding out and co-pay. That is not the issue at all.

Senator Gramm. Well, Mr. Chairman, the point is, we do not want a fixed formula. We set out the aggregate amount that they can have. But if, for example, in a State they do a survey and find out what the average private policy that moderate-income people have is and they look at what it has in terms of co-payments and deductibles, we want to preserve their ability to take

this, in the aggregate, modest amount of co-payment and use it where it will prevent crowding out to the maximum extent.

So we do not want to set it as a fixed amount on everything. It may well be that, for example, insurance policies that are available to moderate-income people in my State either do not cover prescription drugs or have high deductibles or high co-payments. The point is, we want to preserve the ability of the State to try to prevent people from dropping private health insurance.

The point I would like to remind people of, is this is not a category where everybody is uninsured. This is a category where one out of every two children is currently covered by private health insurance. So we are not letting it go above an aggregate level, but we want to keep the State flexibility to decide it, and that is what the whole thing is about.

The Chairman. Senator Bryan.

Senator Bryan. Mr. Chairman, I have two questions. Assuming that Senator Moseley-Braun's amendment is granted, what co-payment, if any, could be charged with respect to those Medicaid benefits that are beyond the requirement of mandating coverage under Federal law?

The second question is, can you quantify for me, excluding for ease of computation the child care

expenses, what the range would be in the total charge of co-payments in each of these two categories? That is, the less than 150 percent and those families between 150 and 200 percent, if you can. That is, what would the maximum, what would the minimum be? For ease of calculation, just assume that there are no child care expenses, which I understand would be deductible.

The Chairman. Dennis?

Mr. Smith. Senator, the first part of the question, this does not affect those who are required to be covered under the mandatory services.

Senator Bryan. I understand that.

Mr. Smith. You asked about mandatory services.

Senator Bryan. No. No, I did not.

Mr. Smith. I am sorry.

Senator Bryan. I asked, assuming that the Senator's amendment passes, what kind of co-payment, if any, is authorized with respect to those benefits that exceed those that are mandated by law?

Mr. Smith. I do not know that I could tell you that, Senator, because of waivers. I do not know all the waivers that have been granted.

Senator Bryan. Perhaps I am confused. I thought the purpose of the change in the mark was to allow for a co-payment, if you are providing a greater benefit than

is required under law. Perhaps I misunderstood. If that is true, it raises the inference that perhaps there is no authority under law to provide for an increased co-payment. Maybe my premise is wrong.

Senator Moseley-Braun. May I respond?

Mr. Smith. I apologize, Senator.

The Chairman. Carol.

Senator Moseley-Braun. The program right now allows for nominal co-payments. As we expand to the HMOs, the question is, will the co-payments be nominal co-payments or will they be this new formula? The new formula will have the effects that I have mentioned, and it is for that reason that I proposed the amendment, the administrative costs associated with it, and the like.

So, in response to the Senator's question, it would allow for a nominal co-payment. So it does allow for a co-payment.

Senator Bryan. It allows for a nominal co-payment, but not the formula that is proposed here.

Senator Moseley-Braun. That is it.

Senator Bryan. All right. I think I understand.

Dennis, if possible, can you tell me within the brackets what would the maximum and minimum payments be under the formulas that are proposed in the Chairman's mark?

Mr. Smith. Well, a family with income of $10,000, the maximum amount they could be would be $300 in a year. Income at the higher levels, a 5 percent maximum up to 200 percent of the poverty level.

Senator Rockefeller. Would the Senator from Nevada yield?

Senator Bryan. I would be happy to yield to the Senator from West Virginia.

Senator Kerrey. First, Dennis, is that $300 limit co-payment deductible and premium?

Mr. Smith. Everything together. That is how we are defining cost sharing, that it is everything, premium, co-payment, deductible, everything.

Senator Moseley-Braun. If Mr. Smith will yield, that is exactly part of the problem, just like when we pay co-payments and deductibles on our insurance, you have to pay it first before you can get your insurance. Theoretically, the way it is written a State could say to somebody making $10,000 a year, pay us $300 first before you can get your kid's ear exam, or whatever.

I mean, theoretically, that is way the formula could work. The co-payment could be required up front before any benefits under the new HMO would be allowable. That, it seems to me, is not right.

That is why I started off saying, we are talking

about expanding kids' health care, and this takes us in absolutely the opposite direction without, unfortunately, I think, a whole lot of thought about the issue. I mean, with all due deference, the staff has done such a great job with this, and this seemed to me to be such a tiny thing.

I did not understand why they would not have recognized, between the administrative difficulties and shutting access off for poor kids, it just did not make a whole lot of sense to do that.

Senator Rockefeller. Would the Senator from Illinois yield?

Senator Moseley-Braun. Yes, I am sorry.

Senator Gramm. Mr. Chairman, let me remind my colleagues----

Senator Rockefeller. I think I have the floor, please. I asked if the Senator from Illinois would yield, and she said yes.

Senator Bryan. It was the Senator from Nevada, and he said yes.

Senator Rockefeller. I appreciate that.

I am simply speaking to my friend from Texas through the Senators from Nevada and Illinois and just simply reading from the Congressional Research Service, because I really resent this idea that 50 percent of uninsured

children have private health insurance, I mean, of Medicaid.

It says, "Most children who are uninsured," and this is CRS, "but were eligible for Medicaid did not have access to group health insurance coverage. Data from the CPS--which stands for Current Population Survey--indicate, of this sample, only 300,000 of these 2.9 million children were members of families in which the head of the family, spouse, or both were covered by group health insurance."

So the concept of 50 percent being covered by private health insurance is simply wrong, I would say to my good friend from Texas.

Senator Gramm. Mr. Chairman?

The Chairman. Yes, Senator Gramm.

Senator Gramm. Mr. Chairman, now that the Majority Leader is gone I am not worried about hiding his handsome profile. I would like my colleagues to look at this chart. Now, this is CRS data I am using, so first of all, I am always trying to urge my children, do not argue about facts, go look them up and argue about what they mean.

Now, the fact is, according to the CRS analysis and data from the Bureau of the Census, between 100 and 149 percent of poverty in America today, 48.6 percent of

those children have private health insurance, insurance that they are paying for.

Let me also say that for roughly half of the families that have the private health insurance, they are generally paying more than we are proposing in a nominal amount that people can be charged to try to set up a procedure where it is not so attractive to drop private health insurance.

But let me ask you, if you can, to just look at these lines. The dark blue line here shows the expansion in the coverage of Medicaid between 1988 and 1995. As you can see, it is a gradually rising line, then it levels out in 1994. This is the percentage of all children covered by Medicaid. The red line is the percentage of all children covered by private health insurance.

As you can see, these two lines are virtually mirror images of each other; the percentage of children covered by private health insurance declines as a percentage of children covered by Medicaid rises, and then the two level off at the same point.

Now, here is what we are trying to do. I want to assure my colleagues that a lot of thought went into this. Since we have already got in this group 50 percent, roughly, of all the children covered by private health insurance where the co-payments, the deductible,

and the cost of purchasing the insurance are often several times the very small amount of money that we are letting States use here, half of the children are already having their families pay more than this.

All we are asking is that we give States the flexibility with this very small co-payment, deductible package which, for a family of $10,000, would be how much money?

Mr. Smith. $300.

Senator Gramm. About $300. Remember, for that family, we have already got half of them that have got private health insurance, so we are just trying to let States have the flexibility to structure the benefits so we do not get everybody to go out and drop their private health insurance.

I know it is very appealing to say we ought to give all this away to everybody, but the last thing we want on earth is for half of these kids to have their insurance dropped so we can cover them with Medicaid. There is just not enough money to do that.

This is an effort to let States try to prevent this crowding out. It is very severely limited. But we cannot tell them in advance what to do. For example, if people are dropping their private health insurance to get pharmaceuticals under Medicaid, they may want to apply

the co-payment there.

Or if they are doing it to get some other benefit, we may want to let them make the adjustment. So what we are trying to do here is cover kids. If we drive half of them out of private health insurance, we have twice as many to cover. That is the point.

The Chairman. There has been an extended debate on this amendment. The Chair would like to call for a vote. The Clerk will call the roll.

Senator Moseley-Braun. Well, could I just have a minute to close?

The Chairman. Yes, I will recognize you.

Senator Moseley-Braun. Just so say that the proposal covers children 6 years of age and older who were born after September 30, 1983, with incomes at 100 percent of poverty, and I mentioned what that was, and elderly and disabled people who qualify as medically needy.

Again, the question is whether it is going to be a nominal co-pay, it supports co-pays, or a co-pay based on a formula that nobody has figured out how to administer. I hope my colleagues will see their way clear to support this.

The Chairman. The Clerk will call the roll.

The Clerk. Mr. Chafee?

Senator Chafee. No.
The Clerk. Mr. Grassley?
Senator Grassley. No.
The Clerk. Mr. Hatch?
Senator Hatch. No.
The Clerk. Mr. D'Amato.
Senator D'Amato. No.
The Clerk. Mr. Murkowski?
Senator Murkowski. No.
The Clerk. Mr. Nickles.
The Chairman. No, by proxy.
The Clerk. Mr. Gramm.
Senator Gramm. No.
The Clerk. Mr. Lott?
The Chairman. No, by proxy.
The Clerk. Mr. Mack?
Senator Mack. No.
The Clerk. Mr. Jeffords?
The Chairman. No, by proxy.
The Clerk. Mr. Moynihan?
Senator Baucus. Aye, by proxy.
The Clerk. Mr. Baucus?
Senator Baucus. Aye.
The Clerk. Mr. Rockefeller?
Senator Rockefeller. Aye.

The Clerk. Mr. Breaux?

Senator Breaux. Aye.

The Clerk. Mr. Conrad?

Senator Conrad. No.

The Clerk. Mr. Graham?

Senator Graham. Aye.

The Clerk. Ms. Moseley-Braun?

Senator Moseley-Braun. Aye.

The Clerk. Mr. Bryan.

Senator Bryan. Aye.

The Clerk. Mr. Kerrey?

Senator Kerrey. No.

The Clerk. Mr. Chairman?

The Chairman. No.

The Clerk. The votes are 7 yeas, 13 nays.

The Chairman. The amendment does not carry.

Senator Graham. Mr. Chairman?

The Chairman. We would, next, call Mr. Murkowski.

Senator Murkowski. Thank you, Mr. Chairman.

Mr. Chairman, included in the Chairman's mark is a provision that would reimburse taxpaying private hospitals at a higher rate than not for private hospitals. Senator Conrad and I feel that the status quo is most appropriate.

I think it is noteworthy to recognize that in the

House Ways and Means Committee it was in the Chairman's mark. It was removed. Bruce Vladeck, the current administrator of HCFA, testified before the Ways and Means Committee last week that the provision in the Chairman's mark is bad policy.

Mr. Chairman, what we have got here is a provision in the mark that proposes a subsidy of 20 percent to hospitals, and these are primarily investor-owned hospitals, at the expense of some 80 percent of the hospitals, mostly the non-profit hospitals.

I think Senator Conrad will agree that the provision is inequitable. States and local property taxes, as well as interest and depreciation costs, can readily be deducted by private hospitals on standard tax returns to provide a Medicare reimbursement on top of a tax deduction, I think, is providing for-profit hospitals with a dual compensation form.

If the Medicare dollars compensate for private hospitals, for property taxes, an incentive is really created for the local governments to raise property taxes. You simply have that exposure. Tax-exempt hospitals are not getting a free ride on Medicare capital payments because tax-exempt hospitals frequently have other costs.

I am passing around a chart that shows, clearly,

depreciation costs are higher, interest costs are higher, the investor-owned are able to get better long-term loans, the non-profits provide considerable charitable benefits.

The real reason is that non-profits do not have the same access to capital that the profits do. So I would encourage you to review the chart and recognize that there really is no justification for an inequity being created, and I would encourage that the status quo remain and that it be stricken from the Chairman's mark based on the arguments and points that I have made.

I would be happy to respond to any question. Maybe Senator Conrad has a statement.

Senator Conrad. Mr. Chairman?

The Chairman. Senator Conrad.

Senator Conrad. Mr. Chairman, first of all, I want to say with respect to this subsidy that has been included in the Chairman's mark, there have not been hearings on this question and we have not had an opportunity to hear from others with respect to what has been proposed.

But when we hear about the proposal that some have made, that there is a situation in which the non-profits are getting a better deal than the for-profits, the facts just do not bear it out. The simple reality is, as

Senator Murkowski has indicated, and has indicated by this chart, if we look at Medicare capital payments per case, to voluntary, which are the non-profits, and the proprietary, which are the for-profits, this is what we see. The non-profits get $640, the proprietary or for-profits get $665. So the notion that the proprietary are getting unfairly treated is just not borne out by the facts.

If we look at the next chart, it shows that in a little different way. This chart shows the Medicare capital payment-to-cost ratio for voluntary and proprietary hospitals. This is for fiscal 1995, the most recent year. You can see exactly the same pattern. The proprietary hospitals, the for-profit hospitals, are getting 102.2 percent. The voluntary, non-profit hospitals are getting 101.3 percent.

So this notion that some have promoted that the not-for-profit hospitals are getting a better deal just is not borne out by the facts. Why is it? The reason is simple. Not-for-profit hospitals do not have the same access to equity markets that the for-profit hospitals have.

So, Mr. Chairman, I would hope that we would have a strong vote for the Murkowski-Conrad amendment on equity grounds, on the substance of the argument, and also

because all of you who have a special relationship with your nuns back home, they will not be happy if you do not vote with us on this amendment.

[Laughter]

The Chairman. Senator Gramm.

Senator Gramm. Well, Mr. Chairman, let me say that we have heard an excellent argument for a case that has no merit whatsoever. Not one single merit exists in this argument.

Let me just specify exactly what the case is. We currently have a policy, which everybody agrees makes no sense whatsoever, that reimburses hospitals for property taxes.

The problem is, the non-profits pay no property taxes, so they are being reimbursed in lieu of taxes that they are not paying. They have to justify for their reimbursement rates to HCFA. So basically what the Chairman's mark says, if you are not paying property taxes, you cannot be reimbursed for property taxes.

Now, if you have got other expenses you can be reimbursed for them, but you cannot be reimbursed for taxes you do not pay.

Let me also say that several years ago when this thing was discussed there was an agreement that this was going to be dropped, it was non-controversial. But what

has happened is, as things have gotten tighter, now we have got hospitals who do not pay property taxes who are saying, look, we do not pay property taxes. You are reimbursing us for taxes we do not pay, but, look, we want this money and we need it. Times are hard.

Well, the point is, if they are hard, let us figure out what the problem is. But it makes no sense, in a bill that is trying to reform Medicaid, to pay people to reimburse for taxes they are not paying.

So, again, we have heard a great argument, but it has no merit whatsoever. In terms of the nuns, Catholic hospitals, or other non-profits, the point is, they are not paying property taxes, but we are reimbursing them as if they were paying for it, and we ought not to do it.

If we ever are going to be able to pay for Medicare, it has got to be a rational system. It cannot be a rational system when we are reimbursing people for expenses that nobody argues they are not paying. That is the argument against the amendment.

Senator Murkowski. Mr. Chairman, clearly we are not reimbursing for the charitable contributions that these hospitals make, and they are very, very significant. I think that is a good consideration for the argument from the Senator from Texas from the standpoint of reality, because a good deal of the charity work that is done in

hospitals is done by the charitable hospitals.

Senator Gramm. Well, Mr. Chairman, we have disproportionate share for that. If we want a debate taking charitable contributions into account, we have them at both profit and non-profit hospitals. That is something that ought to be debated on its merits.

But surely we are not going to say, reimburse people for expenses they do not have because we feel sorry for them. I mean, we got Medicare in the trouble it is in now by doing that kind of stuff. We are never going to get it out of trouble until we start setting some standards.

And the standard that you have set in your mark is simply this: if you do not have an expense, you cannot ask for reimbursement for that expense. That is the whole argument.

The Chairman. I think we have expended a considerable time on this debate. I would like to call for a vote.

Senator Murkowski. Mr. Chairman, let me just make one more point. We have a policy here that is working now. The Senator from Texas makes the point with regard to well, if you are going to go through this in detail you ought to revamp the whole system. But we are not going to do that. That is just the reality.

The Health Care Financing Administration basically

says, to include this provision is bad policy. Now, they are not coming from the point of view of the charitable argument, they are just saying it is bad policy because this does nothing to protect the trust fund, it merely takes from the non-profits and gives to the profits. That is what we are doing here. For-profit hospitals can already deduct their taxes. That is the reality of the situation we are facing.

Senator Conrad. Mr. Chairman.

The Chairman. Are you ready for a vote?

Senator Murkowski. I am ready for a vote.

Senator Conrad. Mr. Chairman, could I just take one minute?

The Chairman. And then we will call for a vote.

Senator Conrad. Mr. Chairman, the argument that is without merit is the argument advanced by the Senator from Texas. Here is the reality: not-for-profit are getting reimbursed $640, for-profit $665. The reason is the capital structure.

Now, we are attempting to address that differential in the manner that we have done it typically, and the mark departs from what we have done to try to address this differential to get a more fair result. I would hope that we would have a strong vote on the Murkowski-Conrad amendment.

Senator Gramm. Mr. Chairman, I have to respond to that, and I will be brief.

The Chairman. All right.

Senator Gramm. The difference in reimbursement on capital is based on the amount of capital. Now, for example, and I am not prepared now, and I think we ought to ask the staff to discuss it, but the point is that this could reflect many different things, that the for-profit hospitals are more capital-intensive, that their facilities are newer and they have been depreciated for a shorter period of time. But nothing could justify a policy to reimburse people for expenses they do not have.

Senator D'Amato. Mr. Chairman, if I might.

The Chairman. Can we vote?

Senator D'Amato. Well, I will give it a quick 30 seconds.

Let me tell you what takes place. If you change this policy, there are financial consequences that flow between the two hospitals. The not-for-profit hospitals lose $8 per patient that they discharge.

Where does that money go? It goes to the for-profit hospitals, who will gain anywhere from $40 to $70 per patient discharge. I do not think it is good policy to do cost shifting at this time and in this manner. For that reason, I support retention of the present system.

Senator Hatch. Mr. Chairman?

The Chairman. We have had considerable debate on this.

Senator Hatch. If I could have 30 seconds.

The Chairman. Well, everybody wants 30 seconds.

Senator Hatch. Well, but I have maybe a compromise that might work. Nobody wants to compromise?

The Chairman. The Chair will say that this matter has been, I think, adequately debated. I think everyone knows what the issues are.

The Clerk will call the roll.

The Clerk. Mr. Chafee?

Senator Chafee. Aye.

The Clerk. Mr. Grassley?

Senator Grassley. No.

The Clerk. Mr. Hatch?

Senator Hatch. Aye.

The Clerk. Mr. D'Amato.

Senator D'Amato. Aye.

The Clerk. Mr. Murkowski?

Senator Murkowski. Aye.

The Clerk. Mr. Nickles.

Senator Nickles. No.

The Clerk. Mr. Gramm.

Senator Gramm. No.

The Clerk. Mr. Lott?
The Chairman. No, by proxy.
The Clerk. Mr. Jeffords?
Senator Jeffords. Aye.
The Clerk. Mr. Mack?
Senator Mack. Aye.
The Clerk. Mr. Moynihan?
Senator Baucus. Aye, by proxy.
The Clerk. Mr. Baucus?
Senator Baucus. Aye.
The Clerk. Mr. Rockefeller?
Senator Rockefeller. Aye.
The Clerk. Mr. Breaux?
Senator Breaux. No.
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. Bryan.
Senator Bryan. Aye.
The Clerk. Mr. Kerrey?
Senator Kerrey. Aye.
The Clerk. Mr. Chairman?

The Chairman. No.

The Clerk. The votes are 14 yeas, 6 nays.

The Chairman. The Murkowski amendment is carried.

We will, next, call on Senator Baucus.

Senator Baucus. Mr. Chairman, my amendment is a scaled back version of the amendment recently offered by Senator Moseley-Braun.

Essentially, I propose that we retain current law that no charges be imposed on Medicaid services that are provided for children under age 18. We are really talking about maintaining the prohibition on cost sharing for children under age 18 with respect to families at less than 150 percent of the poverty level.

I do not want to rehash a lot of the arguments we have had thus far; I can hear Senator Gramm's mind cranking up already in response. But, very simply, Mr. Chairman, I think we do want to encourage low-income kids to see their doctors. Therefore, we should not have cost sharing imposed on low-income kids.

Now, it may be different with respect to low-income adults, where perhaps some cost sharing makes sense. But it just basically seems to me, when it comes to the low-income kids, that is what we are talking about, the most vulnerable population in our country, that there should not be charges imposed on them as a condition for them

getting medical care. That is current law. That is current law today. I think that it makes sense to maintain it.

I might add, too, that there is a Rand study. There is not a lot of evidence on this subject, the degree to which cost sharing helps low-income children's health or discourages low-income health. But basically this Rand study, which I have with me, is a few years old, from 1993.

I will not read all of it, but basically it says, "Low-income children enrolled in a plan with no cost sharing, and low-income children were at highest risk of anemia were much less likely to have anemia at the end of the study," and there are lots of different examples like that.

Essentially, it is just very basic. If we are talking about low-income kids in this country, it just makes sense to me that we want to encourage them to see doctors, encourage them to get health care. It is better for them in the short run, as well as the long run. We are not talking about adults, we are just talking about low-income kids.

The Chairman. Senator Gramm?

Senator Gramm. Mr. Chairman, I can be very brief. We defeated the Moseley-Braun amendment that would have

had nominal co-payments for the 150 percent of poverty to 100 percent of poverty where 50 percent already have private health insurance. What this would do is say no co-payment.

So this, in essence, is the same vote we had before, except going further and saying that, up to 150 percent of poverty where we have reached the point where over half of the people already have private health insurance, that the States can have no co-payment whatsoever.

This is the same vote we had before, except more extreme, and I hope people will vote the same way.

The Chairman. If there is no further debate, the Clerk will call the roll.

Senator Baucus. Mr. Chairman, I want to correct a statement made by the Senator from Texas. This is not exactly the same vote. That is just a gross misstatement. Whereas Senator Moseley-Braun's amendment was applied to perhaps families over 150 percent of poverty, my amendment would only apply to families at 150 poverty or below.

The Chairman. The Clerk will call the roll.

The Clerk. Mr. Chafee?

Senator Chafee. Aye.

The Clerk. Mr. Grassley?

Senator Grassley. No.

The Clerk. Mr. Hatch?
Senator Hatch. Aye.
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. Gramm.
Senator Gramm. No.
The Clerk. Mr. Lott?
The Chairman. No, by proxy.
The Clerk. Mr. Jeffords?
Senator Jeffords. Aye.
The Clerk. Mr. Mack?
Senator Mack. No.
The Clerk. Mr. Moynihan?
Senator Moynihan. Aye.
The Clerk. Mr. Baucus?
Senator Baucus. Aye.
The Clerk. Mr. Rockefeller?
Senator Rockefeller. Aye.
The Clerk. Mr. Breaux?
Senator Breaux. Aye.
The Clerk. Mr. Conrad?

Senator Conrad. No.

The Clerk. Mr. Graham?

Senator Graham. Aye.

The Clerk. Ms. Moseley-Braun?

Senator Moseley-Braun. Aye.

The Clerk. Mr. Bryan.

Senator Bryan. Aye.

The Clerk. Mr. Kerrey?

Senator Kerrey. No.

The Clerk. Mr. Chairman?

The Chairman. No.

The Clerk. The votes are 10 yeas, 10 nays.

The Chairman. The amendment does not carry.

For the order of amendments, we have Mr. Rockefeller, then Al D'Amato.

Senator Nickles. Mr. Chairman, I thought I was in that order.

The Chairman. No. Actually, you are right. You are first, Mr. Nickles.

Senator Nickles. Mr. Chairman, my amendment will not be, I do not think, too difficult for anybody to understand. We are creating a new program with one or two options for the KidCare, one of which would be grants to the States, and one of which would be expansion in Medicaid.

This amendment would make sure that the funds that we are providing for these kids would not fund abortions, unless it is necessary to save the life of the mother, or in cases of rape or incest. It is very plain, it is very simple. It is a new program. I think certainly we want to make sure that this program does not fund abortion, except in those rare circumstances.

This basically copies Hyde language, except for we would be doing it in an authorization bill, which is frankly where it should be done so we would not have to do it annually in appropriation bills.

We are just trying to guarantee that these new programs will not be funding abortions for kids, for abortion on demand, with taxpayer money and with almost all of the program being funded by the Federal Government.

The Chairman. Any comment?

Senator Moseley-Braun. Very briefly. Mr. Chairman, I thank you very much for at least giving us a vote on this as opposed to, earlier, this was part of the larger bill.

But it is 11:30 at night and I know nobody wants to really get into a long, drawn-out debate on reproductive choice at this hour, except to say that if the Senator would allow that there may be instances in which a

woman's health might be involved in this area, that this language would then mean that health of the mother, health of a woman, would not be a consideration. I just think that that puts too many women at risk.

Again, we have had these debates on the floor, that not to allow an exception for the health of the mother, I think, unduly restricts this language and unduly jeopardizes the health and well-being of too many American women and I, for that reason, would have to oppose the language.

Senator Kerrey. Mr. Chairman.

The Chairman. Well, we have Senator Chafee, first.

Senator Chafee. Mr. Chairman, what this is doing is codifying the Hyde amendment into the underlying law. That is different than the way we treat the Hyde amendment. Usually we deal with that in an appropriations bill, and thus we get a chance to reconsider it.

This is an issue that is very, very contentious, as we all know, and it is an issue that people like to have their say on. If this were adopted, it would go in the basic law and that would do it. We would not have another chance at it through the appropriations process that we normally do.

Senator Gramm. Mr. Chairman?

The Chairman. Senator Gramm.

Senator Gramm. Mr. Chairman, we have always set a higher standard for what people did with the taxpayers' money than we have set for what they have done with their own money.

What Senator Nickles is simply asking us to do is what we have done historically in Medicaid. That is, with the exceptions set out in the amendment, we are saying that it is not the policy of the taxpayer to fund abortion. We can come back, if we should change our mind on this. If the Congress decided that they wanted taxpayer money to fund abortion beyond the circumstances set out in the Nickles amendment----

Senator Moseley-Braun. Will the Senator yield?

Senator Gramm. [Continued]. We could come back and change permanent law. I will, but let me just finish my point, Carol. I will be very happy to yield.

We are talking about taxpayer funds. This is not a new issue. We debate it on appropriations every year. The Hyde amendment is generally adopted. What the Senator is trying to do is just have the debate now, then if people felt they had the votes later to overturn it, they could do it, but it would be something we would set out when we begin the program.

I think it is reasonable. It is not about

reproductive choice; people have that choice with their own money. But they not have that choice, except in these circumstances, set out in the amendment with the taxpayers' money.

I would be happy to yield.

The Chairman. Carol?

Senator Moseley-Braun. Would the Senator yield? Not to over-speak the case, it is not a matter of allowing abortion, it is a matter of, what are the circumstances under which it might be a medically necessary thing for a woman to do.

My only point is, it mentions rape and incest, it mentions life of the mother. I do not see that it would be inappropriate to add her health as well. It is certainly not calling on the taxpayers to do anything untoward to protect somebody's health. That is the major objection here.

The point Senator Chafee makes is very well-taken. To tuck it into a bill like this just makes it very difficult for those people who might want to support some of the other issues in this legislation. This is wide-ranging legislation.

To put this in this bill at this point just torpedoes this for a lot of people, because women feel strongly about being able to have other children, for example. If

their health is at risk and if they are poor women and they are women who are covered by this program, they will not have the option. That is the only point. What are the limitations going to be? Life is one thing, but health, I think, is equally important.

The Chairman. Senator Kerrey is next.

Senator Kerrey. Mr. Chairman, I am not in support of the Hyde amendment. I do not, on an annual basis. I think putting it in permanent law is an even worse mistake.

But let me deal with the question that Senator Gramm raised, and I believe Senator Nickles did as well, about taxpayer money being used. I mean, if we want to apply that in a uniform fashion we would have to put restrictions on what Federal employees could do with their salaries and what other benefits we pass out with Federal programs can be used.

I mean, we do not say to members of Congress that we are going to stipulate that our $130,000 can be used for everything other than purchasing an abortion for our daughter. That restriction does not apply.

I just think that what we are doing here basically is not a higher standard, with great respect, it is a lower standard. It basically says that we have a program here designed for lower-income people and we are going to put

a different standard on it than we do for other people.

Senator Gramm. Bob, would you yield on that?

Senator Kerrey. I would be pleased to yield.

Senator Gramm. The point is, if you work for the money and you earn it, whether you work for the government or not, it is your money. This is money that is being given to people. This is being provided by the taxpayer. I think having a higher standard for it makes sense, however you stand on the fundamental issue itself.

Senator Kerrey. But you are inserting a new requirement. Initially, your argument was it is taxpayer money. Fine. So I bring to you examples of where we do not put restrictions on taxpayer money that is going to other individuals.

Now you are saying that the differentiation has nothing to do with that. In addition to being taxpayer money, I have got to have a differentiation that if somebody actually works for it----and there will be great debate as to whether or not 535 of us are working for that. You knew that was coming. You could see it. You were smiling ear to ear.

I mean, it seems to me that all I am saying is that if this argument that it is a higher standard of use of taxpayer money we would have to apply it to much more than just Medicaid. Again, this argument is going to be

played out many, many more times and in many, many more venues.

But I just want to make it clear, I think there is a very solid reason for opposing the Hyde amendment and a very solid reason for opposing the Nickles amendment as well, that also holds to a very high standard.

The Chairman. The Chair will recognize Senator Nickles, then he is going to call for a vote.

Senator Nickles?

Senator Nickles. Mr. Chairman, in response to Senator Kerrey, for Federal employees we do not allow Federal funding for abortion under Federal Employees Health Care plans.

Senator Chafee. That is the money that people did put in.

Senator Kerrey. What we do there, Don, is we say they cannot use their insurance money, but they can use their salaries.

Senator Nickles. The point being, the Federal Government pays for most of that insurance and we do not fund abortion in it. We are creating a new program here that is paid almost entirely by the Federal Government, and too high of a percentage, I might mention. I think there should be more cost sharing with the States, and so on.

But the point being, we are creating a new health program, supposedly a health program for kids, mostly for teenagers. We are saying that this program should not be used to fund elective abortions. It is the same thing as the Hyde language.

And, yes, with this new program we should not be saying, this is eligible for abortion. I think if we do not have the language the omission would be a serious mistake, so I would urge my colleagues to support it.

[Continued on page 257.]

The Chairman. The Clerk will call the role.
The Clerk. Mr. Chafee?
Senator Chafee. No.
The Clerk. Mr. Grassley?
Senator Grassley. Aye.
The Clerk. Mr. Hatch?
Senator Hatch. Aye.
The Clerk. Mr. D'Amato?
Senator D'Amato. Aye.
The Clerk. Mr. Murkowski?
Senator Murkowski. Aye.
The Clerk. Mr. Nickels?
Senator Nickels. Aye.
The Clerk. Mr. Gramm, of Texas?
Senator Gramm. Aye.
The Clerk. Mr. Lott?
The Chairman. Aye by proxy.
The Clerk. Mr. Jeffords?
Senator Jeffords. No.
The Clerk. Mr. Mack?
Senator Mack. Aye.
The Clerk. Mr. Moynihan?
Senator Moynihan. No.
The Clerk. Mr. Baucus?
Senator Baucus. No.

The Clerk. Mr. Rockefeller?

Senator Rockefeller. No.

The Clerk. Mr. Breaux?

Senator Breaux. Aye.

The Clerk. Mr. Conrad?

Senator Conrad. Aye.

The Clerk. Mr. Graham, of Florida?

Senator Graham. Aye.

The Clerk. Ms. Moseley-Braun?

Senator Moseley-Braun. No.

The Clerk. Mr. Bryan?

Senator Bryan. No.

The Clerk. Mr. Kerrey?

Senator Kerrey. No.

The Clerk. Mr. Chairman?

The Chairman. Aye.

The Clerk. The votes are 12 yeas, 8 nays.

The Chairman. The amendment is agreed to.

Senator Rockefeller, I am going to try to keep these amendment debates to 10 minutes in the interest of making progress.

Senator Rockefeller. Fine.

Senator Moseley-Braun. Mr. Chairman, how many amendments have we left to go?

The Chairman. About 86.

Senator Moseley-Braun. Eighty-six. And it is now 20 minutes to 12:00. Are we going to see sunrise together, Mr. Chairman? Or are you planning to adjourn at any time or recess any time soon?

The Chairman. To be candid, I am hoping that we will complete all of the amendments before sunrise. Eighty-six amendments, at 10 minutes, is 14 hours.

Senator Rockefeller?

Senator Rockefeller. Mr. Chairman, this is the amendment, which I have referred to several times in our committee internal discussions, which is the so-called Slimby for low income Medicare recipients. And I am going to offer this amendment, and then I am going to withdraw it. But I want to make a point because under current law the Part B monthly premium, by the year 2002, is projected to be $51.50 cents a month.

Now, the changes in the Chairman's mark from the home health transfer will increase the Part B premium to $69.00 a month, which, in my part of the country, is a lot. In any event, it is an increase of 34 percent and one stroke.

Because he felt that way, President Clinton insisted--in something called the budget agreement, which is often quoted here, but rarely adhered to--and

it was agreed to in the budget agreement, that a $1.5 billion be set aside to protect low income seniors.

And specifically, what the bipartisan budget deal said was $1.5 billion to ease the impact of increasing Medicare premiums on low income beneficiaries. Now, this protection is missing from the Chairman's mark, and that is the right, obviously.

But my amendment simply would say that seniors within incomes of 150 of poverty or lower would be phased into the so-called Slimby Program. That is the low income Medicare beneficiary program.

I think this is going to be a fairly major issue on the floor. It ought to be a fairly major issue on the floor. But we clearly do not have the $1.5 billion set aside here. So I offer the amendment and withdraw.

The Chairman. Thank you, Senator Rockefeller.

Senator D'Amato?

Senator D'Amato. Thank you, Mr. Chairman. Mr. Chairman, the CDC, Center for Disease Control, runs a wonderful program. Currently it screens women; gives them mammographies in cervical cancer for those who do not have insurance and are not covered by Medicaid.

Now, in the six years that it has done that, it screened some 500,000 women. Less than 2,000 over that period have been diagnosed with one form of cancer or

the other.

But because they are under 65, they do not qualify for Medicare. They do not have health insurance. They do not qualify for Medicaid. They fall right in the middle.

This amendment would give them access to Medicaid for the uninsured women diagnosed with breast cancer and cervical cancer through the CDC screening program.

The cost is de minimis. We have not been able to get a cost estimate, but we are talking about 2,000 over a six year period of time, but their needs should not go unused. It would be my hope that we could handle this within the scope of this bill.

The Chairman. I would like to ask the staff what would be the cost of this.

Ms. James. Senator D'Amato?

Senator D'Amato. Yes?

Ms. James. I am not clear if this would be eligibility and coverage only for treatment of the cancer. Or whether it would give Medicaid eligibility to these women for the whole --

Senator D'Amato. No. Just simply treatment for the cancer that is diagnosed pursuant to the CDC program for those women who do not have insurance and who do not qualify for Medicare. Obviously they do not

qualify for Medicaid, and it would be for those women.

The numbers are 2,000 fell into this category over a 6-year period of time. It is a very small number, and obviously it goes beyond the ability to find. Or, if it turns out that this is of a substantial cost factor, then obviously you could not accept that. But I would hope that the committee would accept it.

You have a great program, but you have 2,000 women over six years who need treatment. Today you diagnose the treatment. They do not have insurance. What do you do?

I would suggest that they be qualified for Medicaid for this purpose.

Senator Kerrey. The Senator's amendment that he has passed out though says that this will cover treatment.

Senator D'Amato. Yes. For the cancer. The cancer that is diagnosed. Sure.

Senator Kerrey. So is it the Senator's intent to create something similar to what we have in the renal dialysis program, which is basically a non-means tested, non-AIDS tested program paid for by Medicare?

Senator D'Amato. Yes. Paid by Medicaid. Subject to the fact that --

Senator Kerrey. Paid by Medicaid?

Senator D'Amato. Medicaid. They do not have insurance. They are not sufficiently poor. They are working poor. So they do not qualify for Medicaid. It would qualify them just for these purposes; those who have availed themselves of the CDC screening test who were diagnosed with cancer.

Senator Gramm. Mr. Chairman?

The Chairman. Yes, Senator Gramm?

Senator D'Amato. We already do this, by the way, for tuberculosis. Here is a precedent. We do this now for tuberculosis.

Senator Gramm. Mr. Chairman?

The Chairman. Senator Gramm?

Senator Gramm. First of all, let me clear up my confusion. Now, what happened to the Rockefeller amendment?

The Chairman. It was withdrawn.

Senator Gramm. Okay. Well, I must have slept through that.

Mr. Chairman, I guess the question that I would ask Senator D'Amato is could we set some income limit? I think the fact that someone does not have health insurance -- they might have considerable means and just did not buy health insurance. We want to be sure we do not qualify people for not doing what they ought

to do.

Senator D'Amato. I have no problem with that.

Senator Gramm. Could we have the staff work on an income level below which people would be covered, but above which they would not be covered?

Senator D'Amato. I would say whatever that income limitation is now that governs the CDC program, which is for low income women, should be used as the criteria.

Senator Gramm. Do we know what that is? Does any staff member know what that income level is?

Ms. James. We will have to find that out.

The Chairman. I would like to suggest that we conditionally accept this proposal on the grounds that the costs are minimal. If they are not, then we will have to revisit it.

Senator D'Amato. Fine.

Senator Chafee. Well, Mr. Chairman, I think there is a point here that has been made. There is a difference obviously with tuberculosis, which is a communicable disease.

But it seems to me that these women, to get this, should at least be able to qualify for Medicaid. In other words, be in the income limits that would -- because I think the point is --

Senator D'Amato. Well, if they qualified, Senator, you would not have a need for this. In other words, they would be covered. These are people who make slightly more who do not have health insurance. They would have to be at an income level low enough to qualify for the CDC screening test.

So what I would suggest is we find out what that qualification is, what that income is, and put it in, because Senator Gramm's point is a good. You do not want people of means to take advantage of this.

But certainly people who qualify to take the CDC screening test. You diagnose them. They do not have the resources. And again, if it is estimated there were 2,000 of them to get treatment, you want to see to it that they get treatment.

The Chairman. If there is no objection, we will proceed along the lines I proposed.

The chair is open for further amendments.

Senator Graham. Mr. Chairman?

The Chairman. Bob Graham?

Senator Graham. Thank you, Mr. Chairman.

Mr. Chairman, I am offering the amendment relative to the MSA demonstration project. The amendment would reduce the number of persons participating in this so-called demonstration, from 500,000 to 100,000.

First, this is not a demonstration at 500,000. The Health Care Financing Administration has stated that 50,000 seniors would be more than adequate as a sample pool to determine whether MSAs are an appropriate new option to add to the Medicare program.

Second, we already have an MSA demonstration underway. Last year Congress passed, as part of the Kennedy-Kassebaum Bill, an MSA demonstration, which covers 750,000 individuals over the next five years.

What this is is the reality of a medical savings account program as an option in Medicare, and therefore, it raises all of the concerns that MSAs bring to the medical insurance program. First, those include the fact that it is a very expensive program.

It is estimated that this program will cost an additional $4,000 per person in the demonstration project over the next five years. This is on top of the current annual expenditure of $4,500 for each of the beneficiaries who are participating.

The MSAs also have the effect of fragmenting the Medicare risk pool. It leads to the cherry picking of the healthiest seniors, thus destroying the whole concept of an insurance pool.

Thirty percent of the Medicare beneficiaries have an annual cost of $5.00 or less. Thirty percent of the

Medicare beneficiaries have an annual cost of $5.00 or less. Who do you think are going to be the ones that are going to be looking to join an MSA? It is going to be that 30 percent, and we are going to end up paying the difference between the current $5.00 that they are paying and what is the average within the program of $4,753.

Mr. Chairman, I believe that this is clearly a misnomer to say a program of 500,000 is a demonstration. One hundred thousand, which I propose in this amendment, is double what HCFA says is necessary to gain adequate information.

By adopting this amendment, we will reduce the cost of this from $2 billion, by $1.6 billion, and I propose that we distribute those savings in the following manner:

$300 million for guaranteed issue of Medigap coverage for disabled; $300 million to waive the mammography co-payment, which is currently contained in the Chairman's mark; $400 million for tele-medicine, using as the basis of that S.385, introduced by Senator Conrad and others; $300 million for the Medicare Bone Mass Measurement Standardization Act; $200 million to exempt legal immigrant children from the five year ban on Medicaid eligibility and $27 million for tele-health

demonstrations for states with rural areas that are not necessarily health professional shortage areas.

Mr. Chairman, what we are going to be determining in this amendment is if we think the excess investment of $1.6 in a program that is untested, which is flying under the banner of demonstration, but is, in reality, implementation, if that is a more valuable expenditure of the public's fund then to use it for these important niches that have been left in the Chairman's mark. I urge the adoption of this amendment.

The Chairman. Senator Gramm?

Senator Gramm. Mr. Chairman, let me just say that we had--in our bill we passed two years ago--unlimited use of a medical savings account. The Chairman put in a cap at 500,000 as a way of trying to compromise with the President.

We believe in medical savings accounts. We think it is a sound program. And to go down to 100,000 is to compromise on a compromise that we have already made. And so, if you believe in medical savings accounts and you believe we want to give people a wide range of options, then you were not happy with the 500,000 cap that we put in the bill to placate the President to begin with, and you certainly would not be happy by reducing it by four-fifths.

The Chairman. If there is no further debate, the Clerk will call the roll.

The Clerk. Mr. Chafee?

Senator Chafee. Aye.

The Clerk. Mr. Grassley?

Senator Grassley. No.

The Clerk. Mr. Hatch?

Mr. Hatch. No.

The Clerk. Mr. D'Amato?

Senator D'Amato. Aye.

The Clerk. Mr. Murkowski?

Senator Murkowski. I vote no.

The Clerk. Mr. Nickles?

Senator Nickles. No.

The Clerk. Mr. Gramm, of Texas?

Senator Gramm. No.

The Clerk. Mr. Lott?

The Chairman. No by proxy.

The Clerk. Mr. Jeffords?

Senator Jeffords. Aye.

The Clerk. Mr. Mack?

Senator Mack. No.

The Clerk. Mr. Moynihan?

Senator Moynihan. Aye.

The Clerk. Mr. Baucus?

Senator Baucus. Aye.

The Clerk. Mr. Rockefeller?

The Chairman. Aye by proxy.

The Clerk. Mr. Breaux?

Senator Breaux. Nay.

The Clerk. Mr. Conrad?

Senator Conrad. Aye.

The Clerk. Mr. Graham, of Florida?

Senator Graham. Aye.

The Clerk. Ms. Moseley-Braun?

Senator Moseley-Braun. Aye.

The Clerk. Mr. Bryan?

Senator Bryan. Aye.

The Clerk. Mr. Kerrey?

Senator Kerrey. Aye.

The Clerk. Mr. Chairman?

The Chairman. No.

The Clerk. The votes are 12 yeas, 8 nays.

The Chairman. The amendment is carried.

Senator Jeffords?

Senator Jeffords. Mr. Chairman, this amendment number 161. It is for myself and Senator Conrad. This deals with the Boren Amendment, and we all agreed that it should be repealed. The problem though is as to what replaces and what will be there to protect the

participants in the utilization of nursing homes and nursing home owners, etcetera.

The Boren Amendment had the "reasonable and adequate to cover the costs that must be incurred by efficiently and economically operating facilities." This lead to many, many court cases, and it was a bad system.

The Chairman's mark provides a public notice process, but does not define any standards for reimbursement. The current Boren Amendment, as I pointed out, is controversial because it was so vague in hoping that the providers used it to help the poorer States increase proposed rates.

Although it does not say explicitly, it appears that the Chairman's intent was to prohibit the right of actin in Federal Court, and perhaps we do not disagree with that. But, however, if that is the case, the providers would have no recourse in the event of inadequate rates.

At the same time, simply requiring public notice of rates and allowing comments does not allow sufficient protection for both the providers and the patients.

The proposed compromise retains the assurance of access and quality that underlies the current Boren

Amendment, but, at the same time, it dramatically reduces the likelihood of litigation by providers because it replaces a vague standard with a clear test of actuarial sufficiency determined by an independent actuary.

The amendment would repeal the Boren Amendment and replace it with a requirement that the States provide assurances to the Secretary that rates be actuarialy sufficient to insure quality and access. The States would be required to have an independent actuary, chosen by the Secretary, to review the rates. States would also be required to go through a rule making process when proposing rates or rate changes.

I believe this is intended--certainly on my part--to get over the problems of the past, but also to insure for the future that the providers and the patients have adequate access and have adequate care and treatment.

The Chairman. Senator Conrad?

Senator Conrad. Thank you, Mr. Chairman. Just very briefly.

I think everyone recognizes that the problem with the Boren Amendment is the very vague standard that was set. "Reasonable and adequate." That has lead to litigation. That is why the States want Boren

repealed.

This is an attempt to achieve a compromise that would repeal Boren, but, at the same time, replace it with some standard, and the standard would be actuarial sufficiency; sufficient to provide for the quality standards that are outlined in OBRA 87, sufficient to provide reasonable access.

This would make all of the case law on Boren moot, and I think that is the desire of the Governors. That is why there is repeal of Boren here, but a provision for a replacement, so that we can have some assurance of quality and access.

Senator Breaux. Mr. Chairman?

The Chairman. Senator Breaux?

Senator Breaux. Well, I think that Senator Conrad is onto some language that does not make sense. The problem is that the loss of the provision in the Chairman's mark cost about $1.2 billion, and I am not certain how that is going to be made up without changing the Chairman's mark in a number of other significant ways.

I think that perhaps the language--I agree--is a major improvement over the "reasonable and adequate" standard, which has lead to so much litigation, which I guess is why the Chairman's mark calls for the

elimination of it. But I think that we have to recognize that this costs $1.2 billion. It is going to have to be made up somewhere else in the Chairman's mark, and I am not sure that that has been discussed sufficiently.

Senator Nickles. Mr. Chairman?

The Chairman. Senator Nickles?

Senator Nickles. Mr. Chairman, on behalf of my former colleague, Senator Boren, I know that we really do not appreciate everybody saying you want to repeal the Boren Amendment. I am going to have to talk to him tonight and tell him that his legacy lives, and we have unanimous support for repealing his amendment.

Senator Gramm. We all make mistakes.

Senator Jeffords. Mr. Chairman, just one comment on the cost. That is a CVO estimate, and you have to realize what that presumes. That presumes that the rates are going to be lowered or too low to provide access and care, and therefore, we will have nursing homes that are not doing the appropriate and proper job. And therefore, we say $1.2 billion.

That, to me, is a rather odd way to try and defeat this amendment, is to admit that just repeal is going to lead to economic disaster and patients being uncared for.

Senator Gramm. Mr. Chairman?

The Chairman. Senator Gramm?

Senator Gramm. Mr. Chairman, let me first say that we have a $1.2 billion savings for two reasons. Number one, we are eliminating a lot of litigation that costs everybody money, and we have got no guarantee that this new language is going to be as efficient as the repeal.

In fact, we have every guarantee that it is not. Nobody argues that it is not an improvement over Boren, but we have got a unanimous consent to repeal Boren. So it is not a very strong argument. So we are certainly going to save the $1.2 billion, and clearly you have got hundreds of millions of dollars of cost in adopting this amendment as compared to the bill.

Second, do we really want to set up a standard when we are moving toward price competition that says that the Federal Government and the States cannot competitively bid for nursing home services? Do we really want to set out in law a standard that says that you have got to reimburse based on reasonable and adequate, efficient and economical?

I mean that is the language of the failed system we are trying to get out of. Do we want to set out in law a prohibition against competitive bidding for

nursing home services and price competition? I do not think so.

So the Boren Amendment should be repealed for three reasons. Number one, it saves $1.2 billion. And so there is clearly a point of order against this amendment because it is going to raise the -- it is going to lower the savings levels in the bill.

Second, the Boren Amendment eliminates litigation that will not be eliminated here. And finally, what is about nursing homes that is so different then every other part of the medical system when we are trying to get out of all of this efficient and reasonable and adequate compensation to good old fashioned American bargaining --

Senator Rockefeller. Mr. Chairman?

Senator Gramm. -- where we are saying, if we go out and get competitive bids from nursing homes, and we can get a better price, why not take it.

Senator Rockefeller. Mr. Chairman?

The Chairman. Senator Rockefeller?

Senator Rockefeller. I would just say, in support of the Jeffords-Conrad Amendment, that the Senator from Texas is simply making our case. We do not have a price competitive system at work right now. We are moving in that direction.

But it becomes tremendously important that providers of health care get reimbursed at something which is adequate and sufficient. This may not be a problem in Texas, although it probably is a big problem in East Texas, as it is in North Dakota, West Virginia, Montana and Louisiana. It is important for providers to be reimbursed.

Now, the Boren Amendment may have gone too far in the language because it became subject to a lot of litigation. But the whole concept that there are people out there who are providing service for way below their cost, this is simply to give them some sense, not 100 percent. Just some sense that there is a safety net there for them, and they have reason to provide and continue to provide that service.

This is about people, Senator Gramm. This is not just about saving a $1.2 billion. I know that is what is on your mind, but patients, and doctors giving service to patients, and hospitals giving service to patients is on my mind.

Senator Gramm. Well, Mr. Chairman, let me respond.

This is not about people. This is about protecting people against competition. This about a sweetheart deal. This is about saying that we are

willing to competitively bid for physician services, in HMOs, in hospitals, but we do not want price competition for nursing homes. And what happens when you do that?

With the amount of money we have we end up with less care and not with more. It is one thing to say we are moving toward competition, but if you adopt language that does not allow it, you never get there.

Senator Rockefeller. Mr. Chairman, we are not sure that we want to get all the way there. There is not a consensus that we want to get all the way to the Senator's ideological love of an absolutely free enterprise market let loose in the health care system. That is a debate we have not yet had in Congress.

Senator Gramm. Well, the point is what is so special about nursing homes compared to every other part of the system that when we are moving toward competition everywhere else we want to stop here?

And you are stopped by $1.2 billion as a point of order against this amendment, and I raise it.

The Chairman. Yes. I would like to ask the sponsors of this amendment how would they pay for this loss of income, $1.2 billion? We are involved in reconciliation, the purpose of which is to bring about savings. So I would ask the amendment sponsors how

would they pay for this amendment.

Senator Jeffords. We would have an offset by a faster phase in of DSH cuts.

Senator Gramm. I suggest we vote.

The Chairman. Any further comments?

Senator Conrad. Mr. Chairman, might I clarify? That would be only on the high DSH States. There are only two such States on this committee. We have heard from one of the representatives of those States repeatedly that there have been abuses in his State. That is the State of Texas.

The other State affected is the State of Louisiana. We know the record with respect to DSH.

Let me just say the hospitals have indicated they would prefer to have that occur and to be able to have this new standard applied. I think it is important to respond to Senator Gramm in saying this does not stop competition.

It does put some boundaries around competition to say that the rates ought to be actuarialy sufficient to be able to meet the quality standards that we put in place in law OBRA 87, and we are taking out the "reasonable and adequate" vague standard and putting in a bright line standard.

Senator Jeffords. I would just like to point out

that the reason -- may I have just have two words here?

Just remember why we had the Boren Amendment. We had the Boren Amendment because we had basically open competition, and we had lousy standards, and we had lousy care, and the Boren Amendment came in to save us from that.

The methodology for it was flawed, and we are trying to correct that.

Senator Breaux. Mr. Chairman? Mr. Chairman?

The Chairman. I think the debate has gone on long enough.

Senator Breaux. Mr. Chairman?

The Chairman. Senator Breaux?

Senator Breaux. I just want to make a short comment because our State was mentioned. It certainly would not affect only two disproportionate share of States. It would affect all disproportionate share of States, not just two.

Senator Gramm. Yes. And the costs are going to phase in on everything.

Senator Breaux. It is across the board for every State, not just two.

Senator Conrad. No. That is not correct. In all fairness, this only applies to high DSH States and only to the extent needed to make up for this

legislation.

We are already, they estimate, $500 million over. There are only 8 States affected, and there are only 2 on this committee that are affected.

Senator Gramm. Mr. Chairman, could we hear from the staff about how another $1.5 billion cuts in DSH -- what the affect of that would be? Could it be done? Would speeding it up actually save that amount of money?

I mean, we have a right to know if this is a real proposal or not.

Ms. James. I'm sorry. Are we talking about Medicare DSH or Medicaid DSH?

Senator Gramm. I assume we are talking about Medicaid DSH. But I do not know. Are we?

Senator Jeffords. Medicaid DSH.

Senator Gramm. Or do we know?

Senator Jeffords. Medicaid DSH.

Senator Gramm. Okay. Could you get $1.5 billion by --

Senator Conrad. Wait. Wait. There was nothing about $1.5 billion.

Senator Jeffords. It is 1.2.

Senator Conrad. And we do not even need 1.2 because they are $500 million over already. So we are

talking about $700 million.

Senator Gramm. Who is $500 million over?

The Chairman. The question still is how do we pay for it. The problem is the loss will put into jeopardy all the affirmative spending contained in the reconciliation bill. I do not think we want to put ourselves in a position of doing that.

So, I would ask the Clerk to call the roll.

The Clerk. Mr. Chafee?

Senator Chafee. Aye.

The Clerk. Mr. Grassley?

Senator Grassley. No.

The Clerk. Mr. Hatch?

Mr. Hatch. 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. Gramm, of Texas?

Senator Gramm. No.

The Clerk. Mr. Lott?

The Chairman. No by proxy.

The Clerk. Mr. Jeffords?

Senator Jeffords. Aye.

The Clerk. Mr. Mack?

Senator Mack. No.

The Clerk. Mr. Moynihan?

Senator Moynihan. No.

The Clerk. Mr. Baucus?

Senator Baucus. Aye.

The Clerk. Mr. Rockefeller?

Senator Rockefeller. Aye.

The Clerk. Mr. Breaux?

Senator Breaux. No.

The Clerk. Mr. Conrad?

Senator Conrad. Aye.

The Clerk. Mr. Graham, of Florida?

Senator Graham. Aye.

The Clerk. Ms. Moseley-Braun?

Senator Moseley-Braun. Aye.

The Clerk. Mr. Bryan?

Senator Bryan. No.

The Clerk. Mr. Kerrey?

Senator Kerrey. No.

The Clerk. Mr. Chairman?

The Chairman. No.

The Clerk. The votes are 7 yeas, 13 nays.

The Chairman. The Amendment is not agreed to.

Senator Gramm. Mr. Chairman?

The Chairman. Senator Gramm?

Senator Gramm. Mr. Chairman, I have been waiting for a good opportunity to do Amendment Number 90. As you will recall, States gained Medicaid by imposing taxes on providers, and then rebated the taxes to providers and got Federal matching based on the new cost of the providers after the State tax was imposed.

This was clearly a sham and a fraud perpetrated by the States on the Federal tax payer. We did move to tighten it up, but we did not repeal it.

Now, my argument in this amendment is very simple. We ought to prohibit rebated taxes that are used to gain the Medicaid system or that would be used to gain the new system which we have adopted. We have had reference here to State fraud. This is a clear case where everybody knows that this provision was used to gain the system.

And my proposed amendment would simply say that we would go the final step, from the tightening that we tried to do before, and simply prohibit provider taxes where the tax is imposed and then rebated to the provider, but the Federal share is raised as a result of that ruse.

This is a good Government proposal. It will

affect every State that is engaged in doing this, it is something that we are all against, and I wanted to give us an opportunity to do it. I hope it will be adopted on a unanimous vote.

Senator Rockefeller. Would the Senator yield?

Senator Gramm. I would be happy to yield.

Senator Rockefeller. The Senator is entirely correct in his amendment.

Senator Gramm. Thank you.

The Chairman. Those in favor --

Senator Conrad. Mr. Chairman, do we have a copy of this amendment?

Senator Gramm. It is supposed to be being distributed now. I will give you my copy.

The Chairman. Can we go ahead with the vote?

Senator Conrad. Well, it would be helpful if we could see what the amendment said before we voted on it.

I mean, the way this amendment says, "Present law permits States to impose tax on health care providers serving Medicaid eligible patients. The revenue is used to increase State payments to disproportionate share hospitals, which results in higher Federal DSH payments to the State. The amendment prohibits such taxes."

That is not a Shakespearean statement of clarity as to what we are doing here. Frankly, my State, for the better part of 15 years, has had a tax specifically on health care providers, in order to create a state pool to A) Assist in paying for indigent coverage that is not covered by Medicaid; and B) To level some of the playing field between the public hospitals that are provided the overwhelming amount of the indigent care and the proprietary hospitals, which are providing relatively little of the indigent care.

Those are rational, non-abusive uses of a provider tax. They are not in violation of the 1991 and 1993 Acts that Congress has passed relative to the inappropriate use of provider tax. I cannot tell, from this amendment, whether that program would or would not be prohibited.

Senator D'Amato. Mr. Chairman?

The Chairman. Senator D'Amato?

Senator D'Amato. Let me tell you something. I have not characterized anybody's legislation, but this is mean spirited legislation. I am going to tell you. Absolutely. It is incredible.

Now, if a State wants to raise revenues to take care of the indigent, to take care of the poor, and you have got a city hospital, and you have got tens of

thousands of people who come in there who do not have the wherewithal, who are not covered, where do you think you get the money to do that?

All of a sudden you are going to say to the State you cannot choose to have a provider tax, whether it be by way of insurance companies or whether it be by way of hospitals and take those monies and use them to take care of the indigent? What the heck are we trying to do here?

I mean I can follow this grand philosophy just about so far, but this is ridiculous. On one hand we talk about empowering the States. On the other hand, we come over here, and we say, no, we are not going to let you do that. You are gaming the system. Gaming the system my foot.

Now, this is nonsense, and it is mean spirited. How do you take care of the bad debts, the people who come in there who are dying, who need all kind of procedures? The gun shot cases? You name them over and over. You are going to just simply say no, we are not going to treat you?

Or hospital go bankrupt. We are not going to allow States to have a methodology to raise revenue to take care of these needs.

Now, that is what this would do. It would

prohibit New York -- we just talked about a plan that we have here. How do you think raised the money, $110 million? Provider taxes to take care of 130,000 children who would not have health insurance.

On one hand we say we do not trust the States. On the other one, the States are trying to raise revenue to take care of their needs. We say, oh, no. We are not going to let you do it. You cannot have it two ways.

I do not understand what the intent is. What are you going to do here? Do you raise any revenue here? What are you going to do? You are just going to make it impossible for local people to take care of the needs that we say we want them to take.

Mr. Chairman, this is a mean spirited amendment.

Senator Gramm. Mr. Chairman, could I respond on this mean spirited amendment?

The Chairman. Senator Gramm?

Senator Gramm. What we have allowed is States to tax the Federal Government. States to tax the Federal Government by taxing providers so that when the Federal Government provides a share of the cost, that they, in essence, are able to tax the Federal Government indirectly and change the Federal Government's share.

It was a rip off that States adopted to get around

paying their share under Medicaid. It is one of the reasons that the Medicaid costs, in the last decade, have exploded by 16 percent. So I do not think anything is mean spirited when you are simply trying to prevent people from abusing the system.

Now, States can impose whatever taxes they want to impose. But the point is those taxes should not affect the Federal Government's share for its program.

Now, maybe we do not want to fix these abuses, but if we are going to talk about abuses, and we are going to talk about people gaming the system, we ought to be willing to do something about gaming the system, and we all know this is the biggest that has occurred.

Senator Graham. Mr. Chairman, we do not all know that. And for us, at this hour of 12:23, to be voting on an amendment which has three words, "prohibit such taxes," period, is an affront to this committee.

I would ask that this amendment be ruled out of an order until we got an amendment that stated, in appropriate English language, more than the phrase "prohibit such taxes."

We are unable to cast an even quasi awake, much less intelligent vote with that language.

Senator D'Amato. Mr. Chairman, let me tell you something. Gaming the system is not providing a

methodology for cities and communities to take care of the emergency cases that pour into these large city hospitals by the thousands. That is not gaming the system.

And maybe the Federal Government should have some share if they are imposing so there might be some cost factor there. But let me tell you, how do you take care of the poorest of the poor? All of a sudden now we are going to come up, we are going to take that right away?

Senator Gramm. Mr. Chairman?

The Chairman. Yes?

Senator Gramm. Mr. chairman, I think I can save us time. First of all, I do not think Shakespeare ever spoke in clearer English than prohibit the tax. Me thinketh thou protesteth too much.

But what I will do, given these concerns that have been raised at this late hour, I will withdraw the amendment and try to look at legitimate uses of these taxes. But where the taxes have been used to simply jack up reimbursement, which has then been rebated to the provider, we ought to do something about it.

And I will work to see if I can deal with the concerns of our two colleagues and maintain happiness on this committee, which we are all for.

The Chairman. Senator Rockefeller?

Senator Rockefeller. Mr. Chairman, the next amendment has to do with something which I think is very exciting, which is opposed by the insurance companies and which is very much supported by health care providers about whom we have just been talking, and that has to do with the Provider Service Organization.

It is an alternative way of physicians and hospitals setting up their own health care plans, thus bypassing the need to go to the insurance company for everything, which you have so much now, even with the evolution in managed care, etcetera. You have doctors having to do exactly what they did before, except they have to do it to the managed care companies, the HMOs.

They know that you have to provide a service. They call up the same 800 number line; they get the same bureaucratic response on the other end. There is no difference between the HMO in this respect and the insurance companies.

I think Senator Frist and -- and, of course, he is a doctor. We came up with this. In fact, I came up with it and went to him, and he agreed to work with me on it, as well as Senator Grassley.

It would add another option to what it is, the

definition of PSO, and that is very important. For some reason, the definition of the PSOs does not allow for partnerships or joint ventures as between providers where they would share a substantial risk, and this has to be a part of it.

One of the reasons is, particularly in rural areas where you just are not going to have HMO capacity, you are not going to have managed care capacity of any sort, doctors, hospitals, etcetera, have to be able to form partnerships to be able to provide this aspect of the PSO, which is a marvelous new way of getting health care to individuals.

The Chairman. Julie, would you comment on this provision?

Ms. James. Yes, Senator. The definition of affiliation in the Provider Sponsored Organization provision really relates to try to distinguish these entities from other kinds of risk bearing entities.

And the idea is that the local community providers would own and operate these, and there is a test that they have to provide directly a substantial proportion of the services. And so the test for this is how many of the providers would be counted towards delivering that substantial proportion of the services.

There is nothing in the provision that would

prohibit that kind of a relationship with providers. It is just that that kind of a relationship would not count towards the test.

And the concern is that if you allow providers to simply be on a contractual basis where they are, for example, getting a capitated amount and perhaps there is a withhold, if the entity gets into trouble, then the providers could just not renew their contracts and would not have a stake in the organization to make it work. And if it begins to get in trouble, then have to share in that responsibility.

Senator Rockefeller. Mr. Chairman, and Julie, I left out something very important, which Senator Breaux reminded me of.

This is a 3-year period of time that we are talking about. It is not like a demonstration, but you have to get Federal certification for a period of 3 years. After that, it would stop. That is just for the truth of telling that part. Everything you said was also correct.

Ms. James. I understand.

The Chairman. Any further comment?

Senator Grassley. Mr. Chairman, I would like to comment.

The Chairman. Senator Grassley?

Senator Grassley. I support what Senator Rockefeller is doing, and the reason I do is because, once again, there is special problems that we have in rural America.

And it seems to me that if we do not do what Senator Rockefeller proposes, we are going to impede forming PSOs in rural areas, because in order to be viable, PSOs are likely to need to form on a regional basis in rural areas where individual communities do not have the population or the provider base necessary to support a PSO.

Most rural communities do not want to give up their control of local providers by selling them. Shared risk arrangements provide flexibility to form joint venture structures that leave local governance rights in place, but from entities in which all of the communities have a say, through their providers, in how the PSO is organized and operated.

There would not be enough flexibility in forming PSOs. Providers would have to merge or acquire each other to form the affiliated group of a PSO. They could not form partnerships or joint ventures to do so.

So I think it is very important that we give flexibility, particularly those of us on the rural health caucus. We want to make sure that we take every

opportunity in the marketplace, every opportunity for competition, to make sure that we have facilities for the delivery of care that they have in the urban areas.

The Chairman. I would like to proceed with the vote. Those in favor, signify by saying aye.

(Chorus of ayes.)

The Chairman. Opposed, nay.

(No response.)

The Chairman. The ayes have it. The amendment is agreed to.

Senator Bob Graham?

Senator Graham. Thank you, Mr. Chairman.

Mr. Chairman, I am offering Amendment Number 1 of my list, which was Amendment Number 73. This amendment is being offered in conjunction with Senator Chafee, and it relates to portions of the HMO Emergency Room Act, which were not included in the Chairman's mark.

The Chairman has included the provision contained in our legislation, which provides that the standard for the delivery of care to a Medicare beneficiary in an emergency room shall be the standard of a prudent lay person.

What was omitted were two other provisions. One that relates to the post-stabilization period. That is, after the person is in the emergency room, they

have been stabilized, and then what do you do with them from there on?

Under the bill that we had filed, it required the emergency room to call the HMO, and the HMO, within 30 minutes, to respond with a course of action as to what to do with the now stabilized patient in the emergency room.

That 30 minute requirement was of some concern to several of the HMOs. We have discussed this and negotiated and have modified our amendment to contain language, which will direct the Secretary of Health and Human Services to establish a process of authorization for post-stabilization care based on the post-stabilization provisions outlined in S.356, which these processes would include, among other things, a requirement that a provider of emergency services make a documented, good faith effort to contact the managed care plan in a timely fashion to request approval, etcetera.

I can represent that this language has now secured the agreement of the affected industry, and I believe I can represent that the industry has withdrawn its concern to this proposal.

One other provision that we reinstate is the phrase severe pain as a definition of emergency medical

condition. We are in the anomalous situation. We have a Federal law called the Access to Emergency Medical Services, or IMTALA Act, which requires emergency rooms to provide services.

One of the standards in that Act, that Federal Act, is severe pain as an indicator of the need for emergency services. By restoring this, we would be making compatible these two Federal enactments. I urge the adoption of this amendment.

The Chairman. Senator Chafee?

Senator Chafee. Mr. Chairman, I want to echo what Senator Graham said. I have a letter here from our largest hospital at home that talks about the pain issue that we have in our amendment. And, as Senator Graham pointed out, that has been part of an emergency -- whatever IMTALA means. Emergency something or other.

In the late 1980s, it was part of the Federal law. For some reason, the pain was not included here.

But the other part was the post-stabilization, which our emergency room people feel is very important. So I think it is a good amendment, Mr. Chairman.

The Chairman. Julie, would you?

Ms. James. Senator, I would like to clarify what we have in the mark. We do adopt the prudent lay

person standard, but then we call on the Secretary to develop the regulations and the guidelines for dealing with the issues of the post-stabilization, as opposed to putting a lot of specific detail into statute about how this would have to be governed.

The Chairman. In other words, you are saying that it would be preferable to do it by the Secretary because it could be changed from time to time and not be written into a code?

Senator Graham. Mr. Chairman, if I could say, that is what the revised version of our amendment does, but it does provide some legislative standards. The mark directs the Secretary to develop such regulations, but without any legislative directive as to what those regulations should be.

We have established the standards within which the Secretary shall develop the post-stabilization provisions.

The Chairman. I think one of the concerns is that, in a sense, this is micro managing. In any event, let's proceed with a vote. The Clerk will call the roll.

The Clerk. Mr. Chafee?

Senator Chafee. Aye.

The Clerk. Mr. Grassley?

Senator Grassley. Aye.

The Clerk. Mr. Hatch?

Mr. Hatch. Aye.

The Clerk. Mr. D'Amato?

Senator D'Amato. Aye.

The Clerk. Mr. Murkowski?

Senator Murkowski. Aye.

The Clerk. Mr. Nickles?

Senator Nickles. Aye.

The Clerk. Mr. Gramm, of Texas?

Senator Gramm. No.

The Clerk. Mr. Lott?

The Chairman. No by proxy.

The Clerk. Mr. Jeffords?

Senator Jeffords. Yes by proxy.

The Clerk. Mr. Mack?

Senator Mack. Aye.

The Clerk. Mr. Moynihan?

Senator Moynihan. Aye.

The Clerk. Mr. Baucus?

Senator Baucus. Aye.

The Clerk. Mr. Rockefeller?

The Chairman. Aye.

The Clerk. Mr. Breaux?

Senator Breaux. Aye.

The Clerk. Mr. Conrad?

Senator Conrad. Aye.

The Clerk. Mr. Graham, of Florida?

Senator Graham. Aye.

The Clerk. Ms. Moseley-Braun?

Senator Moseley-Braun. Aye.

The Clerk. Mr. Bryan?

Senator Bryan. Aye.

The Clerk. Mr. Kerrey?

Senator Moynihan. Aye by proxy.

The Clerk. Mr. Chairman?

The Chairman. No.

The Clerk. The votes are 17 yeas, 3 nays.

The Chairman. The amendment is agreed to.

Senator Graham. Mr. Chairman, Amendment Number 2 is a verbatim Number 1, except it is applicable to Medicaid, Number 1 being applicable to Medicare. I would move the adoption of Amendment Number 2 by the same vote.

The Chairman. Without objection.

Ms. James. Senator?

The Chairman. Julie?

Ms. James. The Medicaid amendment is scored as a cost by CBO. It is $100 million.

The Chairman. How much cost?

Mr. Smith. Senator, the mark, as it is drafted, includes the prudent lay person standard. That, in itself, was scored at $100 million. So if you add addition to that, I assume that it will score as well.

Senator Grassley. How can a Medicaid amendment score and a Medicare amendment not score?

Ms. James. Senator, on the Medicare side, most of this is currently in regulation. So it does not make much a difference in the way that Medicare operates.

Senator Graham. Mr. Chairman, I would point out that under the previously adopted MSA Amendment we have approximately $100 million left over from the projected savings, if that is a matter of concern.

The Chairman. We do not actually have a score on that, so we have no idea. I guess what we will do is accept it, subject to or finding somebody to pay for it.

Senator Graham. All right.

The Chairman. Senator Mack is next.

Senator Mack. Thank you, Mr. Chairman. I want to commend you for the National Bipartisan Commission on the future of Medicare that you have included in the mark. As you know, I have had conversations with you in the past with respect to the Commission.

It is my feeling that if there is going to be a commission, another commission, that there needs to be some method that brings the Congress into the process where we would act on what the commission concludes. I do not think it is really worth the time and the effort to have another commission if, in fact, there is not some enforcement mechanism.

And so my amendment basically proposes that we add to it; to add to your commission a fast track process in order to bring the recommendations of the commission to a vote by the Congress.

The Chairman. And that fast track would be subject to amendment?

Senator Mack. The fast track procedure that I am proposing is similar to the base closure fast track procedure.

The Chairman. In other words, there would be no amendments allowed?

Senator Mack. That is correct.

The Chairman. Pat Moynihan, please.

Senator Moynihan. Mr. Chairman, I very much understand Senator Mack's desire that something should follow a commission. But having been through the Greenspan Commission on Social Security, which was appointed in 1981, then we went through 1982, we ended

up having failed, and then Senator Dole suggested should we try again, and it worked itself out in the few weeks after the commission had come to two opposite conclusions.

I do not think you can depend on a commission coming up with a series of two, three, four things to be dealt with in a direct manner like that. If you have persuaded the community of the Congress, you get action, but I do not think you would want to restrict yourself to a very close time table. I am just offering my experience here.

Senator Mack. Again, I appreciate your comment. The reality is that without some enforcement mechanism, the Congress will not act until the crisis is at hand, which is exactly what happened --

Senator Moynihan. There was a crisis at hand in Social Security I grant.

Senator Mack. Right.

Senator Conrad. Mr. Chairman? Mr. Chairman?

The Chairman. Yes, Kent?

Senator Conrad. I think some of what we have done here tonight belies that. I mean, we have taken some serious steps here in this committee, and I would hope my colleague, who I think shares a real serious conviction that more be done with respect to Medicare

to insure its long-term health. I just think dealing with a situation in which no amendments are permitted, dealing with a program as important to the future of the country as Medicare, is just an unacceptable conclusion here.

I cannot imagine that we would adopt a circumstance in which Congress cannot offer amendments, and that we would be compelled to accept what a commission sent to us with respect to the program of Medicare.

Senator Mack. I would suggest that we remove the idea of a commission then because it was not very long ago in which we had a report from a commission. But I would be delighted to withdraw the amendment, since I see my colleagues are not enamored with the idea that we should take action. I withdraw the amendment.

The Chairman. The next is Senator Rockefeller.

Senator Rockefeller. Thank you, Mr. Chairman.

Mr. Chairman, I would just say this. It is going to sound slightly fatuous. But the point was made by several over here that you have been exceedingly fair in the way that you have not just conducted things, but also arranged for things to come together and reached out to both sides. So I wanted to say that.

This amendment simply says that we cannot

tolerate, in anything new that we do or anything that we have, which is the current law, for balanced billing. Balanced billing has a history. It goes back to 1989.

And it is what Julie would refer to as the history begins with RBRVBS, which is the Resource Based Relative Value Scale, which was meant to sort of basically bring specialists and generalists into parity and which did not because HCFA proceeded to absolutely ruin it. But, nevertheless, it is still a good idea.

But one of the corollaries of that was that we would phase down balanced billing over a period of -- I think it was three years. Wasn't it? Something of that sort. And we did that.

Under that law, doctors are prohibited from charging beneficiaries more than 115 percent of the Medicare fee schedule amount. In other words, previously they had charged rich patients, like Senator Breaux here, for example, 145 percent, and then they would charge me 75 percent and that would be fair in life. And that is the way they kind of made their deal.

But my modification has to do with all Medicare choice plans. That is the point; that no balanced billing should continue to be the law with all Medicare

choice plans and prohibits plans from charging senior citizens co-insurance amounts of 50 percent or more for all their health care services.

It is complicated, but let me just say that the average income for a senior in my State of West Virginia is $10,700, and the average senior spends an enormous amount; 21 percent of their incomes on health. For frail and elderly, 85 and older, it is about $4,000 a year.

Balanced billing we do not need in all Medicare choice plans, and that is the purpose of the amendment.

The Chairman. Julie, would you care to comment?

Ms. James. Senator Rockefeller, would this mean that all of the plans then, the private fee-for-service plan would have to adopt the Medicare prices for everything?

Senator Rockefeller. Yes. Including FFS. Yes.

Ms. James. Yes. Well, in the mark, the private fee-for-service plan is intended to be a plan that is an unrestricted plan that is separate from the prices that are established in the traditional Medicare program. It is really a freedom of choice, for people who want that kind of a plan, to opt for that kind of a plan.

So the balanced billing limits specifically do not

apply to that plan or to the medical savings accounts because of the whole different cost sharing structure, and we do provide that in the information section the Secretary make that it is very explicit to beneficiaries what the balanced billing requirements are, and so therefore, people can make an informed choice.

Senator Grassley. Mr. Chairman?

The Chairman. Mr. Grassley?

Senator Grassley. I think that there is something unamerican about this amendment. If there is anything that Americans take pride in about our country, it is the freedom to spend their money, that they have earned, the way they want to spend it.

And this is a special new opportunity that is provided in this bill for people to have a combination of Government financed, as well as their own private money, to put together and buy a plan that they want. And what is wrong with that? I mean, after all, it is their money.

The only other position you can take is that every penny that you have ever made in your life, some bureaucrat ought to have a right to tell you how to spend it. Now, this is Washington nonsense, and what we need is a little bit of common sense. And let me

say Iowa common sense, but I know there is other States that have a lot of common sense, too.

We have to have some common sense replaces, and it is just wrong, I think, what is being done by this amendment.

Senator Gramm. Mr. Chairman?

Senator Rockefeller. Senator Grassley, could I just respond that this is not about spending, but about charging.

Senator Grassley. It is about whether or not I am willing to pay for a service beyond what the Government will give me.

The Chairman. Senator Gramm?

Senator Gramm. Well, Mr. Chairman, let me be sure now before I go off on this that I clearly understand, because that last comment, I thought I understood completely, and I did not think it was mean spirited. And I am not sure it is unamerican either, but I do not think it is good policy.

There is nothing wrong with the guy offering it, but I do not think it is good policy. But the last comment kind of threw me off, Julie, and let me see if I understand.

As I understood it, what this amendment would do is say if the conventional Medicare plan, which by

definition I did not choose, if I chose another plan from among our menu, reimburses doctors, for example, at a certain rate, then the plan I chose, because I thought it would be more efficient and get me more health services at the same price than the traditional Medicare, would have to reimburse at the same rate that Medicare reimburses. Now, is that right?

Ms. James. That is my understanding.

Senator Gramm. Well, let me explain why that is just a terrible idea. We are providing a menu of choices. Every Medicare beneficiary has a right to choose the plan that will reimburse exactly as Senator Rockefeller wants it. Irrationally.

Now, if, on the other hand, a private insurance company can put together a plan and say to my mother, for example, "Florence, if you will buy our plan, we will keep fee-for-service with the providers that we enter into contract with, but we will use our buying power to get lower prices, and we will pay for your pharmaceuticals," what the Rockefeller Amendment would say is they cannot do it.

They cannot bargain with these doctors. They have got to pay them exactly the same rate that Medicare does. If we do this, we destroy the whole purpose of giving a menu of choices.

If a private provider can get a lower price and Medicare beneficiaries, by choosing it, can get pharmaceuticals, who are we, at Chuck Grassley's word, to tell them how they ought to spend their money? They chose it. They could have had the system that Senator Rockefeller is proposing, but they did not chose that system. They chose another one.

And so I believe, Mr. Chairman, that this is not good policy. It is not unamerican, but it is just not good policy.

The Chairman. I would like to proceed with the vote. The Clerk will call the roll.

The Clerk. Mr. Chafee?

Senator Chafee. No.

The Clerk. Mr. Grassley?

Senator Grassley. No.

The Clerk. Mr. Hatch?

Mr. Hatch. 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. Gramm, of Texas?

Senator Gramm. No.
The Clerk. Mr. Lott?
The Chairman. No by proxy.
The Clerk. Mr. Jeffords?
The Chairman. Yes by proxy.
The Clerk. Mr. Mack?
Senator Mack. No.
The Clerk. Mr. Moynihan?
Senator Moynihan. No.
The Clerk. Mr. Baucus?
Senator Baucus. Aye.
The Clerk. Mr. Rockefeller?
The Chairman. Aye.
The Clerk. Mr. Breaux?
Senator Breaux. Aye.
The Clerk. Mr. Conrad?
Senator Conrad. Aye.
The Clerk. Mr. Graham, of Florida?
Senator Graham. Aye.
The Clerk. Ms. Moseley-Braun?
Senator Moseley-Braun. Aye.
The Clerk. Mr. Bryan?
Senator Bryan. No.
The Clerk. Mr. Kerrey?
Senator Kerrey. No.

The Clerk. Mr. Chairman?

The Chairman. No.

The Clerk. The votes are 7 yeas, 13 nays.

The Chairman. The amendment is not agreed to.

Senator Grassley. Mr. Chairman, can I ask a question?

The Chairman. Yes.

Senator Gramm. It is almost 1:00. Are we going to stay and finish?

The Chairman. Just a few more amendments.

Mr. Hatch?

Senator Murkowski. Maybe we could move it along a little because several of these amendments we really did not need to vote on.

Senator Gramm. They did not know it until we had it.

The Chairman. Anyway, let's proceed. Mr. Hatch?

Mr. Hatch. What my amendment would do--this is Amendment Number 7--is it would delete the five percent risk adjuster for new enrollees.

Medicare payments to HMOs are based on 95 percent of the average per capita costs in the area. The payment rates vary by specific demographic variables, including age, sex, institutional status and Medicaid status. Other than for these demographic variables,

the payments are the same for all enrollees in any areas.

What this amendment would do is it would delete the new proxy risk adjuster for Medicare payments for new Medicare choice enrolles, and this is five percent.

Now, this payment cut for new enrollees will have serious unintended consequences. Number one, it will decrease choice and disadvantage new plans. New Medicare choice plans, PSOs and other new plans, will be comprised of all new enrollees.

The Senate Finance Committee mark would disadvantage these plans by cutting their entire payments by five percent in the first year, while existing plans will face much less impact. And since new plans face significant start up costs, this will be a serious disincentive for the creation of new plans. This is a key goal of the bill.

Number two, this five percent cut will particularly hurt rural areas. Since most rural areas have few, if any, HMO options today, these areas will be disproportionately impacted.

This new enrollee proxy could offset the increases provided in the proposed revision of the HMO payment formula, which is designed to provide greater equity in payments to rural areas.

And number three, it would be administratively very difficult to implement this new payment reduction.

Senator Rockefeller. Could we have order, Mr. Chairman?

The Chairman. Please proceed.

Mr. Hatch. Now, in my opinion, the savings from this proposal could be achieved through a lower annual update for payments for all Medicare choice plans, and that would be more equitable until a reliable, accurate risk adjustment methodology could be developed and implemented.

Now, HCFA believes that such a methodology could be available for implementation by the year 2000 or 2001. But basically, the Chairman's mark includes a proxy for a risk adjustor until HHS can develop and implement an accurate and effective risk adjustment methodology.

And so by reducing the mark, reducing payments to Medicare choice plans by five percent, it does take away choice, it does hurt rural area, and it will be difficult to collect and administer anyway.

So I would hope that my colleagues would be willing to support the Hatch Amendment to resolve this problem.

Senator Breaux. Mr. Chairman?

The Chairman. Senator Breaux?

Senator Breaux. Mr. Chairman, I would oppose it. The provisions have been recommended by the Physician Payment Review Commission. We had hearings that Senator Grassley chaired with me a couple of weeks ago, and it appointed out that HFCA said that we were overpaying HMOs by about $2 billion a year because what we pay them is based on an arbitrary 95 percent of the fee-for-service in the area, and many of these HMOs have enrolled only very healthy patients.

So we are wasting about $2 billion a year in overpayments, and the Chairman's mark has the recommendation of the Physician Payment Review Commission that allows for a risk adjustor in these HMOs to get closer to what they are actually costing them to treat people enrolled in their HMOs.

I think to not even have this adjustment factor would be a serious mistake.

The Chairman. I would ask Julie to comment on it, but I would also ask what would we lose in revenue.

Ms. James. It is in the vicinity of $3 billion over the five year period. I would point out that in President Clinton's budget proposal he proposed an across the board five percent reduction, to go from 95 to 90 percent of the AEPCC effectively.

And this one, just to put it in comparison, this is a much smaller adjustment. It would be about a 1.6 percent reduction in the year 2000, as opposed to the one that was proposed by the President that would effectively be 5.3 percent.

And also, I have a letter here from the Physician Payment Review Commission. They had a retreat this last weekend, and it says, "The Commission discussed the policy again at its retreat last week and unanimously recommended introducing a new enrollee risk adjustor as an interim measure until implementation of an improved risk adjustment based on clinical data become feasible."

Mr. Hatch. Well, that is all true, but it still disadvantages new HMOs, new plans and HMOs, and it still disadvantages the rural areas. And we do not have a methodology that is established yet, and I think we ought to wait until we get the methodology established, rather than just disadvantage at least both of those areas.

Ms. James. Three billion dollars.

The Chairman. The Clerk will call the roll.

Senator Gramm. Mr. Chairman, hold on a second, please. How would Senator Hatch pay for this?

Mr. Hatch. Well, I said the way we would do it

is the savings from this proposal could be achieved through a lower annual update for payments for all Medicare choice plans. That would be more equitable, that is until a reliable, accurate risk adjustment methodology could be developed and implemented.

And HCFA believes that that will not happen until 2000 or 2001. So this is a much more fair way of handling that than what the mark has in it.

Senator Gramm. Well, Mr. Chairman, could I just respond?

The Chairman. Briefly.

Senator Gramm. Mr. Chairman, you know, we are here to save $115 billion, and, as a result, you have got to make cuts somewhere to save $115 billion. And nobody likes this risk adjustment, which is simply a mechanical factor and phases out over five years, but the point is it does save a lot of money.

And to go it, which we have had the staff look at, which we under and which is a temporary measure to reducing the update for all of the providers that we are bringing into the system, I think is a tremendous change, and I do not think it is justified.

I think that we ought to reject this amendment. Not that there is not a problem with the risk adjuster, but there is no better way to save $1.5 billion than

anybody has come up with.

The Chairman. We will proceed with the vote.

The clerk will call the roll.

The Clerk. Mr. Chafee?

Senator Chafee. No.

The Clerk. Mr. Grassley?

Senator Grassley. No.

The Clerk. Mr. Hatch?

Mr. Hatch. Aye.

The Clerk. Mr. D'Amato?

Senator D'Amato. Aye.

The Clerk. Mr. Murkowski?

Senator Murkowski. No.

The Clerk. Mr. Nickles?

Senator Nickles. No.

The Clerk. Mr. Gramm, of Texas?

Senator Gramm. No.

The Clerk. Mr. Lott?

The Chairman. No by proxy.

The Clerk. Mr. Jeffords?

The Chairman. No by proxy.

The Clerk. Mr. Mack?

Senator Mack. No.

The Clerk. Mr. Moynihan?

Senator Moynihan. No.

The Clerk. Mr. Baucus?

Senator Baucus. No.

The Clerk. Mr. Rockefeller?

The Chairman. No.

The Clerk. Mr. Breaux?

Senator Breaux. No.

The Clerk. Mr. Conrad?

Senator Conrad. No.

The Clerk. Mr. Graham, of Florida?

Senator Graham. No.

The Clerk. Ms. Moseley-Braun?

Senator Moseley-Braun. No.

The Clerk. Mr. Bryan?

Senator Bryan. No.

The Clerk. Mr. Kerrey?

Senator Kerrey. No.

The Clerk. Mr. Chairman?

The Chairman. No.

The Clerk. The votes are 2 yeas, 18 nays.

The Chairman. The amendment is not agreed to.

Senator Baucus?

Senator Baucus. Mr. Chairman, my amendment is in the same subject as the one last offered by Senator Hatch, but it is much, much more narrowly drawn. And the point of it is to allow managed care to take root

and to take hold in rural areas.

I think there is good reason, as Senator Breaux pointed out, of why the risk adjusters. In effect, I think it makes sense for new enrollees to be paid less in HMOs. But my amendment basically provides that new plans, not new enrollees, but new plans get the benefit of one year delay in the risk adjuster--just one year--to enable them to compete with other forms of health care providers.

Very simply, just to repeat, if you are a new health care plan, the risk adjuster was delayed for one year only for that new plan. We are trying to find some way to allow health care plans and HMOs to germinate, take root in and get started in rural areas, otherwise, they are at a disadvantage.

If they do not get this slight break, it is going to be difficult for them to compete in rural areas.

Now, I do not what the cost of this is, but the offset that they have come up with is to delete the one percent increase provision that the HMOs are able to choose from when they choose the greater of three payment options. It is a blend of national and local rates. That is one option.

The other is a minimum floor rate of 350. The third option under the blended rates is the same

payment as the previous year, but with a minimum percent increase of one percent.

So I would just say that that one percent would not be allowed to pay for this one year delay for new HMOs.

Senator Grassley. Mr. Chairman?

The Chairman. Senator Grassley?

Senator Grassley. Yes. Now, I voted against Senator Hatch's proposal because it was very costly. But the arguments that Senator Hatch used, and the arguments that Senator Baucus used have to be listened to.

Now, there is different solutions to solving it, and I think Senator Baucus has a good solution because we have got to remember that our whole goal of AEPCC reform is to make sure that there is access to managed care plans in all of America. And where we have this problem is in rural America.

And if you apply the adjustment to those new plans, it is going to defeat the purpose of increasing payment equity. So giving plans the one year exemption that Senator Baucus talks about gives these plans an opportunity to get off the ground.

In other words, we can make all the changes in the AEPCC, but if you do not have that floor high enough

for those plans to come in, or if you offset it through this risk adjustment for plans that aren't even started, and it is a negative to getting them started, then everything that we are talking about here through enhancing the AEPCC just is of no avail. We are just going to be back to square one.

And this is probably the last opportunity we have between now and the year 2002 to do something about the problems of managed care not being available in rural America. So I hope you will take a very good look at what Senator Baucus is trying to do.

The Chairman. Julie, can you comment on this?

Ms. James. I would just like a clarification. What this amendment does is just say that for the first year you are in operation, it does not apply. Is that correct?

Senator Baucus. For new plans.

Ms. James. For new plans. Right.

Senator Baucus. Only new plans.

Ms. James. Right.

Senator Baucus. All these would still be subject to the same risk adjuster in current plans. So with respect to new plans, just a one year delay.

The Chairman. Do you have any estimate of how much that would cost?

Ms. James. No, Senator. I think though that this offset would be probably more than enough. What this does is reduce the minimum update that plans are guaranteed, from one percent a year to no percent a year.

The Chairman. Who would that penalize?

Ms. James. Those would be those areas where there is a lot of medical education and disproportionate share spending because we are changing how that is treating, and those areas that are currently very highly paid, which we held harmless or established a one percent minimum update.

Senator Baucus. Mr. Chairman, I might suggest, if it is more than enough, I would scale it back to whatever a one year delay would come to. I might add, I have got a list here.

Senator Moseley-Braun. Mr. Chairman?

Senator D'Amato. May I ask how this is paid for, Mr. Chairman? I voted for the other one, but we were not taking money away from other HMOs.

Senator Moseley-Braun. Yes.

Senator D'Amato. Now, I have been given to understand that what this does is it makes up this deficiency by taking money that otherwise would go to the HMOs that operate in our urban centers. Am I

wrong?

Senator Baucus. I can answer the question.

Senator D'Amato. Well, I would like the staff to. How do you make up this money? Don't some HMOs lose money as a result of this? You take one percent away from certain HMOs and distribute it to these particular ones?

Ms. James. Well, I understand the suggestion is now that you reduce the minimum update, which is now set at one percent, by a sufficient --

Senator D'Amato. Where does that one percent go?

Senator Baucus. The one percent goes to pay --

Ms. James. A sufficient amount to pay for this amendment.

Senator Baucus. Exactly.

Senator D'Amato. Where does the one -- you are going to reduce a payment by one percent. Where does that one percent go?

Senator Baucus. Who does that hurt he is asking?

Ms. James. Those are the plans that are in the highest paid areas.

Senator D'Amato. Oh, the highest paid areas. Okay. So let's not talk in this abstract. You know, I have difficult. One percent from the -- you know, we are really saying that the plans that operate in the

cities. Right? In the metropolitan areas. Higher cost. Right? Are going to lose this one percent. Is that right?

Ms. James. Well, a part of it.

Senator D'Amato. A part. Yes.

Ms. James. A part of the one percent.

Senator Baucus. Mr. Chairman, I can help the Senator from New York a little bit. How many counties are there in New York?

Senator Moynihan. Sixty-two.

Senator Baucus. Well, there is 62 counties in New York. I will tell you. One, two, three, four, five counties would receive somewhat less than they otherwise receive.

Senator Moynihan. Well, New York king's queen.

[Laughter]

Senator D'Amato. It has got 75 percent of the population.

Senator Baucus. No county is affected in Delaware.

The Chairman. Are we ready for the vote?

Senator Moseley-Braun. Mr. Chairman?

The Chairman. The clerk will call the role?

Senator Moseley-Braun. Mr. Chairman, if I may? Recognizing what Senator Baucus and Senator Grassley

are trying to do as a laudable goal, we do want to try to give some assistance to rural areas to get these managed care plans off the ground and to help them out.

Is there no way that we can offset the amount of money that is required for this more modest proposal in ways that do not require us to borrow from Peter to pay Paul?

I mean, it does not make sense to try to hurt existing HMO plans to achieve this goal. It seems to me that we ought to be able to find the financing for it in some other way.

Senator Baucus. Two counties are affected in Illinois. Two.

Senator Moseley-Braun. Yes. Cooke. Right. I mean, it really hurts enrollment where it least can afford it is the problem. I am trying to help you here, Max.

Senator Baucus. It is the same as what you received last year.

The Chairman. Can I make a suggestion?

Senator Baucus. But not the one percent increase.

Senator Moseley-Braun. Well, but the one percent may be the difference.

The Chairman. Max and Carol, if I could make a

suggestion? We do not what the costs are. We do not know how to offset it. Why don't we try to work together before we go to the floor and see if something can be worked out.

Senator Moseley-Braun. That is a good idea.

Senator Baucus. Julie will finance it.

The Chairman. All right. Let's proceed with Senator Nickles.

Senator Nickles. Mr. Chairman, thank you. I think I have two amendments that we can agree to pretty quickly, one of which may have been adopted.

We had a consumer protection on PSOs, and I had a question mark by it with that long list of amendments that we have already agreed to. Has that been agreed to? It was number two on my list and number --

Ms. Spitznagel. If we could just have another moment for that one?

Senator Nickles. All right.

Mr. Chairman, the other amendment that I wanted to bring up is Number 234, Number 9 on my list. It would preserve the rights of States to sanction, i.e., reduce welfare payments to recipients that did not comply with welfare law, i.e. we gave a welfare bill last year where we gave States the right to reduce welfare payments if a welfare recipient did not have their kids

in school, they did not have their immunized, if they did not comply with the -- oh. Kids attending school and so on.

So the States could sanction welfare recipients for non-compliance. The Administration came up with a minimum wage requirement that says the States, on work requirements, would have to pay minimum wage. Some would say that would reduce the States' ability to sanction or reduce welfare payments.

This would insure that States could sanction for non-compliance. I would hope it would be adopted.

The Chairman. Any comment? Are we ready for the vote?

Senator Moseley-Braun. Mr. Chairman? Mr. Chairman?

Do I understand correctly? It says if the parent fails to cooperate and these other things, "the State shall reduce the family's benefit by at least 25 percent and may reduce it to zero as a sanction." Is that correct, Senator Nickles?

Senator Nickles. That is current law.

Senator Kerrey. This amendment has not been distributed. I do not have a copy.

Senator Moseley-Braun. Right. The amendment says, "States would not be prohibited from utilizing

sanction authority due to any minimum wage requirement."

Senator Nickles. That is correct.

Senator Moseley-Braun. So a person making minimum wage could wind up making less than the minimum wage if they failed to meet some of the States' other requirements?

Senator Nickles. Let me back up a little bit. We put in work requirements for the States.

Senator Moseley-Braun. Right.

Senator Nickles. The welfare recipients, a certain percentage of those are supposed to be working, maybe 20 hours, and then it would increase 25 and so on. The Administration came up with a regulation that said that work requirement should meet minimum wage.

Senator Moseley-Braun. Right.

Senator Nickles. There is some debate whether the work being done should be paid minimum wage, or should that include welfare, food stamps, Medicaid other things. That is another debate.

Senator Moseley-Braun. Right.

Senator Nickles. What I am saying is that the States had the authority, under the bill, to sanction to get compliance on a couple of things. Mainly, getting kids in school; getting kids immunized; making

sure that dead beat dads signed up establishing paternity.

Those are a few things that if individual welfare recipients did not comply with, the States could hold back money.

Senator Moseley-Braun. Right.

Senator Murkowski. I would like to preserve the rights of States to hold back money, regardless of the Fair Labor Standards compliance. The States should have the right to sanction. That is the law. That is what we passed. I do not want to see those sanctioning authority of the States to be undermined by the Administration.

Senator Moseley-Braun. Senator Nickles, I understand where you are trying to go with this. But if you think about it for a moment, it may be that the most honest debate--honest point in the whole debate--was that we would have to build some more orphanages because, quite frankly, this money is supposed to go to support the children, if the parents are bad actors and they do not perform.

What you are suggesting with this is that they be able to be reduced to zero and still have to go to work because they had failed to meet the other requirements.

Senator Nickles. That is current law, Senator.

Senator Moseley-Braun. I understand. But below the minimum wage they could be reduced to zero. And all I am saying to you is then what do you do with the children? I mean the whole idea is that they are getting support for the kids in the family.

Senator Nickles. That is already current law. I am trying to preserve the rights of the States to do that and trying to make it perfectly clear that they can do that. I think it is pretty simple. But we passed that.

Senator Moseley-Braun. To take them below the minimum wage. That is my point.

Senator Nickles. No. The Administration came up with minimum wage. The States are going to have a hard time complying with it. There is a big debate on welfare. We are trying to make sure that we move people away from welfare.

Senator Moseley-Braun. I am not confused about that, Senator.

Senator Nickles. And we are trying to make sure that their kids get in school. And States have found very significant improvements on making sure that welfare kids get in school if they can impose --

Senator Moseley-Braun. They threaten the parents. I understand.

Senator Nickles. If they impose that sanction.

Senator Moseley-Braun. But the effect of this is to take these people who are working then below minimum wage as a consequence of whatever the conduct is that is been prescribed.

Senator Nickles. No. It is to maintain the States' authority to be able to sanction those people so they can get those kids in school, get immunized or get them to register.

Senator Rockefeller. Mr. Chairman?

The Chairman. Senator Rockefeller?

Senator Rockefeller. Just a plea on this one. As I understand it, the sanction, for example, could go against the welfare parent for bad behavior for not having caused their child to be immunized. This could be good; this could be bad.

My point is this is a rather big subject. I mean it is a delicate subject, and it just seems to me that since literally -- I mean, I am working off of a yellow sheet of paper that I have got from staff, and I have this one here. We have not seen it.

Would it be possible to put it off until the morning, because we are getting into tricky stuff on this. This is delicate.

Senator Nickles. I would be happy to. Do not

make a bigger deal out of it then it is. Present law allows the States to sanction. The Administration came up with a questionable ruling that States had to pay minimum wage, and no one yet has defined what that minimum wage is for welfare recipients on the work requirement. Does that include food stamps and so on?

I am not getting into that debate. I am saying, regardless, States still maintain the right to sanction, to withhold some funds in order to get these kids in school.

But I will be happy to postpone it until tomorrow if we are going to be working on this tomorrow.

The Chairman. Well, it is tomorrow.

Senator Nickles. It is tomorrow. Well, I am ready to vote then.

The Chairman. But let me point out we have a very busy full schedule, and I had been hopeful that we might be able to finish tonight. I would like to get an idea of how many more amendments are going to be raised.

Senator Nickles. No more from me. Zero.

The Chairman. One? That is two. How many do you have? Seven.

Well, I think, if we only have seven amendments --

Senator Kerrey. Kevin has got five.

Senator Baucus. He has got a full boat over here.

Senator Nickles. Do them in block.

The Chairman. Well, I would like to proceed.

Senator Grassley. If we come in at 7:30 in the morning, we could be done in time to do the taxes tomorrow. I mean we do things a silly way in this town.

[Laughter]

The Chairman. Well, the problem, if we come back in the morning, we will have four dozen instead of 12.

Senator Moynihan. Why don't you lock in.

The Chairman. All right.

Senator Grassley. Ask unanimous consent, the number of amendments that can come up. Lock everybody in.

The Chairman. I would like each one to give us which amendment you want to bring up so that we can lock them all in.

Senator Kerrey. Well, Mr. Chairman, hearing that the Senator from Iowa would say that I was unamerican or did not have common sense, and, as a consequence, actually voting against Senator Rockefeller's amendment earlier on the issue of balanced billing for Medicare

choice, I am not going to offer my amendment to make balanced billing illegal on MSAs.

I actually am persuaded that the consumer does not need to be protected in that case. But I intend to offer what is known as the Chafee Amendment Number 5, a Medicaid amendment involving managed care for special needs children.

The Chairman. I would like to go down the line. Richard?

Senator Bryan. Mr. Chairman, I hope I will not be penalized. We have been able to work out the matters that we had. So I do not intend to offer anymore amendments this evening, unless you would like me to do so.

Senator Kerrey. But he does intend to support mine.

The Chairman. Carol?

Senator Moseley-Braun. I just had one, Mr. Chairman.

The Chairman. Can you identify it, which number?

Senator Moseley-Braun. It is 211.

The Chairman. Bob Graham?

Senator Graham. Mr. Chairman, number 78, 79, 82, 84, 85 and then another amendment relative to disproportionate share hospitals.

The Chairman. Is it on file?

Senator Graham. No. We will provide the material to the staff.

The Chairman. I would hope we could limit ourselves to the amendments already filed.

Senator Conrad?

Senator Conrad. Mr. Chairman, 37, 45 and 50.

The Chairman. Senator Breaux?

Senator Breaux. I have one on the demonstration project with Senator Mack. They are working on that now.

The Chairman. Senator Rockefeller?

Senator Rockefeller. Mr. Chairman, I will want to do one on VA.

The Chairman. Which number?

Senator Rockefeller. Which is number 252, and number 246, number 243--I apologize--and absolutely 257 and a question about 256.

The Chairman. Senator Baucus?

Senator Baucus. Mr. Chairman, I do not have any, assuming we can work out that last amendment. But if that amendment cannot be worked out, the one I offered on the risk adjustment for new plans for rural areas, then I will have to ask for a vote.

The Chairman. Senator Moynihan?

Senator Moynihan. I have no further amendments.

The Chairman. John?

Senator Chafee. Mr. Chairman, I have 18, and 27 I will present, but withdraw.

The Chairman. Senator Grassley?

Senator Grassley. Yes. Amendment 100. But if the Baucus Amendment is worked out, I will not have that amendment to offer. Amendment 101 for sure.

And then I have been told by your staff that we are going to be able to work language on the State Veterans Home arrangement or amendment that I was going to offer, and we are assuming that that is going to be worked out.

The Chairman. Senator Hatch?

Mr. Hatch. Bill, I have got the FQHC, which I think we can work. That is 123. Then the Christian Scientists, which I think we can work out, which is 128. I do not see any reason why we do not work that out.

And then, frankly, 129, the Chiropractor Demonstration Project. Even though we do not have a CBO, why could we not work that out?

The Chairman. Senator D'Amato?

Mr. Hatch. If it has any cost, we can always find some way around it. But those are the three.

Senator D'Amato. Mr. Chairman, I would like to think that I have two. Amendment 61, which is a cancer rehabilitation center. It is really not though. It is a center for the treatment of the terminally ill, and I think Senator Moynihan would join me with that Calvary Hospital. It is no cost, and I really hope we could work that out.

And then we have one other. Oh, yes. That is number 61, and then number 61. I would even be willing to trade one. But I would hope that we could work that out with the staff.

Senator Moseley-Braun. Senator D'Amato, reserving the right, Mr. Chairman, I was under the impression I was going to co-sponsor with Senator D'Amato's number 59. And if you are not going to go with that, then I am going to have to.

Senator D'Amato. Fine. Let's go with it.

Senator Moseley-Braun. All right. Thank you.

The Chairman. Frank?

Senator Murkowski. Number 224, Medicaid equity.

The Chairman. And Don Nickles?

Senator Nickles. Do we have the PSO dealing with consumer protection?

Ms. Spitznagel. Yes. Yes.

Senator Nickles. If that one has been accepted,

Mr. Chairman, then I would only have one. And that would be the welfare sanctions that I just discussed.

The Chairman. Phil?

Senator Gramm. Mr. Chairman, I have four. I think you are going to end up accepting two. I do not see them as very controversial. But they are 88, 90, 91 and 94.

Senator Lott. Mr. Chairman, I have one, which is 195.

And I would like to have a clarification on just how silly we operate in this town. Do I understand we are coming in at 7:30 in the morning?

Senator Gramm. Chuck is coming in at 7:30. We are coming in at --

[Laughter]

The Chairman. We will come in at 10:00 if everybody will cut their amendments in half.

Senator Lott. Good deal. Fair enough.

The Chairman. How many do we have then? So we have a total of?

[Pause]

The Chairman. I would point out we still have 35 amendments, but we will recess for the rest of the evening and come back in at 10:00.

I would ask each of you again to review your list

so that we can pair them down as much as possible.

Senator Murkowski. Are you going to close amendments now? Or are you going to still take amendments?

The Chairman. It is with the understanding that this is the limit, the only amendments that can be brought up tomorrow.

Senator Graham. Mr. Chairman?

The Chairman. The committee is in recess.

Senator Graham. Mr. Chairman?

The Chairman. Senator Graham?

Senator Graham. Mr. Chairman, I offered the sense of an amendment on disproportionate share. I could not have offered it based on the time for amendments because we did not have the disproportionate share language until earlier today, and this is an amendment to the language. That is why it was not one of my previously filed amendments. I just want to be sure it was on the list.

[Whereupon, at 1:21 a.m., the hearing was recessed, to be reconvened on Wednesday, June 18, 1997, at 10:00 a.m.]