RICHARD
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ORIGINAL

EXECUTIVE SESSION

THURSDAY, MAY 28, 1987

U.S. Senate

Committee on Finance

Washington, D.C.

The committee was convened, pursuant to notice, at 10:25 a.m. in Room SD-215, Dirksen Senate Office Building, the Honorable Lloyd Bentsen (chairman) presiding.

Present: Senators Bentsen, Matsunaga, Moynihan, Baucus, Bradley, Mitchell, Pryor, Riegle, Rockefeller, Daschle, Packwood, Dole, Roth, Danforth, Chafee, Heinz, Wallop, Durenberger, and Armstrong.

Also present: Ms. Patricia Knight, Deputy Assistant Secretary for Legislation (Health), Department of Health and Human Services; and Mr. Tom Burke, Chief of Staff, Department of Health and Human Services.

Also present: Messrs. Bill Wilkins, Majority Staff Director; and Bruce Kelly, Majority Health Counsel; Ms. Marina Weiss, Chief Analyst for Health and Human Resources; Messrs. Frank Cantrel, Minority Tax Counsel; and Ed Mihalski, Minority Deputy Chief of Staff.

(The press release announcing the session and the prepared written statements of Senators Mitchell, Riegle, Rockefeller, and Chafee follow:)

George J. Mitchell

Statement of Senator George J. Mitchell

Medicare Catastrophic Loss Prevention Act of 1987

Mark-up

May 27, 1987

For more than twenty years the Medicare Program has provided the elderly and disabled of our nation with access to quality health care. Without Medicare, the elderly would face health care expenses that would consume nearly 50% of their median per capita income. Our government can justifiably be proud of our commitment to quality health care for all of our citizens over 65, regardless of income.

While the Medicare Program has protected the vast majority of the elderly from overwhelming costs of health care that could devastate a lifetime of savings, the program does have its shortcomings. There are gaps in coverage.

The elderly are the heaviest users of health services. They account for 29% of all hospital discharges and 33% of the nation's personal health care expenditures even though they constitute only 11% of the population.

The legislation introduced by Sen. Bentsen, myself and others on the committee will provide catastrophic illness protection from some of the costs of acute care for the nation's 31 million Medicare beneficiaries. The benefits included in the bill are both responsive to the needs of the elderly with acute catastrophic expenses, as well as responsible in terms of the current federal budget deficit.

Thus, while the cost of providing the additional benefits described in this bill are estimated at $2.4 billion in FY'88, the methods used to finance this program have been designed in a fair and progressive way. Our financing method is a sincere attempt to provide an equitable way to distribute the burden of additional costs of expanded benefits fairly among the elderly population.

S. 1127 in its present form does not address two important sources of acute out of pocket expenses of the elderly-prescription drugs and mental health disorders. The lack of a reasonable Medicare benefit in these areas creates significant hardship for millions of older Americans. Both of these areas present major problems in devising a benefit that is both effective and affordable. However we can and must confront these important problems. I intend to hold hearings and introduce legislation directed at addressing these areas in the very near future.

Legislation to correct limitations in Medicare coverage of acute catastrophic expenses is an important first step toward providing elderly persons with adequate health care protection from catastrophic costs that can wipe out a lifetime of savings and rob them of peace of mind and quality of life in their last years.

However, we must acknowledge that neither this bill, nor the bill currently being considered by the Ways and Means committee of the House of Representatives, fully addresses the most serious threat to the financial health of the elderly and to both state and federal budgets-the cost of long term care. Over 80% of catastrophic out-of-pocket health care expenses of the elderly are for the expenses incurred for long term care.

I would like to point out that we have included in this bill a study by the Institute of Medicine that will further define and clarify the issues involved in developing a Medicare long term care benefit. Further since the vast majority of the elderly believe that Medicare covers the cost of long term care, the bill requires the Department of Health and Human Services to notify beneficiaries annually of what Medicare will and will not pay for, and how coverage is different for individuals enrolled in the catastrophic plan. This is an important step toward educating the elderly about the need to prepare for the costs of long term care.

To devise an equitable and comprehensive plan for long term care will be a difficult task, ~~for our nation to undertake.~~ But we cannot ignore the growing crisis of long term care. ~~We cannot afford to say that it is too difficult an objective this year, or next year.~~ Every year we delay will only add to the crisis. Our work on the legislation before us today is only a beginning.

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The Chairman. This hearing will come to order.

Let me state that the first item of business will be the Fraud and Abuse Bill, and that is S. 661 that is introduced by Senators Heinz, Glenn, Mitchell, Durenberger, Bradley, Rockefeller, Melcher, and I am sure others.

Both the House Committee on Ways and Means and the House Committee on Energy and Commerce have reported out an identical bill, and the bill is essentially the same fraud and abuse legislation agreed to by the Finance Committee last year.

I would assume, and hopefully, it will not take us too long, and then we will move on to catastrophic illness.

Let me state now -- it should read "remember" -- that in the event we happen to finish catastrophic illness and report it out this morning, and that is a very ambitious thought, but if we don't we will meet on Friday, tomorrow. And if that doesn't finish it, we will meet on Tuesday.

But I want it remembered that, insofar as votes up until 5:30 in the afternoon, that does not apply after the bill is reported out of this Committee. The reason for that being, of course, that whomsoever votes to report the bill out has to know what is in the bill, and that is why we apply that rule. That has been part of the rules announced at the beginning of this session; but I wanted to be sure that everyone understands that and that we don't have a slip-up on it.

Now, with that in mind, would you proceed, Mr. Kelly, with

your comments regarding the Fraud and Abuse Bill?

Mr. Kelly. Yes, Mr. Chairman.

As you mentioned, this bill is S. 661, which was introduced by Senator Heinz and a number of cosponsors from the Committee. It is essentially the same as a bill that was agreed to by the Finance Committee last year, H.R. 1868. That bill had passed the House last year and was reported out by the Finance Committee but was not adopted at the end of the session.

A companion bill, H.R. 1444, was introduced in the House this Congress, and has been reported out by both the Ways and Means Committee and the Energy and Commerce Committee. Essentially, the purpose of the bill is to protect Medicare and Medicaid beneficiaries from incompetent providers or physicians who have lost their license in one State and continue to practice in other States. It also strengthens the powers of the Inspector General to exclude providers and practitioners from these programs and to create a central clearinghouse sort of arrangement where a provider or practitioner who loses his license in one State, that that information will go to the Secretary of Health and Human Services, so that the same provider would be excluded in other States where he may have another license.

I can run through the basics point-by-point. We have a summary that each of you should have.

The Chairman. Mr. Kelly, I think this bill is so well

known by the Committee that you can make it a very short summary, if you will.

What we are trying to do in this, as you state, is to get rid of some of the bad apples in the profession; and, in addition to that, my understanding is the cost is $6 million the first year and then drops down to about $3 million a year thereafter. It is based on the recommendations of the General Accounting Office, for one thing, as I understand it. Is that correct?

Mr. Kelly. That is correct, Mr. Chairman.

The Chairman. Does the Administration care to comment on that? Would the Administration give their viewpoint on the legislation?

Ms. Knight. I am from HHS. We support the bill, with the exception of Section 9, and we recommend that that be deleted. But we strongly support the bill, with that one exception.

The Chairman. Strongly support the bill -- except for what?

Ms. Knight. Section 9 of the bill, sir, which is essentially unrelated to the objectives of the legislation: "Sign a moratorium contained in the Deficit Reduction Act."

The Chairman. Oh, I see. All right.

Senator Packwood. Could I raise just one question?

The Chairman. Yes, of course, Senator Packwood.

Senator Packwood. I understand we had a problem about the

possibility of no hearings involving doctors and hospitals and possible penalties. I understand that has been worked out between the majority and the minority and is in the draft now. Is that correct?

Mr. Kelly. That is correct, Senator.

Senator Packwood. Thank you.

I appreciate that, Mr. Chairman.

The Chairman. Surely.

Are there other questions concerning it?

Yes?

Senator Baucus. I am sorry, I missed that. What is Section 9?

Mr. Kelly. Section 9, Senator, is a provision known as the Medicaid Moratorium. It is a providion that has been agreed to by both the House and the Senate on several occasions but has never been enacted, because it has ended up in different bills.

Essentially, it provides that the Department of Health and Human Services cannot deny Medicaid payments to States who have slightly different rules or income tests that they apply to non-cash beneficiaries -- that is, non-welfare recipients, the so-called "medically needy."

Many States have slightly different rules that they apply for determining eligibility for these "medically needy" groups.

In 1984, the Deficit Reduction Act, Congress imposed a

moratorium on HHS's ability to impose penalties on States who had different rules for the medically-needy programs. The Administration did not enforce the moratorium, because they claimed there was a technical problem with the way it was set up, and they felt that they did not need to enforce it.

Since that time, both the House and the Senate agreed to this more or less technical fix to that moratorium as part of the Conference Agreement in the TOBRA legislation in 1985; however, that was later stripped out, along with a number of other provisions when that bill was finally passed.

It was also agreed to last year by both the House and by the Senate Finance Committee. Essentially, it says that HHS cannot impose these penalties until 18 months after they have completed a study to look at whether there are legitimate differences in the ways you should look at income for the medically-needy program as opposed to the welfare recipient. They were told to do that study in 1984, and they have not yet completed it.

Senator Baucus. Thank you.

The Chairman. Are there other statements or questions by members of the Committee?

Senator Moynihan. Mr. Chairman?

The Chairman. Senator Moynihan.

Senator Moynihan. Thank you for moving forward with this, and let us be done with it.

The Chairman. May we have a motion to report?

Senator Moynihan. So moved.

Mr. Kelly. Mr. Chairman?

The Chairman. Yes.

Mr. Kelly. To clarify -- do I understand correctly that the Committee has agreed to modify Section 661 with the agreement that Senator Packwood referred to as far as the Administration is concerned?

The Chairman. That is correct, if there is no objection. If there is no objection, that will be done.

We are ready to report the bill out, the motion has been made. Senator Heinz, would you like to second the motion on your own bill?

(Laughter)

Senator Heinz. I second the motion, wholeheartedly.

The Chairman. All right, fine.

All in favor of the motion as stated, make it known by stating Aye.

(Chorus of Ayes)

The Chairman. Opposed?

(No response)

The Chairman. The motion carries.

Congratulations.

Now, ladies and gentlemen, for more than a decade the Members of Congress have been trying to improve health care

under Medicare, and that is true, certainly, of every member of this Committee; but one of the areas that has alluded us is really trying to do something to structure benefits for those that suffer catastrophic illness.

During the first months of the One Hundredth Congress we have held numerous hearings on the question of modifying Medicare, to add a catastrophic loss-prevention feature to the current program. Witness after witness has testified that the elderly pay a lot more for health care than do younger persons.

Secretary Bowen, before us, testified that the average spending by elderly Americans on health care was a startling $4200 a year -- that is two and a half times the population as a whole.

We have a just-released GAO report that underscores the need for swift action with its assessment that legislative changes enacted in recent years have increased out-of-pocket costs to the elderly and disabled by 34 percent.

Now, that increase in out-of-pocket costs requires Medicare enrollees to expend 6 percent of their annual income for coverage services -- and I am underlining that, "for coverage services."

It is important to emphasize that those figures apply to coverage services only, such as inpatient hospital care. Medicare beneficiaries also face substantial out-of-pocket expenses for non-coverage services such as preventive health

care, long-term care, prescription drugs, dental, and vision care; and we know the cost of those kinds of services can be very substantial.

Medicare was designed originally as an acute-care program, and by all accounts it has been a success. It provides 28 million elderly and 3 million disabled persons a measure of insurance protection superior to what was available prior to 1965.

Now, despite that kind of a track record, there are still significant gaps in protection under the current program. Certainly, hospital coverage is limited. For example, after 60 days, a Medicare patient is required to make increasingly costly co-payments rising from $130 a day for the first 61 to 90 days, and then $260 per day for days 91 through 150, and then full liability for any days beyond 150.

In addition, there is a 20 percent payment for all physician services, and that has a balance that goes to it: if you have someone who doesn't take an assignment.

Moreover, when we put in the prospective payment system for hospital-based services, that increased the demand for post-hospital transition care, that offered in skilled nursing facilities or by home health providers. Yet, those needed services are not universally available, due to varied interpretations of coverage by the intermediaries.

Approximately 65 percent of beneficiaries have private

insurance, or Medigap, to supplement their Medicare coverage.

You have another 10 to 13 percent that are eligible for supplementary coverage under Medicaid, but fully 20 percent or one-fifth of Medicare enrollees have no private insurance or Medicaid.

Now, for those with Medigap policies, the coverage standards approved by this Committee in 1980 offer some assurance of financial protection; yet, your out-of-pocket costs to the elderly and to the disabled can still be very substantial.

For example, Medigap policies need not limit costs associated with hospital deductibles. Under the current law, a beneficiary can pay as many as six $520 deductibles in a single year.

Medigap standards also permit companies to limit their exposure to $5000 in Part-B expenses, effectively leaving the patient vulnerable to any additional Part-B costs which can increase exponentially depending on the nature of the patient's illness.

Finally, existing standards do not address skilled nursing facility co-insurance. That can amount to as much as $65 per day in 1987.

While private policies offer additional protection against unanticipated health costs for some individuals, not all elderly Americans are able to afford supplementary insurance.

Fully one-third of the elderly with family incomes of less than $9000 a year have no coverage beyond Medicare, as compared to one in 10 families with incomes over $25,000.

The sad fact is that the gap in coverage is most serious among the oldest program participants. Twenty-five percent of Medicare beneficiaries over the age of 80 have no supplementary private policy or Medicaid, despite the fact that the out-of-pocket expenses for this population are more than twice those of enrollees with supplementary coverage.

In sum, these deficiencies are serious -- so serious that witnesses testifying before this Committee on behalf of organizations and insurers that market private policies, these are the ones that are partially filling this role, but they urge the Congress to amend the Medicare program to improve its scope of coverage.

Perhaps the most frequent criticisms of Medicare pertain to the complexity of the current system. And as I have gone through these numbers, you can see some of the problems I am talking about. Again and again, beneficiaries, insurers, and consumer advocates testified that the current program is confusing to those who must rely on it. Some elderly Americans, fearful of financial ruin from costly illness, buy too much additional insurance coverage; while a lot of others believe that the coverage is a lot more extensive than it really is.

Now, these uncertainties could be removed by closing gaps in the existing program so that the beneficiaries and their families can be assured of adequate coverage if a lengthy hospital stay or transitional care in a skilled nursing facility, or at home, is needed.

You know, at the same time, we shouldn't be misleading the elderly by suggesting that our work here over the next few weeks will result in a restructured Medicare program that offers truly comprehensive health care. We are not there yet with this piece of legislation, but it is a long step along the way.

I think most of us agree that our goals should be to improve the existing Medicare program, and -- and -- to maintain a meaningful role for the private sector. And that is what we have tried to put together in this legislation.

Particularly, it is my hope that the greater the beneficiaries' understanding of what Medicare does and does not cover, it will encourage more insurers to offer policies that address chronic care needs such as nursing home stays, health services delivered in the home, which many of us have worked on and have felt very strongly about trying to improve.

Most members of the Committee have sponsored legislation that is designed to simplify the current Medicare program and to curb excessive out-of-pocket health costs for the nation's elderly and disabled.

Enactment of any of the major bills introduced this year would benefit nearly two million of the 31 million Americans who participate in Medicare and who will incur personal costs for acute care services of $1700 to $2000 in 1988.

Now, for each of these individuals, modification of the Medicare program to offer catastrophic coverage will generate, I think, greater confidence that they can count on Medicare when unexpected serious illness strikes, and the peace of mind will be the greatest for the 30 percent of those elderly Americans with incomes below $10,000. For most of these individuals, the Congressional Budget Office estimates that without catastrophic coverage a single hospital stay will consume more than 20 percent of their annual income.

What we have here, I think, is a rare opportunity to make a vast improvement in Medicare coverage, and we can do it this year. The President, together with a broadly representative and bipartisan group of Members of the Congress has recommended a series of modest but important improvements in the existing program.

Yet, as important as these improvements are, it is also important that they be financed responsibly. It is critical that we not exacerbate an already staggering federal deficit or require excessive financial sacrifice from those least able to pay for an improved benefit. In order to put those kinds of objectives together and meld them, I, along with

15 other members of the Finance Committee, propose what we think is an innovative income-based premium structure.

It is based on two principles, really, that all who benefit from the new program should pay something for the coverage, and that those with higher income should pay progressively more than those with low income.

Moreover, the proposal would be deficit-neutral -- not only for the short term, but also for the long term. Here is our chance to work together on behalf of 31 million Americans and their families to craft a bill that will give meaningful protection against health care expenses that can threaten an entire family's life savings. But we will work to do it in a responsible way, I think remaining sensitive to the financial burden on the elderly, and maintaining a significant role for the private sector without further increases in the federal deficit. That is a tough package to put together, but I think we have it here.

Senator Packwood. Mr. Chairman?

The Chairman. I now yield to Senator Packwood.

Senator Packwood. Mr. Chairman, I don't have a long opening statement, but I think the Chairman has done an extraordinary job on putting this bill together. I think I agree with 95 percent of it.

I know there are amendments to be offered, and there are some meritorious amendments to be considered and adopted; but

I think, Mr. Chairman, you have done an extraordinary job in reaching a consensus on this bill that I hope we can hold together and hold through conference.

The Chairman. Well, I know of your deep and continuing interest in it, Senator, and of your knowledge in the field, and I appreciate your comments.

Now, this is the sequence of arrival: Baucus, Moynihan, Mitchell, Durenberger, Rockefeller, Danforth, Packwood, Chafee, Daschle, Bradley, and Heinz. I would urge the members not to make as lengthy a statement as did the Chairman.

(Laughter)

The Chairman. I now call on Senator Baucus.

Senator Baucus. Mr. Chairman, I think I speak for all of us in joining Senator Packwood in complimenting you on the package.

There are two areas which are not addressed in here and which will have to be addressed at some time. I do not think it is appropriate to address them at this time. One is how do we pay for long-term care in this country; and the second one is paying for prescription drugs, a developing problem and will be a greater problem. We don't want to address that in this bill, but I think basically it is a deeper problem that is going to have to be addressed at another time, although I hope it is a fairly quick time.

But it is a great bill, and I compliment you.

The Chairman. Thank you, Senator.

Senator Moynihan?

Senator Moynihan. The very same sentiments, Mr. Chairman. And just to add one thought to the Committee and to our staff here, is it possible we can have some discussion of the matter of AIDS this morning, or in the course of this markup?

Since the advent of Medicare in 1966, we have had this most extraordinary catastrophic illness to visit the Twentieth Century, and our present arrangements just don't correspond to its reality. There is a two-year waiting period for anybody receiving disability insurance under Social Security before they can receive Medicare, and in two years AIDS patients are dead.

We have an epidemic, but of what proportions we don't know, and I think our health care arrangements have to somehow address this most catastrophic illness that has appeared among us, particularly perhaps with respect to drugs.

The Chairman. Senator, there is no question but what it is a very major issue and one that will have to be addressed by this committee.

In this particular instance, on this legislation, we are talking about something that is being paid for by the elderly, and I think it would have to be addressed in a separate situation.

Senator Moynihan. Perhaps on the issue of drugs we might

do, but I accept that, and I know you will do.

The Chairman. Senator Mitchell?

Senator Mitchell. Thank you, Mr. Chairman.

I want to join in commending you for the truly outstanding leadership you have displayed in this legislation; it is a very difficult and complicated area, and I do support it.

I think I would make two points: First -- not to repeat but simply to associate myself with the remarks made by Senator Baucus regarding the other areas that we have to look at: typically, the mental health benefit and the prescription drugs. I intend to hold subsequent hearings on that issue and hope to move in that area.

The other area that I have mentioned previously on this subject I would like to mention now. I ask that my full statement be put in the record, and I will speak to just a portion of it.

The Chairman. Without objection, that will be done.

Senator Mitchell. It is that we have to acknowledge that, as important as this step is, neither this bill nor the bill currently considered by the Ways and Means Committee, fully addresses what is the most serious threat to the financial health of the elderly and to both States and Federal budgets, and that is the cost of long-term care in the health area.

Over 80 percent of catastrophic out-of-pocket health care expenses of the elderly are for expenses incurred for

long-term care not covered by this bill.

I should point out, Mr. Chairman, that included in this bill is a study by the Institute of Medicine that will further define and clarify the issues involved in developing Medicare long-term care benefits. And further, since the majority of the elderly now believe -- erroneously -- that Medicare covers the cost of long-term care, the bill requires the Department to notify beneficiaries annually of what Medicare will and will not pay for and how coverage is different for individuals enrolled in the catastrophic plan.

That is an important step for educating the elderly and developing a plan to prepare for the cost of long-term care. How to devise that in an equitable and comprehensive way, that is, a long-term care benefit, will be a very difficult task; but we cannot ignore it because of its difficulty, because it is really the crisis in long-term care. And each year we delay will only add to the crisis.

So I would simply say we are making a very important step, but it is only the beginning, and we will soon have to come to grips with what is the real crux of the problem in catastrophic illness, and that is long-term care.

Thank you, Mr. Chairman.

The Chairman. Senator Mitchell, I share with you the concern about the additional things that we have not been able to take care of and, as you know, strongly support the

hearings that you will be holding and chairing.

Senator Durenberger?

Senator Durenberger. Mr. Chairman, thank you.

If you don't mind, I am going to take a minute of the ranking Member's time also, because I have been working on catastrophic now since I got here in 1979, and it is really thanks to you and your leadership this year that we are able to bring this to the point that it is at, and thanks to the leadership of the President on the issue. A lot of people, in a bipartisan fashion, have been involved in the very difficult task.

This is the most significant change in the Social Security Act since 1965, when both Medicare and Medicaid came in. And it is significant not so much for the fact that it is generosity but for, as you pointed out, its simplicity. It addresses the one thing that our forefathers on this Committee should have seen 20 years ago, that our parents and the elderly in this country really need it. They need protection from the fear of being trapped in a health condition that they couldn't afford.

I think it was a mistake not to put catastrophic in Medicare in the beginning; and it is a mistake which, today, we are rectifying.

The presence of the catastrophic feature in the Medicare program enabled my folks, who are 75 and 80 years old and are

making that decision every year about coverage, to be smarter, better informed buyers of health care.

What is good about this particular catastrophic bill is that it is castrophic in financial terms. We didn't measure it in medical terms; wisely, we measured it in financial terms.

And it is to your credit, Mr. Chairman, and the credit of the members of this Commitee, that the bill was structured also in generational terms, so that those who would benefit would also be the ones who would pay.

I think that is probably the first time that that has happened in this Committee, that in effect we haven't shipped the bill for the new coverage off to the children or the grandchildren.

The savings that come in this bill to the elderly can be used by the elderly to buy this additional coverage.

Others have mentioned some of the things that this doesn't do that are important; it still looks like a government program, it still has a Part A that you get for free, so to speak, and a Part B that you have to make a decision on, and then there is still some Medigap that you have to look at. I think we should be thinking in terms of combining the Part A and the Part B.

It still has two deductibles that aren't going to make any sense to anybody. It still has a large deductible for a hospital -- to get in a hospital, when we are keeping them

out anyway with DRG's, and a very small deductible on the area that people use a lot, which is the medical side. And I think in the future we certainly need to deal with that.

It still has a bias towards medical care and against mental health care, and there are members of this Committee that have proposals that we will hear about today to rectify that mistake.

It still has a bias towards sickness rather than towards keeping people healthy. And at some point we are going to have to address that one. The benefits here ought to be in the direction of staying healthy and well and not in the direction of rewarding illness.

We have not been able to come up with a proposal to manage over-utilization. Once you get to $1700, it is sort of like "Katie bar the door," and I think case management and managed care, which is occuring in other sectors, ought to be looked at as far as Medicare is concerned.

One of the things that I feel strongly about that we have not been able to do here because of our limitations is a promise that some of us made to our colleague Jake Javits. You may remember him sitting right there at that end of the table a couple of years ago and talking to us about chronic illness and about Lou Gehrigs and Alzheimers and those diseases that really afflict the elderly, and how he was in the two percent of elderly Americans who could afford attendant care and

somebody to help him with his oxygen, and wheel him around in his wheelchair, that a lot of other people weren't.

This bill doesn't yet come to help Jake and people like Jake, and I hope in the near future we will be able to do that as well, Mr. Chairman.

Thank you.

The Chairman. Thank you very much.

I acknowledge the deep interest and the contribution you have made, Senator; you have been very concerned with this issue.

Senator Rockefeller?

Senator Rockefeller. Thank you, Mr. Chairman. I will just make one comment and ask that my statement be put in the record in full.

Obviously, I am very proud to be a cosponsor of this excellent work with you, under your leadership.

I had a home health care hearing in West Virginia just two days ago relating to the home health benefit, and the problems, with respect to denials, that were put forward by home health care agencies just vividly described the work that has to be done, much of which is covered in this legislation.

I would agree that the definition of "homebound" and "intermittent" as pinned down in this legislation is really going to clear up a lot of confusion and chaos that plague home health agencies and Medicare beneficiaries.

I agree also with Senator Baucus and Senator Mitchell, and what you yourself said, Mr. Chairman, that there are other things beyond acute care benefits that our senior citizens are looking at -- prescription drugs certainly being very, very high on their list. That came through so powerfully in West Virginia. And mental health services. And of course, the biggest challenge of them all, the nursing home and other forms of long-term care.

I agree with you that the cost factor is a discipline force here. That has to be the case, and that is the case; and overall, therefore, I feel this is an excellent bill.

It is true that when Congress made our Medicare commitment to seniors, I think seniors assumed that we will intend to address a whole variety of problems that we probably won't be addressing in this bill. Senator Mitchell has indicated that we need to do that, and I agree with him.

But I am proud of this bill. I think it does a lot, and I admire the Chairman's leadership on this matter.

The Chairman. Thank you.

Senator Danforth?

Senator Danforth. Thank you, Mr. Chairman.

I simply join with the other members of the Committee in expressing our regard for what you have accomplished. This is an idea that has been a long time coming.

I can remember back in the late 1970's, Senator Dole

became very interested in this same issue and enlisted the support of a variety of people, most of whose first initials were "D." There was Senator Durenberger, Senator Domenici, and myself, and it was called the 3-D or 4-D Bill, and so on.

What you have done is to bring to us a version of this idea, which I have no doubt will be reported out of the Committee by an overwhelming vote.

It has been a long time coming. It is long overdue.

I want to just briefly touch on a comment that Senator Moynihan made. It is really not apropos of this bill, but it is clearly ~~something that we in the Congress~~ are going to have to face up to, and time is of the essence, and that is the question of AIDS.

Unfortunately, in my mind, this first came to the Senate in the form of two amendments to an Appropriations bill. It had not gone through the normal process of legislation in the Congress. I had great concern last week that we were going off half-cocked in an issue that is going to be truly catastrophic. The AIDS issue is going to in fact create a whole new definition for the word "catastrophic." It is going to create not only human tragedy but claims on our national resources, which are absolutely unparalleled.

Mr. Chairman, I think one of the problems -- and we saw this on the floor on Thursday -- is that the Aids debate tends to polarize people on philosophical lines. That is too bad.

This Committee has been, I think, the least partisan, least philosophically divided, and maybe most able committee in the Senate. I have great pride in the Senate Finance Committee, and I would hope that in the immediate future we might have the opportunity -- not on any partisan or philosophical basis and in a very low-keyed way -- to perhaps be briefed, maybe in the back room so that there are no cameras and no lights, on this issue, on the factual background and on some of the very tough ethical questions, economic questions that we are going to have to be facing in the near future.

It seems to me that the Finance Committee is the best possible forum to do that -- not the floor of the Senate, not the Appropriations Committee, not the Health and Human Services Commitee, but the Finance Committee.

So, while it is not really germane to the bill that is before us, it is clearly a question which is of great moment and of great urgency, and I would hope we would find thoughtful ways to begin educating ourselves and dealing with it.

The Chairman. Senator, I appreciate that, and this Committee will be addressing that problem.

Senator Chafee?

Senator Chafee. Thank you, Mr. Chairman. I have a statement I would like to include in the record, if I might.

The Chairman. Without objection.

Senator Chafee. I would just like to make a couple of

remarks, if I might.

First, I congratulate you in filling this gap, but it is a very modest step forward, as we all acknowledge. But, Mr. Chairman, what happens when we get into a situation like this is the realization that there is something wrong with the medical coverage system in the United States of America. I mean, to merely look at the statistics -- and perhaps as well to call the attention -- the United States spends more of its gross national product on health care than any country in the world. And yet, the question is: Do we get as good coverage as other countries get? I think the answer is clearly No.

Briefly, the statistics: Last year we spent on Medicare $74 billion -- the expenditures. Not all U.S. Government. Medicaid cost $25 billion. The tax subsidy program resulted in $32 billion, of a tax expenditure, of lost revenue.

Yet, with all of that spending, we still have children who receive no health care services, pregnant women who receive no prenatal care, disabled individuals who are forced to live in institutions and away from home and family, we have families that are devastated financially and torn apart because of illness.

Thirty-seven million Americans have no health insurance at all. And of course, we know about senior citizens who have to spend down and impoverish themselves in order to receive long-term care -- namely, Medicaid coverage.

Mr. Chairman, I think the results of this study here -- because we have had testimony, and we have gone into the gaps that aren't covered despite the very substantial increased cost that people are going to have to pay under Part B -- shows that our system is a disaster.

I would hope that none of us would leave here today feeling that this small step we have taken has really gotten us very far.

It is my hope, Mr. Chairman, that we will step back and say to ourselves at some point, "We have got to reexamine this whole business."

Now, I know that we are going to have welfare reform hearings that the Senior Senator from New York is so interested in and has been helpful on; but welfare reform is directly tied to health care insurance and health care coverage.

One of the problems, as we all know, is that to get Medicaid you have to be an AFDC.

So, Mr. Chairman, it is my hope that while we make this splendid small-step forward, we will say to ourselves at some point, and some point soon, that we will step back and look at the whole American health care system and say to ourselves, "Is this right? Let us see what other countries are doing. How come Canada can cover people, and we can't?"

So that is my hope, Mr. Chairman, as we look at some of the gaps that we are going to have amendments on today. I am

strongly supportive of a drug amendment, and there will be others -- the care for catastrophic illnesses for children -- and those will be brought forward.

So I congratulate you but I do urge, Mr. Chairman that this Committee -- because this is the right Committee to do it -- will say to itself, "We have just got to look at the whole health care system."

Thank you, Mr. Chairman.

The Chairman. Thank you.

Senator Daschle?

Senator Daschle. Thank you very much, Mr. Chairman.

I certainly would associate myself with many of the remarks of Senator Chafee. This bill is going to be brought before the Committee at the early stage of my career on this Committee, and I don't have the historical perspective that Senator Durenberger and so many of the other Committee members bring to the debate on this issue.

But I must say that in addition to the justified compliments paid our Chairman for his leadership, as a Democrat I think it is also appropriate that we cite the leadership and the courage of Secretary Bowen for his willingness ot bring the issue before the Committee in the way that he has. I think that he has done our people and this Committee a real service in providing the kind of cooperation and leadership that he has.

I think this bill, as so many have already said, is a very, very appropriate beginning; but, like so many who have also expressed their concern, I wish this bill would be able to go farther regarding prescriptive care, regarding long term health care.

I understand the impatience of those who may be suggesting other proposals that would broaden the base and scope of this legislation and may even support some of their efforts; but, beyond that, I understand the need to limit the scope perhaps in this measure to those in the sunset of life. But I think it is also appropriate that at some point, perhaps in my career on this Committee, that we consider those in the dawn of life as well as the shadow of life, and their need for catastrophic health care as well.

We may not be able to do it now, but at some point in the future I think it is appropriate to consider inclusion of people in these categories. I want very much for us to take the hearings that Senator Mitchell is going to be holding, create a basis from which to expand the consideration of additional care to those people as well.

So, in applauding the Chairman, I also share the view expressed by many that this is an excellent first start, and I enthusiastically endorse its concept.

The Chairman. Thank you, Senator.

Senator Bradley?

Let me say for the membership that we understand there is a vote at 11:30.

Senator Bradley. Mr. Chairman, my statement should be completed by then.

(Laughter)

The Chairman. Senator, I assure you it will be.

(Laughter)

Senator Bradley. Long-term care is a $50 billion item. As Senator Mitchell said, when we can figure out how to pay for it, we'll probably do it. I think we should look into it.

Catastrophic care for a general population? Senator Chafee said other countries do it; some day we will figure out how to do it. This bill doesn't deal with either one of those areas, so it means the Finance Committee in the health area has a very full agenda in the years ahead.

What the bill does do that I am very pleased, Mr. Chairman, that you have included is to expand the home health provisions. In particular I am very pleased that daily home care has been expanded to 45 days. That is very important; it is more than double what it is now under current law.

And as Senator Rockefeller expressed, I am very pleased with the clarification as to what exactly "home-bound" means, so that people can get the coverage.

I am also pleased that you have included extra home care benefits for persons discharged from skilled nursing homes --

another 50 days. That is enormously important.

I think this is a significant bill, and I am very pleased that we have been able to get this kind of consensus on a bill this important to so many people in the country.

The Chairman. Senator, you have been a big part of building that consensus, and I appreciate the efforts you have made.

Senator Heinz?

Senator Heinz. Mr. Chairman, I won't go much past 11:30 either.

The Chairman. You would have the same problem with the Chairman, too.

(Laughter)

Senator Heinz. I want to commend -- as everybody has -- you, most deservedly, for this bill. Bill Bradley has pointed out the home health care improvement that both he and I, and Senator Durenberger and George Mitchell have a great deal of interest in.

You have an improved skilled nursing benefit that also ought to be singled out for commendation. You have a very significant improvement -- a modest one -- in the drug area, with the inclusion of immunosuppressants as a part of what counts against a deductible, and this is an important step forward.

But as George Mitchell pointed out, and it cannot be

pointed out enough, most people will probably, when they hear we have passed a catastrophic bill, be further lulled into a greater illusion that Medicare, which they now think covers long-term care, has really, finally, done the job to protect them against the cost of a nursing-home type of extended illness, or that we have done something that, if they do get Alzheimer's Disease and have to put a loved one in a nursing home, that we will take care of them. And no matter all of the good in this bill, and there is much, the fact is that this Committee is not ready to address that subject. It is a vast, expensive and difficult subject, and I just want to reemphasize as George Mitchell has that nobody should be under the illusion that we are addressing that problem. In fact, we are likely to make people think that we have done so.

Second, as John Chafee pointed out, there are some 33 million Americans without health care coverage who are not likely to get any from this bill, and they are people, they are somebodies, that should get our attention in the very near future.

With respect to this bill, there are two areas that I would like to see improved, if we can. One or two people have mentioned them, and the first is in the area of prescription drugs. I intend to offer an amendment that I believe we can pay for fully that will limit the out-of-pocket expenses to Medicare beneficiaries to $500 per year, plus 20 percent of

each prescription drug filled.

I will offer that because we have approximately 2.7 million seniors who will spend, this year, in excess of $1000 on average for prescribed medications.

I received a letter from a constituent in my home town of Pittsburgh who wrote that his income from Social Security was being devastated by prescription drugs. His costs averaged $180 per month for the past year, and he knows of "many others whose limited means are simply being ravaged."

A second amendment that I plan to offer, Mr. Chairman, is a modest one, but it addresses a group of very poor senior citizens who are Medicare beneficiaries, roughly about 750,000 of them, who will not get any help under this bill unless we require and in further cases allow the States to buy into this program, using Medicaid as the means of paying for the buy-in for some estimated 750,000 senior citizens who are too poor to afford any Part B premiums, any of the costs associated with this. And I hope when the time comes to debate that so-called "buy-in amendment" that we will get some attention to the issue and the support of my colleagues.

The Chairman. Thank you, Senator. For your information, I have called on the Controller General to give us additional estimates on costs for some of the added benefits that might be thought of in the way of future coverage.

Senator Pryor?

Senator Pryor. Mr. Chairman, because time is of the essence, one, I would like to associate myself with all of the beautiful compliments given to you this morning, and I certainly sincerely say that.

Second, I would like to yield back the balance of my time.

The Chairman. God bless you; although I would hardly call time on those kinds of comments.

(Laughter)

The Chairman. Senator Wallop?

Senator Wallop. Mr. Chairman, I have no opening statement. I would agree that this is a much better proposition than many of those which first came in front of us.

I would hope that the Committee, in its zeal to be sort of all "Mr. Frances" of the nation, might also look to its pockets. It is going to have to be paid for by somebody, from somewhere.

The reason I like what you have done is the restraint that is in it, and I hope that the Committee can maintain some element of that restraint.

The Chairman. Thank you.

Senator Armstrong?

Senator Armstrong. Mr. Chairman, thanks. I join in the general round of compliments to the Chairman, but I would like to reserve judgment on the bill.

(Laughter)

The Chairman. Senator, I will take it any way I can get it.

Dr. Weiss, would you proceed with an explanation of the bill?

Dr. Weiss. Yes, Mr. Chairman.

The bill that we will be working from this morning essentially is S. 1127, which is cosponsored by 16 members of the Committee. I will give you a brief review of the provisions of that bill, and then, if you like, make some comparisons with other bills that have been introduced.

The Chairman. Why don't you give us about a 10-minute review and then start the comparisons, please.

Dr. Weiss. All right, fine.

With respect to eligibility for coverage under the catastrophic benefit, all individuals who enrolled in Medicare Part B would automatically be enrolled in the catastrophic insurance component of the program.

There is a cap of $1700 on out-of-pocket expenses incurred under Part A or Part B, individually or combined, for Medicare-covered services. The cap in future years is indexed to the Social Security cost of living adjustment.

The Chairman. I would like to interrupt. Two of the Senators came in after my list was handed to me.

Senator Roth, for any comments you might have.

Senator Roth. Mr. Chairman, I too will be very brief. I

do want to join the others in complimenting you for what you have done. I strongly am supportive of catastrophic protection of some type.

Let me just raise briefly one concern, and that is the means of financing it. I think it is important that everybody understand that, if we adopt the legislation, at least as I understand it, this represents a very significant departure as a means of paying for the new coverage. A means test in this area I suspect will just lead to further proposals down the road that all Social Security be so handled. I have to say that is a matter of real concern to me.

I understand the problem: we have to pay for it. But if I understand this current proposal, it could mean as much as $2000 additional tax in the future. This is a very, very significant increase, and it is a form of surtax I guess you might say on the more affluent of the community, and I reserve judgment at this time on whether this is the way to go or to have some sort of flat fee.

Thank you, Mr. Chairman.

The Chairman. Thank you.

Senator Riegle?

Senator Riegle. Thank you, Mr. Chairman.

Let me commend you, as others have, for producing this bill. It is a starting point, and I think it is a very good start. There is a lot of work left to be done. I know seniors

will not be misled into believing that this solves all of the health care problems, because clearly it does not. We are not in a position at the moment to be able to do everything we would like to do.

But I look forward to working with the Chairman and ask that the rest of my statement be put in the record.

The Chairman. Thank you.

As to the concern that has been expressed repeatedly that this does not cover all the concerns and problems -- and we all share that -- we do provide in this that each of these persons covered will receive information once a year as to those things not covered and be given further information.

We have gone a long ways to try to help them be advised of what specific coverage they do have.

Now, Dr. Weiss, if you would proceed.

Dr. Weiss. Part A benefits included under the catastrophic bill are as follows:

The bill would eliminate hospital co-insurance and the current limit on hospital days.

The bill limits beneficiary liability to one hospital deductible annually but makes no changes in the indexation of the deductible as adopted last year.

There is an increase in Medicare coverage of skilled nursing facility days from the current 100 per benefit period to 150 per calendar year.

The bill further changes the skilled nursing facility co-insurance system so that beneficiaries would pay co-insurance equal to 15 percent of the national average Medicare skilled nursing facility costs per day for the first 10 days of a stay in a skilled nursing facility, but in no case would there be payments of more than 10 days in a single year.

Current beneficiaries pay co-insurance for days 20 through 100, and that insurance is set at 1-A for the hospital deductible. It runs about $65 per day today.

The bill increases the number of days for which beneficiaries can receive daily home health care from 21 to 45 if the beneficiary has recently been hospitalized, within the last 30 days.

It clarifies further that under current law all beneficiaries are eligible for a full 21 days of daily care, regardless of prior hospitalization or catastrophic coverage. This would apply whether or not the individual purchased catastrophic coverage. It is a clarification of the current benefit.

It also clarifies that current law requirement that beneficiaries be homebound to receive home care. There has been some difficulty with respect to intermediaries utilizing different interpretations of the homebound guidelines, and this is in an effort to make more uniform the

application of guidelines across the country.

The bill eliminates the current 210 day limit on hospice coverage for all beneficiaries -- again, regardless of whether or not they purchase catastrophic coverage.

The spell of illness concept --

Senator Moynihan. Dr. Weiss, may I make a point?

Dr. Weiss. Yes.

Senator Moynihan. I don't know if everybody knows that we have in this bill eliminated that fixed period for hospice care, which is something I think we can all be very pleased with.

Dr. Weiss. Yes, that is correct.

The bill eliminates the spell-of-illness concept per benefit period, which is very complex. You heard many witnesses testify to the effect that it is extremely difficult for the beneficiaries to understand how this system works.

It gives beneficiaries additional protection against catastrophic expenses by providing that beneficiaries who pay a deductible in December would not pay another deductible in the months immediately following -- January is a new year. So, there is a transition benefit with respect to the hospital deductible.

Now, under Part B: Beneficiary costs for immunosuppressive drugs would count toward the catastrophic

cap. Medicare currently covers the cost of 80 percent of the cost of the immunosuppressive drugs for one year only.

The bill further requires that the Department of Health and Human Services request that the Institute of Medicine study the issue of drug coverage under Medicare, with a 12-month turnaround time for the results of that study.

There is an annual notification feature in the bill that requires the Department of Health and Human Services to notify beneficiaries annually as to what Medicare does and does not cover, and how that is different for individuals who purchase the catastrophic coverage. The text of that notice that would be provided to beneficiaries is to be developed in cooperation with the insurance industry and with representatives of the elderly.

With respect to Medigap, the bill provides for adoption of any changes to model standards that are currently used, that these changes be made within 90 days by the State insurance commissioners to reflect the changes in coverage that are included in the bill. If the State insurance commissioners do not amend their standards to reflect changes in the need for supplemental insurance within 90 days, then the Secretary must issue revised standards which would become effective one year later.

Now, with respect to Medicaid, with the adoption of this bill or any of the catastrophic bills, a windfall under the

under the Medicaid program will accrue to the States and to the Federal Government. This bill requires that the Secretary of Health and Human Services estimate, State by State, the savings that would accrue in the Medicaid program. States must then use those funds -- the windfall funds that they receive -- either to expand coverage for Medicare beneficiaries with low incomes or to support spousal impoverishment initiatives.

There is a long-term care study included in the bill requiring the Secretary of Health and Human Services to request the Institute of Medicine study the use of public and private options for the financing of long-term care, and there are a series of technical changes needed to conform the Medicare HMO rules to the new benefit package.

That concludes the summary, Mr. Chairman.

The Chairman. All right.

Senator Bradley. Mr. Chairman?

The Chairman. Yes, Senator Bradley.

Senator Bradley. Are you prepared to go prior to the amendments?

The Chairman. Yes.

Senator Bradley. On the home health care benefit, the 45 days, we require prior hospitalization. My understanding is that in the House bill there is not the requirement for prior hospitalization.

My sense is that when we get to conference, you are going to be flexible on that provision. I would hope.

(Laughter)

The Chairman. How many House staff members are in the audience?

(Laughter)

The Chairman. I understand your concerns, Senator.

Senator Bradley. Thank you very much, Mr. Chairman.

The Chairman. And let me say I share them. I share your concerns.

Senator Chafee. Mr. Chairman?

The Chairman. Yes.

Senator Chafee. I wonder if we could get into that hospice business a little bit and the rationale for that change. That was something we worked on in this Committee for a good while. Could you go into a little of the background and then the rationale?

Dr. Weiss. Under current law, Senator Chafee, a beneficiary who is terminally ill may elect to forego the usual Medicare coverage in a hospital and opt instead to receive care through a hospice program. That election can be made for up to two 90-day periods and one additional 30-day period. Payments that are made on behalf of the individual are capped at $7300 per year per beneficiary, and that is indexed to the medical care component of the CPI.

Now, this bill would allow any beneficiary, without regard to whether he is covered for catastrophic benefits under the Part B arrangement or not, to continue the hospice benefit after the expiration of those 90 and 30 day election periods. No change is made in the payment cap at all; this is just a question of allowing the beneficiary to continue to receive hospice benefits beyond that period of time.

Information from the Department of Health and Human Services indicates that during the latest year for which they have information, 1984-85, approximately 22 individuals in the entire country exceeded the number of days currently covered under the hospice benefit. This is just a question of allowing individuals to continue to receive coverage if they don't pass away before the end of the coverage period. But there is no change in cost.

Senator Chafee. Thank you.

Senator Heinz. Mr. Chairman, I would just like to say I think it is a very good change.

The Chairman. Good.

Let me say, as to procedure, I believe that we have agreement generally, a consensus, on most of the basic points in this bill and a pretty intimate knowledge of it. So, rather than going section by section, and trying to save time, I would like to just open it up to any amendment that might be offered.

Senator Heinz. Mr. Chairman?

The Chairman. Yes, Senator Heinz.

Senator Heinz. I would like to offer an amendment on prescription drugs.

The Chairman. All right.

Senator Heinz. Mr. Chairman, the amendment that I am offering is being handed out. Let me provide a little bit of background, if I may.

I said earlier that the principal features of the amendment would be to have a benefit package that would cover prescription drugs -- that is to say those that are approved for use by the FDA -- which are used on an outpatient basis, and they would be covered by Medicare's Part B.

The deductible would be $500 a year. There would be the co-insurance of 20 percent, which would apply to all drug purchases, and the reason this to me is so significant is that for a very significant number of the elderly, almost 3 million of them, there are prescription drug costs of more than $500 a year. And for those people who do pay more than $500 a year, their average expenditure is $1050 per year.

Clearly, if we are trying to cover catastrophic costs for people who have become acutely ill, and we do not make an effort to include this particular cost, which is one that is incurred subsequent to hospitalization, we are leaving a very large hole in the catastrophic coverage safety net that we are

attempting to fashion.

Obviously there are other issues and elements in this amendment -- cost control, which I can talk about; the way we should reimburse pharmacists; the kinds of ways in which the benefit should be technically administered.

But I would suggest that while there may be improvements we can make in this approach, if we do not address this issue we will really be cutting a very large hole in the catastrophic coverage net and one that we should not leave unattended.

Undoubtedly, the issue of cost is one that we have to be concerned with. The cost of this benefit, as it has been reported to me most recently by CBO, but they may have updated figures, is $600 million in the first year. It grows somewhat after that.

To give the Committee an idea of what $600 million a year means if we decided to pay for it with an increase in the Part B premium -- and that is not what I suggest -- it would be the equivalent of a $3.50 per month increase in the Part B premium.

There are a number of options as to how to pay for it. My preferred option, and the one that is part of this amendment, would be to require all State and local employees to be covered by Medicare. And under that proposal, what we would do -- because I know there is some sensitivity to this issue in some States -- is to phase in the employer share --

the "employer" that is is the State and local government share -- over a substantial period of time, some six to eight years. And even with that lengthy phase-in I am told by the estimators that that process would bring in ample revenues to cover this benefit.

Mr. Chairman, there are other issues I could go into, but I know some of my other colleagues have an interest in this amendment, and if they have any comments I don't want to get in their way, because we are going to have a vote shortly and have this discussion interrupted.

I do know that Senator Mitchell has an amendment on drug coverage that he is interested in. I know that Senator Chafee has expressed a good deal of interest in this, and other amendments, and I think that there is a considerable interest on the part of the Committee in addressing this issu. And I hope we can do so.

Senator Chafee. Mr. Chairman?

The Chairman. Senator Chafee.

Senator Chafee. Mr. Chairman, clearly this is the single most important concern to the elderly under the whole Medicare program, the cost of drugs.

As you notice in this proposal, it is hardly a giveaway; there is a deductible of $500, plus there is a co-insurance of 10 percent that would apply to all purchases -- actually, 20 percent.

I am an enthusiastic supporter of this; I think it makes a lot of sense. The method of funding for it is provided; it is a phase-in on the funding; it is an area that I think we definitely ought to take care of, and I support the Heinz amendment.

Senator Mitchell. Mr. Chairman?

The Chairman. Senator Mitchell.

Senator Mitchell. Mr. Chairman, I have prepared an amendment which I was intending to offer but will not do so. I believe that we should defer action on any drug amendment at this time until we have hearings, which I will hold in the near future, and explore the various possibilities.

I agree with Senators Heinz and Chafee that this is an important area, and I think that we are going to act on this; but I have some serious reservations about this provision.

In the interests of time, let me be specific: First is that the mechanism for paying for it is a disappearing revenue source. Since under prior law all State and local employees hired after 1985 are already under Medicare, to impose an additional tax on current employees not now covered ensures that as those employees die or leave State or local employment, the revenue source disappears. So, it is simply deferring to a future time where the money is going to come from to pay for it.

Second, it is extremely unfair to those States which are

not now under Medicare and Medicaid -- mine is one of them. It would impose a very harsh burden on all municipalities just at the time when we have eliminated revenue sharing, now to impose this additional burden, and it is minimized somewhat but not eliminated by the phase-in.

Third, it would be very difficult to control cost and utlization. The ultimate decision on what this program would cost would be the amount that private drug companies decided to charge for their drugs. They are fully free at any time to raise their prices to whatever amount they see fit, and under this proposal Medicare would be obligated to provide reimbursement for that cost once the deductible was met.

Fourth, providers could what is called "game the system" by simply converting patients from forms of medication that are available in expensive over-the-counter form to prescription form for the same drug; thereby, gaining access to reimbursement where it would not previously exist.

We all know there are many durgs which, at certain levels of dosage, are available over the counter. With any increase in the dosage of the key ingredient, they become prescription drugs. And the administrative costs of handling literally billions of transactions -- I think we haven't fully come to grips with it.

So, in conclusion, Mr. Chairman, I apologize to my colleagues for the length of this statement, but I think this

is a critical area; I think this is an important proposal. I strongly urge the Committee to wait until we have a hearing and we can consider all of the proposals in this area and try to come up with a rational program that we can pay for in a fair and equitable way from the elderly.

The Chairman. Senator, I strongly endorse your comments and your concerns. I share the desire to try to work out a practical, feasible program on drugs, and I look forward to your committee hearings to do it. I hope that this will not be pressed for a vote this morning, but I want all the members here to hear it, because it is important, and I share the concerns of what you are trying to do.

We have a vote on, and I suggest that we all leave now and come back. Hopefully we will be back in 15 minutes to proceed.

(Whereupon, at 11:40 a.m., the hearing was recessed.)

AFTER RECESS

(12:00 p.m.)

The Chairman. Please cease conversation and take your seats. The hearing will come to order.

I share the concern of Senator Mitchell and others, and I share the feelings of Senators Heinz and Chafee in trying to get something done on this. I recognize the need and the problem. I also know that private insurers are having trouble handling the drug benefits and those that do lose money.

I also understand that there is an enormous administrative problem in adding a drug benefit. HHS estimates that 400 million claims per year would have to be processed, and 67,000 pharmacies would have to be involved. There are two or three approaches to this that are under consideration.

We have developed concensus pretty well on this bill, on the major items. I want us to develop something to deal with the drug problem; and that is one of the reasons I have encouraged Senator Mitchell in the hearings, to try to really understand some of the concerns and to implement this and make it effective.

So, I am hopeful that we will be able to develop a committee amendment finally through the hearing process and that we could take it to the floor and address this particular issue. Senator Heinz would be very supportive of that, I am sure. That is what I would urge.

I know that others want to speak on this issue. Senator Durenberger, you had some comments?

Senator Durenberger. Yes, Mr. Chairman. We all have sympathy with Senator Heinz's proposal because I think we all know the value of certain drug alternatives to other kinds of care. And yet, as you have so succinctly pointed out, a lot of work and effort went into crafting the catastrophic piece of legislation; and we sure wouldn't want to lose that over a disagreement on what we meant when we said we were going to do a prescription drug program or a drugs available by prescription only program--and there are some important distinctions there; how we set it up in terms of compliance, what the appropriateness is of deductibles, of copays. And aren't there better ways to run this program because this is sort of something new to all of us?

I would strongly endorse your suggestion and that of Senator Mitchell that we take the ideas of Senator Heinz and others to a hearing process as soon as possible and then make every effort to come to the floor with an amendment, which I would hope would bear his name.

Senator Heinz. Mr. Chairman, I don't want to interrupt anybody, but --

The Chairman. I would like to let the Administration speak to this. Mr. Burke?

Mr. Burke. Mr. Chairman, we have looked at this issue

of a drug benefit quite extensively as part of the report to the President and in crafting the Administration's proposal. The problems we have there, if I can summarize it: If you want it bad, you get it bad. There is very little data.

The Government has no real experience with this program, and the actuaries can't seem to agree on what the costs would be. Administratively, they tell us it could be as high as $750 million per year just to administer the benefits.

Our data that we had costed out under the Bowen Proposal, we found that the cost of a drug benefit with a $500 deductible, added to the $2,000 stop-gap loss feature of the Administration's proposal, would cost $28.00 per month, or more than four times the original deductible for the entire program. This is why it was not put in.

Now, of the three actuarial groups that are looking at it, we have variations among the actuaries of as much as 100 percent on what the cost estimates would be. The data is sparse, and I think it does need to be studied more extensively.

The Chairman. Senator Heinz?

Senator Heinz. Mr. Chairman, first let me make clear to everybody here what we are talking about. We are talking here about the drugs that people need in order to overcome what are essentially chronic and debilitating conditions that have been treated in the first instance in a hospital. Nobody would get this benefit who had not been hospitalized, that is in

regard to this benefit. And we are talking about people who, if they don't have antihypertensive drugs, if they don't have antiarthritic drugs, or if they don't treat their angina and other chronic conditions, literally are not going to function very well; and they are going to end up back in the hospital at $500 or $700 or $900 a day.

Now, I do appreciate, as Mr. Burke pointed out, that there are wide disagreements on the cost of this kind of an approach; but I would argue that there are a lot of hidden costs due to not doing anything on it. There are some 10 million Medicare hospitalizations a year, and the estimates I have seen are that there are as many as 10 percent--that is one million Medicare hospitalizations--that are due specifically to patients failing to follow their prescription medications. That is to say, they don't take the medicine they are supposed to take.

And we do know that there are several hundred thousand hospital admissions each year that are due to patients not complying with their physicians' orders for cardiovascular drugs alone. The reason for the noncompliance or the nonuse is apparent from a survey conducted in 1981 by AARP, which found that between 22 and 36 percent of the elderly reported that they just didn't have the money all the time to purchase the prescription drugs that their doctors said they needed.

And that finding was confirmed again last year in an AARP

survey in which the elderly listed cost as the second greatest cause of noncompliance with prescriptions.

So, I just want to make the point that not doing something in this area is very costly. We don't recognize the cost. We just kind of assume that that 10 percent of those hospitalizations each year is going to go on forever and ever, but it is just as real a cost as the cost of doing something.

Now, I did listen carefully to George Mitchell's concerns. Putting his concerns about revenues aside, and he has some special concerns, I understand, about States that don't now cover or require coverage under Medicare.

First, on the question of cost and utilization and the difficulty of controlling it, what I really just said is that right now there is high underutilization of prescription drugs that has people ending up back in hospitals. With respect to his concern about providers being able to "game" the system where he said that it would be possible for over-the-counter drugs to move into the category of prescription drugs, since only prescription drugs that are authorized by FDA are going to be covered by this, I think that to the extent that that is a theoretical problem, it could be clearly addressed by the administering authority.

As to administrative costs, while I would not argue that we have addressed every single aspect of adminstration, and there might be some improvement in that regard, one of the ways

we minimize the kinds of administration that the Administration or HHS was describing is that we would make and compensate accordingly the pharmacist the billing agent, just as the doctor is the billing agent under Part B when he accepts assignment for this program.

And a number of States have used that system; and in terms of the number of pieces of paper flowing into the administering authorities at the State levels, this is a procedure that we know has worked well. The main argument will always be: How much should we pay the pharmacist for administering this benefit? Should it be $1.00 or should it be $5.00 or should it be $4.00--which is probably about where it ought to be?

And one of the reasons I have drafted this legislation to give the authority to the Secretary of Health and Human Services to set that fee is that it is a decision that has to be undertaken very, very carefully so that the administrative costs, regardless of what the center of the administration of those costs--whether it is the pharmacy, whether it is State level, whether it is Federal level--is done not only efficiently but fairly with respect to the administrators.

But I think we can find in this day and age of computerization, in this day and age of information management, a way to administer this program efficiently.

And by the way, I want to make clear that Senator Chafee

is a cosponsor of this. I would hope, Mr. Chairman, that we might really address these issues and not simply make a set of claims that this is too tough to administer, nobody has done it; there are States that do it.

And if somebody wants to go through and specify where we have a really serious problem instead of generalities, that is one thing; but I would be reluctant just to say that one or two people have spoken against the amendment, and therefore, it is impossible. States are doing this, so it is possible.

The Chairman. Senator Dole?

Senator Dole. Mr. Chairman, thank you very much. I haven't had a chance to talk about this with Senator Heinz, but I did talk briefly with Senator Mitchell. I have a bill which addresses the drug problem, requires some studies, and does certain other things. I know there is a great deal of merit in Senator Heinz's proposal. We introduce a very significant cost if we go down that path, not only program costs but administrative costs.

And I would hope that, based on the suggestion of Senator Mitchell--he has indicated he would have hearings and they would be immediate and would be held before this bill is taken up on the Senator floor, as I understand it--there would be an opportunity to address many of the questions that some of us may have and others may have and some in the private sector may have.

It would be my hope that we would discuss this issue. It is important. It should not be swept aside just because it may be expensive or controversial or whatever, but I would hope that we would not vote on it today. I would hope we would do whatever else we need to do on this, have the hearings; and if we can reach some agreement on it in the committee, we can have a committee amendment on the floor. I would certainly be willing to adopt that procedure.

The Chairman. Senator, I have agreed with Senator Mitchell to have the hearings, and he will be holding them, and we will be addressing that. Senator Moynihan has been seeking recognition.

Senator Moynihan. Mr. Chairman, I just want to agree with what Senator Dole has said. This is something that we should inquire into in a formal way. Earlier, Senator Mitchell, I mentioned the whole issue of the eligibility of the AIDS patients for Medicare. That is a two-year waiting period, which they don't survive.

And I believe I mentioned that the issue of drugs is something we have to address, and I am sure you will be willing to address it.

The Chairman. Senator Chafee?

Senator Chafee. Mr. Chairman, the problem is a serious one, as has been stressed here. As I mentioned before, it is certainly the number one problem with my senior citizen

constituents, outside of the long-term care situation.

It seems to me that the proposal made here is a fair one, and that is one that Senator Mitchell has committed himself to early hearings. And second, a group will work together on this to come forward with a committee amendment which can be presented on the floor prior to the measure's final consideration on the floor, that is the overall catastrophic legislation. If that is the intention of the chairman and-- principally, the last point, of course--is getting together with a group and resolving it so that we will have a drug amendment--a prescription drug amendment or a regular drug amendment--on the floor, I certainly would find that a satisfactory solution.

The Chairman. Senator, the chairman will commit to trying to get together to work out a concensus on this and work with Senator Mitchell. He will be holding hearings on it before the legislation is on the floor.

Senator Heinz. Mr. Chairman, I think that is not an unreasonable proposal. This committee has done that on previous occasions, and I would be very willing to cooperate and be a part of that. And I would hope it would be possible to get a concensus amendment.

The alternative is that, if we don't get a concensus amendment, I will continue to work on it, to refine that amendment, and offer it on the floor; but I would much rather

do it, frankly, with the support of the committee because it is a serious problem, and our chances of success have always been best if we work together.

So, I accept both your and Senator Mitchell's offer. I think it is a good offer, one I ought to accept, and I do.

The Chairman. Thank you very much, Senator. Senator Baucus?

Senator Baucus. Mr. Chairman, I think first of all, as we work toward this goal, I might ask the Senator to keep in mind--and I know the Senator will--that there is a problem with this amendment as it concerns rural areas. There is the degree to which this depends upon the participating pharmacist; as you well know, in many communities there is sometimes only one pharmacist, or maybe only two, and they may not want to participate. That certainly is true in some rural communities where physicians have decided not to participate in the other programs.

So, that is going to be a major problem in rural areas.

The Chairman. Senator Mitchell?

Senator Mitchell. Mr. Chairman, I just want to thank Senator Heinz for his continued interest in this matter. I commend him for being a leader in this area. He is the person most responsible for bringing this to the attention of the Congress and the American people, and I want to assure him and all members that we will in good faith try to arrive at an

agreement. Now, it is clear that there are wide differences of opinion on this, but we are going to make a good faith effort to do so. I am grateful to Senator Heinz, and I look forward to working with him.

The Chairman. Thank you, Senator. Are there other amendments?

Senator Durenberger. Mr. Chairman?

The Chairman. Yes, Senator Durenberger?

Senator Durenberger. Mr. Chairman, in the spirit with which this important and difficult matter has been handled, I would like to raise the issue of mental health benefits.

As the chair is well aware because of his own personal interest in providing more adequate balance in the Medicare Program between acute medical care and mental health. Several members of this committee have had proposals in legislative form which would expand mental health benefits under Medicare.

The American Association of Retired Persons estimated in a press release I saw here recently that 15 to 25 percent of Americans over the age of 65 have significant mental health problems, so that the incidence of suicide is much higher among the elderly than among teenagers. And we all know the tremendous growth of the rate of suicides among teenagers in this country.

The current limit--the annual limit--on reimbursement for mental health has been the same since 1965; it is a ridiculous

$250 per year. That is like two and a half visits or three visits, something like that.

I won't try to describe for you--because of time--my particular suggestions for an approach to this. I know my colleague from Hawaii, Senator Matsunaga, who has been at this even longer than I on this issue, has a slightly different approach. Senator Mitchell has a somewhat different approach.

And I would like to recommend to the chairman that--and I know you have thought of this already--we use the track that has just been designed for the drug bill as a way to deal with this issue. Rather than do it today, we could try to blend the three or four approaches that are around this table into a committee amendment that we might be able to take to the floor at the time of the consideration of this bill.

I will not propose my specific amendment. I will withhold that and recommend to my colleagues that approach, if that is the wish of the chair.

The Chairman. Let me state, Senator, that what we are talking about here, of course, is an expansion of Medicare benefits. We are not talking about the catastrophic bill that is before us. That is another thing that gives me some concern --that is adding that to this at this time.

We have a situation where the elderly are paying for the catastrophic illiness benefits. In this instance, you would have this age group paying for the mental health benefits, too;

and that gives me a great deal of concern. Let me see if Mr. Burke has some comments on this. Mr. Burke?

Mr. Burke. No, sir.

The Chairman. Senator Matsunaga?

Senator Matsunaga. I take it then that the Senator from Minnesota is not offering his amendment?

Senator Durenberger. If I could get a commitment from members of the committee or the chair that we would make an effort to bring a committee amendment on this subject--which is financed appropriately--to the floor, then I would withhold that amendment.

Senator Mitchell. Mr. Chairman?

The Chairman. Senator Mitchell?

Senator Mitchell. If it meets with your approval, I will be glad to consider it in the same manner as the drug amendment and try to work out an agreement that will be acceptable to all.

Senator Matsunaga. Mr. Chairman, I was prepared to offer an amendment. Perhaps the chairman of the Subcommittee on Health might look at my amendment, cosponsored by Senator Rockefeller and Senator Moynihan and others have expressed willingness to do so. Inasmuch as the House bill, H.R. 2470, that is the Medicare Catastrophic Insurance bill, already has the provisions which I had intended to offer--and will offer unless the subcommittee chairman has objections to it--my

amendment would merely raise the cap on the ongoing program for outpatient mental health benefits which is now limited to $250 after copayments and deductibles.

That is an equivalent in present day dollars of only $57.00; so even if we do raise it to $1,000, it would be equivalent to only $228 in 1965 dollars. That is the only thing that it will do.

The law relative to the treatment of outpatient mental health for the elderly will be exactly as it is now; and inasmuch as the House already has this provision in the bill, I thought the Senate might show its sensitivity towards the needs of the elderly and do the same.

The Chairman. If I may, Senator, in thinking about trying to construct an amendment, I would go along with that if we can give ourselves a little maneuvering room here in trying to work it out. If we add it to catastrophic, we get back to the point that I am concerned about, that is expansion of the benefits. And yet, we are asking for the elderly to pay for it. If you could give us some leeway where we could consider that also on reconciliation, what you want to do is get the benefit finally there.

Let us see if we can't construct something that we can develop a concensus on where we could get one or the other; that would give us a little more lattitude, and I think that would be helpful.

Senator Mitchell. I agree, Mr. Chairman. While I think that the Senator's point is well taken, the chairman's point is correct that this is a catastrophic bill. What we would like to do in the mental health area, as in other areas, is to attempt to concentrate our efforts in the area of improved catastrophic mental health expenses. I think that we may well come around to that, but yours is a benefit that is not limited in that area.

If you would be willing to do so, I would like to work something out under the leadership and the guidance of the chairman that is acceptable to all of us.

The Chairman. Senator Dole?

Senator Dole. I think the area has to be addressed. I think it is an issue that we have been pushing aside for a number of years. As I understand it, the amendment deals only with outpatients. There may be a way to finance this, looking at outpatient and inpatient, without raising the premiums; but I certainly think the chairman has offered a good suggestion on this. I hope that Senator Durenberger will be in

Senator Durenberger. Mr. Chairman?

The Chairman. Senator Durenberger?

Senator Durenberger. Just so that I understand the distinction the chair is drawing. I think this has as much relativity to catastrophic as does the drug proposition we

just disposed of. So, I wouldn't want to see the chair or my colleagues drawing a distinction between the treatment that this mental health matter is going to get and the drug matter is going to get.

In other words, I take it both will be treated the same. Every effort will be made to try to find a way to include them here; but if that turns out to be impossible, then we would look at reconciliation.

The Chairman. Senator, we are looking at finding a way where we are not having those who pay for this benefit having to pay a benefit that goes beyond their age group; and if we can't work that one out, then we will look at reconciliation. One way or another, we will try to develop an amendment that we can find a concensus on.

We have not had any hearings on mental health since the 1970s. I think it is important that this be a part of those hearings that Senator Mitchell will be conducting; but give us the flexibility as we try to attain your objective and that of others on this committee to choose between the two.

Senator Matsunaga. Mr. Chairman, just so we dissociate what I would have proposed from catastrophic, any medical expenses that impose an unbearable strain on an individual or a family is catastrophic. And as Secretary Bowen has repeatedly stated, for Medicare beneficiaires, mental health services often fall into that definition, the definition used by his

Catastrophic Advisory Committee since the beginning of their deliberations.

But I am willing at this point, Mr. Chairman, to comply with your request and the chairman of the health subcommittee.

The Chairman. I appreciate very much the cooperation of the Senator from Hawaii and Senator Durenberger. We have another vote coming up very soon.

Senator Baucus. Mr. Chairman, I have an amendment that in just a few minutes I think we can dispose of.

The Chairman. All right.

Senator Baucus. Very simply, Mr. Chairman, this is one I think most everybody agrees with. This would help reduce some of the confusion that may apply to some of the catastrophic coverage under the so-called Medicap provisions.

Very simply, it states that the present 30-day free look that applies to mail order insurance and also applies to insurance agents selling mental health insurance. Second, it would require insurance companies to apply not only their prospective loss ratios but their actual loss ratios to the insurance commissioners. The insurance commissioners would take any action appropriate to help the consumers.

Third, the amendment provides for the Inspector General of HHS to furnish a telephone number for folks to call in if they have questions or if they have complaints. So, those are the three provisions.

The Chairman. Who on the staff is prepared to present this?

Ms. Weiss. I can, sir.

The Chairman. Listening to the Senator, as I understood him, this has been discussed with staff. Is that correct?

Ms. Weiss. Yes, it has, Senator.

The Chairman. All right.

Ms. Weiss. All right. Essentially, what we are dealing with here is an effort to ease the transition between the current so-called -- standards that are applied to policies marketed as Medigap policies and the new revised standards that will need to be in place as a consequence of changing the benefit package.

I don't have the language in front of me, but Senator Baucus is suggesting basically a series of four changes: that the look-behind period be altered--is that correct?

Senator Baucus. That is correct.

Ms. Weiss. So, that under circumstances where policies are marketed by mail, there is a similar time period between that type of marketing arrangement and other types of marketing arrangements for a 30-day period that individuals can utilize to review the policies and make a determination as to whether or not they would like to take that policy.

The second item is to give consumers the telephone number of the State Insurance Commissioner and the hotline--the

Inspector General's number--so that they can interact with some organization or agency that could be knowledgeable in the area of Medigap insurance to answer their questions.

Third, requiring States to monitor actual loss ratios.

The Chairman. Let me ask this: Is there any opposition to the amendment?

Ms. Weiss. Not that I am aware of; no, sir.

The Chairman. Is there any member of the committee who has a problem with the amendment?

(No response)

The Chairman. May we have a motion on it?

Senator Baucus. Mr. Chairman, I move the adoption.

The Chairman. Opposed?

(No response)

The Chairman. The motion is carried.

I think we ought to push on through with this meeting. We have the permission of the floor to continue to meet. We have a vote on the floor. I would suggest we be back here at 1:30 or 2:00. Is 2:00 a better time for you, gentlemen?

(Chorus of ayes)

Senator Mitchell. I have an amendment that has to do with conducting a study. I wonder if there is any opposition to that.

Senator Chafee. Who has to do the study?

Senator Mitchell. The Treasury Department will conduct a

study of tax policies needed to encourage private financing of long-term care. It would compliment a section already in the bill mandating a study by the Institute of Medicine for various options for improving public funding.

The Chairman. Is there any opposition to the study?

Senator Heinz. May I ask what the Administration's position is, if they have any objections?

The Chairman. Yes.

Mr. Burke. I believe we are already doing this.

Senator Mitchell. You are already doing this? Fine. I would just ask that you produce those results by next January.

The Chairman. All right. Any problem with that?

Mr. Burke. No.

The Chairman. Do you propose the amendment?

Senator Mitchell. Yes, I do.

The Chairman. All those in favor of the amendment signify by saying "Aye."

(Chorus of ayes)

The Chairman. Now, let's go have lunch and vote. We will be back at 2:00 p.m.

(Whereupon, at 12:33 p.m., the meeting was recessed, to be reconvened this say

AFTERNOON SESSION

(2:38 p.m.)

The Chairman. Please cease conversation, and take a seat if you are not seated. Are there other amendments to be offered?

Senator Daschle. Mr. Chairman?

The Chairman. Senator Daschle?

Senator Daschle. We addressed the Medicap issue this morning, and I would like to revisit it with an amendment, if I could that deals with an issue that we brought up in a hearing, very effectively I think, with regard to Medigap insurance.

The Baucus legislation this morning addressed Medigap and expanded upon the intent of the law with regard to ensuring adequate coverage and adequate consumer information.

My amendment does somewhat the same thing but in a different way. It would provide that, for those Medigap policies that are three years old or more, that have been in effect for three years, a simple disclosure somewhere in plain English in the policy requiring disclosure of the loss ratio would be incorporated in the policy somewhere.

My feeling is that on a number of the Medigap policies, the loss ratio is substantially lower than the stated intent here of 60 percent. Now, I don't want to mandate that we do 60 or 70 or whatever percentage, but I do feel the consumers

need to know; they have a right to know before they sign the policy just what the loss ratio is. What will be benefits be?

This simply says right up front that the loss ratio is 30 or 40 percent, and there may be good reason for it. This simply would require the salesperson to say it is only 40 percent because of whatever case they may have.

Now, I have talked to some of the Medigap people, especially the Prudential Insurance Company, which has indicated to me that, given their record of some 80 percent loss ratio, that they see no difficulty with something like this. In the original Baucus amendment, we are dealing with projections. What would be the projection of a loss ratio and setting the guideline at 60 percent.

In this amendment, basically we are dealing with actual loss ratios; and we are simply requiring the company to disclose--again in plain English--on those policies that are well established, that is three years and older, that the ratio between premiums and benefits is established.

I think it is a good amendment, and I would certainly hope the committee would look favorably upon it.

The Chairman. Do we have some comments? Would the Administration make a comment first?

Mr. Burke. I don't believe the Administration has a position, but I have a question, if I may?

The Chairman. You think the Administration's position is

what?

Mr. Burke. I don't think they have a position on it, other than testimony that was heard on this subject as part of the Bowen Commission and the question arose then: What would be the impact on a policy that was rolled over each year?

Senator Daschle. The policy--as established by the Secretary--would have to have been established for at least three years. They would be required to put that somewhere in the policy itself.

The General Accounting Office, of course, has done an excellent report on Medigap insurance and reports the cumulative loss ratio by every company in Medigap today. They range all the way from about 95 percent to 29 percent. That is pretty startling information, when one thinks about it, given the Baucus amendment, having the information so readily available. It seems to me to be a very simple question of consumer information here, especially those most vulnerable.

If you are an elderly person who is being sold a policy of this kind, you may not know what questions to ask, but certainly having a statement like this right up front that says our loss ratio is 60 or 80 percent and it exceeds the minimum Federal guidelines. That is a pretty good illustration perhaps of the quality of the policy itself.

Again, I guess I feel that it makes some sense. It doesn't

seem to me to require any additional burden on the insurance company since they already have this information. It is just a matter of putting it in the policy itself.

The Chairman. Are there others on the staff that have a comment on it?

(No response)

The Chairman. Are there comments by members of the committee? Senator Baucus?

Senator Baucus. Mr. Chairman, I think Senator Daschle has offered an important amendment. He carries the provisions that I offered before we recessed at the noon hour another step--a step further. The amendment that we approved before we recessed asked the insurance companies to provide their actual loss ratios to the Insurance Commissioner. The idea was that the Insurance Commissioners and the State regulators could then make the provisions that they might in accordance with the customary factors, that is where insurance is regulated by the State, more than by the Federal Government.

I had considered the idea in Senator Daschle's amendment that the information be provided by insurance companies to consumers in addition to the State regulators. This is not as simple a matter as it may appear to be.

Senator Daschle is absolutely correct that the GAO came up with many different abuses of supplemental medical coverage. Many of those are mail order firms, but some of them are not.

Part of the problem is that different policies have different coverages and different benefits. So, the loss ratio may or may not be a good indicator of whether the company is providing the proper coverage given the premiums that it is collecting.

If all insurance policies were the same--if they were uniform--then the loss ratios would be more relevant. That is not to say it is irrelevant--it is a factor.

My personal view is that, although this is an important amendment, it is not the time to adopt this amendment. The reason is that it tends to be not a simple subject. It is one where I think we should let the State regulators make some decisions on their own on how best to handle it; or perhaps we should ask the National Association of Insurance Commissioners to find ways to address those companies that not only have the worst loss ratios but loss ratios that reflect that the company is not providing the proper product.

This is not an easy decision for this Senator, but I have come to the decision that this is not the time and place to require State Insurance Commissioners to provide the actual loss ratios for their policies.

It is my belief that when the information is given to the Commissioners themselves, then the Commissioners will begin--particularly through the National Association of Insurance Commissioners--to develop ways to get the proper

information to the consumers in their jurisdictions.

I think, looking down the road, one has to study this more fully before we take this step.

Senator Daschle. Will the Senator yield?

Senator Baucus. Certainly.

Senator Daschle. The original Baucus amendment has a guideline of 60 percent. That was not the only criterion, but certainly a relevant criterion, for a given policy. You emphasized a couple of years ago when you introduced it that it ought not be the only criterion; but as I stated, 60 percent is really a pretty conservative goal when you consider that Medicare itself had a ratio of over 90 percent.

So, I think this is simply an extension of philosophy of what the Senator himself advocated when he offered the initial 60 percent amendment. If we set that as a Federal guideline, why not require these companies to reveal their loss ratios? If they fall short of 60, perhaps it is important that the salesperson, the individual insurance agent, explain what it may be that may encumber them from attaining 60 percent as a projected goal?

It just seems to me to be a natural followup to what you are suggesting originally, that is a 60 percent loss ratio.

Senator Baucus. As we move in this area, particularly with the adoption of this catastrophic bill we are enacting here, that is going to affect the loss ratio of some of these.

I just think at this point it would be inappropriate because this is an area that is going to need a little settling down, particularly with the catastrophic bill that we are going to enact, and that is going to affect supplemental policies and the loss ratios of those policies, particularly remembering that different policies have different benefits and different coverages.

I think, all things considered, it should be left to the Insurance Commissioners. Now, the original Medigap amendments still honor that principle. They provide that the States provide the standards. If the insurance company wanted to do more than the State required, they could do that.

The Chairman. Senator Chafee has been seeking recognition.

Senator Chafee. Mr. Chairman, this may well be a good amendment for all I know. I have a feeling that we are getting into an area that frankly we don't know an awful lot about.

I wish that we could look at it. Perhaps it should be raised again as a committee amendment or something like that when the bill is on the floor, but I personally would feel much more comfortable having a chance to think more about it.

For example, if somebody comes around with a loss ratio that is 95 percent, has he got a better policy? If he pays out 95 cents for every dollar in premiums, it may mean that the company is about to go on the rocks, but on the policy it will look very attractive to the purchaser.

My own feeling, Mr. Chairman, is that I would like to spend a little more time thinking about this and examining it and talking with some folks who know a good deal more about it than I do.

The Chairman. Let me state that I have been advised that there are some 50 amendments pending. The leadership is a little short on temperament at the moment, and they are moving to table many of these amendments. I frankly think we will not be able to get it done this afternoon.

With that in mind, let's reconvene tomorrow morning at 9:30 a.m.

Senator Chafee. You are not going to propose his amendment?

The Chairman. No, because there are several who want to speak to his amendment. I have been advised also that there are other Senators who want to speak to this amendment.

So, we will take it up tomorrow morning. It will be the next thing on the agenda tomorrow morning. We will reconvene at 9:30 a.m.

(Whereupon, at 2:52 p.m., the meeting was recessed, to be reconvened on Friday, May 29, 1987 at 9:30 a.m.)

C E R T I F I C A T E

This is to certify that the foregoing proceedings of an Executive Session of the Committee on Finance, held on May 28, 1987, were held as appears herein and that this is the original transcript thereof.

William J. Moffitt

WILLIAM J. MOFFITT
Official Court Reporter

My Commission expires April 14, 1989.

OPENING STATEMENT BY
CHAIRMAN LLOYD BENTSEN
MAY 28, 1987

GOOD MORNING. FOR MORE THAN A DECADE MANY OF US IN THE CONGRESS, INDEED EVERY MEMBER OF THIS COMMITTEE, HAVE WORKED TO IMPROVE HEALTH INSURANCE UNDER THE MEDICARE PROGRAM. HOWEVER, A BENEFIT STRUCTURE THAT PROTECTS THE ELDERLY AND DISABLED FROM CATASTROPHIC HEALTH COSTS HAS ELUDED US THUS FAR. AS THE PRESIDENT SO POIGNANTLY SAID IN HIS STATE OF THE UNION MESSAGE, ". . . LET US REMOVE A FINANCIAL SPECTER FACING OUR OLDER AMERICANS -- THE FEAR OF AN ILLNESS SO EXPENSIVE THAT IT CAN RESULT IN HAVING TO MAKE AN INTOLERABLE CHOICE BETWEEN BANKRUPTCY AND DEATH."

DURING THESE FIRST MONTHS OF THE 100TH CONGRESS, WE HAVE HELD NUMEROUS HEARINGS ON THE QUESTION OF MODIFYING MEDICARE TO ADD A CATASTROPHIC LOSS PREVENTION FEATURE TO THE CURRENT PROGRAM. WITNESS AFTER WITNESS TESTIFIED THAT THE ELDERLY REQUIRE MORE MEDICAL CARE THAN YOUNGER PERSONS. SECRETARY BOWEN OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TESTIFIED THAT IN 1984, AVERAGE SPENDING ON HEALTH CARE BY ELDERLY AMERICANS WAS A STARTLING $4,200, OR TWO AND ONE-HALF TIMES SPENDING FOR THE POPULATION AS A WHOLE. A JUST-RELEASED GAO REPORT UNDERSCORES THE NEED FOR SWIFT ACTION WITH ITS ASSESSMENT THAT LEGISLATIVE CHANGES ENACTED IN RECENT YEARS HAVE INCREASED OUT-OF-POCKET COSTS TO THE ELDERLY AND DISABLED BY 34 PERCENT. THIS INCREASE IN OUT-OF-POCKET COSTS REQUIRES MEDICARE ENROLLEES TO EXPEND 6 PERCENT OF THEIR ANNUAL INCOME FOR <u>COVERED</u> SERVICES. IT IS IMPORTANT TO EMPHASIZE THAT THESE FIGURES APPLY TO <u>COVERED</u>

THIRTEEN PERCENT ARE ELIGIBLE FOR SUPPLEMENTARY COVERAGE UNDER MEDICAID. BUT FULLY 20 PERCENT, OR ONE-FIFTH OF MEDICARE ENROLLEES, HAVE NO PRIVATE INSURANCE OR MEDICAID.

FOR THOSE WITH MEDIGAP POLICIES, THE COVERAGE STANDARDS APPROVED BY THIS COMMITTEE IN 1980 OFFER SOME ASSURANCE OF FINANCIAL PROTECTION. HOWEVER, OUT-OF-POCKET COSTS TO THE ELDERLY AND DISABLED CAN STILL BE SUBSTANTIAL. FOR EXAMPLE, MEDIGAP POLICIES NEED NOT LIMIT COSTS ASSOCIATED WITH HOSPITAL DEDUCTIBLES. UNDER CURRENT LAW, A BENEFICIARY CAN PAY AS MANY AS SIX $520 DEDUCTIBLES IN A SINGLE YEAR. MEDIGAP STANDARDS ALSO PERMIT COMPANIES TO LIMIT THEIR EXPOSURE TO $5,000 IN PART B EXPENSES, EFFECTIVELY LEAVING THE PATIENT VULNERABLE TO ANY ADDITIONAL PART B COSTS WHICH CAN INCREASE EXPONENTIALLY DEPENDING ON THE NATURE OF THE PATIENT'S ILLNESS. FINALLY, EXISTING STANDARDS DO NOT ADDRESS SKILLED NURSING FACILITY COINSURANCE THAT CAN AMOUNT TO AS MUCH AS $65 PER DAY IN 1987.

WHILE PRIVATE POLICIES OFFER ADDITIONAL PROTECTION AGAINST UNANTICIPATED HEALTH COSTS FOR SOME INDIVIDUALS, NOT ALL ELDERLY AMERICANS ARE ABLE TO AFFORD SUPPLEMENTARY INSURANCE. FULLY ONE-THIRD OF THE ELDERLY WITH FAMILY INCOMES OF LESS THAN $9,000 HAVE NO COVERAGE BEYOND MEDICARE, AS COMPARED TO ONE IN TEN FAMILIES WITH INCOMES OVER $25,000. THE SAD FACT IS THAT THE GAP IN COVERAGE PROBLEM IS MOST SERIOUS AMONG THE OLDEST PROGRAM PARTICIPANTS. TWENTY-FIVE PERCENT OF MEDICARE BENEFICIARIES OVER THE AGE OF 80 HAVE NO SUPPLEMENTARY PRIVATE POLICY OR MEDICAID,

INSURERS TO OFFER POLICIES THAT ADDRESS CHRONIC CARE NEEDS, SUCH AS NURSING HOME STAYS AND HEALTH SERVICES DELIVERED IN THE HOME.

MOST MEMBERS OF THE FINANCE COMMITTEE HAVE SPONSORED LEGISLATION DESIGNED TO SIMPLIFY THE CURRENT MEDICARE PROGRAM AND TO CURB EXCESSIVE OUT-OF-POCKET HEALTH COSTS FOR THE NATION'S ELDERLY AND DISABLED. ENACTMENT OF ANY OF THE MAJOR BILLS INTRODUCED THIS YEAR WOULD BENEFIT NEARLY TWO MILLION OF THE THIRTY-ONE MILLION AMERICANS WHO PARTICIPATE IN MEDICARE AND WHO WILL INCUR PERSONAL COSTS FOR ACUTE CARE SERVICES OF $1,700-$2,000 IN 1988. FOR EACH OF THESE INDIVIDUALS, MODIFICATION OF THE MEDICARE PROGRAM TO OFFER CATASTROPHIC COVERAGE WILL GENERATE GREATER CONFIDENCE THAT THEY CAN COUNT ON MEDICARE WHEN AN UNEXPECTED ILLNESS STRIKES, AND THE PEACE OF MIND WILL BE GREATEST FOR THE THIRTY PERCENT OF ELDERLY AMERICANS WITH INCOMES BELOW $10,000. FOR MOST OF THESE INDIVIDUALS, THE CONGRESSIONAL BUDGET OFFICE ESTIMATES THAT WITHOUT CATASTROPHIC COVERAGE A SINGLE HOSPITAL STAY WILL CONSUME MORE THAN 20 PERCENT OF THEIR ANNUAL INCOME.

WE NOW HAVE A RARE OPPORTUNITY TO MAKE NEEDED CHANGES IN THE MEDICARE PROGRAM. WE CAN DO IT THIS YEAR. THE PRESIDENT, TOGETHER WITH A BROADLY REPRESENTATIVE AND BIPARTISAN GROUP OF MEMBERS OF THE CONGRESS, HAS RECOMMENDED A SERIES OF MODEST BUT IMPORTANT IMPROVEMENTS IN THE EXISTING PROGRAM.

YET, AS IMPORTANT AS THOSE IMPROVEMENTS ARE, THEY MUST BE FINANCED RESPONSIBLY. IT IS CRITICAL THAT WE NOT EXACERBATE

Ed Danielson
Markup 5/28/87

CATASTROPHIC HEALTH INSURANCE
SENATOR BOB DOLE
MAY 28, 1987

MR. CHAIRMAN, I AM VERY PLEASED TO BE HERE TODAY AS WE BEGIN TO CONSIDER A MEDICARE CATASTROPHIC HEALTH INSURANCE BILL. IT SEEMS I HAVE BEEN HERE BEFORE - IN FACT SEVERAL TIMES - AS HAVE MANY OF MY COLLEAGUES, MANY OF WHOM ARE HERE TODAY. WE HAVE BEEN CONSIDERING PROPOSALS RELATING TO CATASTROPHIC HEALTH INSURANCE FOR MANY YEARS, DATING BACK TO THE LONG-RIBICOFF BILL.

IN 1979, I INTRODUCED MY FIRST CATASTROPHIC BILL ALONG WITH SENATORS DANFORTH AND DOMINICI, OTHERWISE REFERRED TO AS THE "TRIPLE D" BILL, AND AS RECENTLY AS LAST YEAR, SENATOR BENTSEN INTRODUCED A CATASTROPHIC BILL, AS HAVE MANY OTHERS OVER THE YEARS. IT HAS BEEN A LONG ROAD, AND HAS TAKEN A YOEMAN'S EFFORT TO REACH THIS VERY IMPORTANT STAGE -- NAMELY THE VERY DISTINCT POSSIBILITY THAT WE WILL BE ABLE TO REACH A CONSENSUS ON CATASTROPHIC HEALTH INSURANCE FOR THE ACUTE CARE NEEDS OF THE ELDERLY.

I WOULD LIKE TO BEGIN BY CONGRATULATING SECRETARY BOWEN ON HIS FINE WORK ON THIS ISSUE. HIS PROPOSAL LAID THE GROUND WORK THAT LED US TO WHERE WE ARE TODAY. THE PRESIDENT'S EARLY LEADERSHIP ALONG WITH SECRETARY BOWEN'S SET THE STAGE FOR THE DEBATE WE ARE ABOUT TO BEGIN, AND HELPED US TO FOCUS OUR EFFORTS. ALSO OF COURSE, SENATOR BENTSEN IS TO BE CONGRATULATED. HE HAS WORKED CLOSELY WITH US AND IN FACT INCLUDED SEVERAL OF THE PROVISIONS FROM OUR EARLIER BILL WITHIN S. 1127. THIS WILLINGNESS TO TAKE INTO CONSIDERATION THE WORK

OF OTHERS IS AN IMPORTANT PART OF THE PROCESS THAT ALLOWS FOR SOLID, BI-PARTISIAN LEGISLATION TO BE DEVELOPED. MR. CHAIRMAN, YOUR GOOD WILL HAS BEEN APPRECIATED. ADDITIONALLY, HE IS TO BE COMPLEMENTED ON HAVING PUT BEFORE US A NEW FINANCING MECHANISM WHICH FINALLY HELPS US TO HELP THOSE WHO ARE LOW INCOME. HAVING STRUGGLED WITH THIS ISSUE FOR MANY YEARS, I KNOW HOW DIFFICULT IT MUST HAVE BEEN.

AND FINALLY, TO MY OWN REPUBLICAN MEMBERS THAT WORKED SO CLOSELY WITH ME THIS YEAR, MY

THANKS FOR THEIR CONSIDERABLE ASSISTANCE IN DEVELOPING OUR BILL, AND FOR THE SUPPORT AND GUIDANCE THEY HAVE PROVIDED IN THE PAST.

TODAY, WE ARE TRYING TO PROVIDE THE BEST BENEFIT MIX FOR THE ELDERLY WHILE NOT ADDING TO THE FEDERAL DEFICIT. WE NEED A RESPONSIBLE PROGRAM, NOT A PROGRAM THAT SERVES AS AN INVITATION FOR MASSIVE INCREASES IN BENEFITS, BUT RATHER ADDRESSES SPECIFIC BENEFITS WHICH ARE IMPORTANT TO THE NEEDS OF THE ELDERLY. THE BILLS BEFORE US TODAY AND THE AMENDMENTS THAT

WILL BE CONSIDERED, WILL PROVIDE US THE OPPORTUNITY TO DISCUSS, IN OPEN FORUM, THE BEST POSSIBLE BENEFIT PACKAGE THE GOVERNMENT CAN PROVIDE.

IN DEVISING A PLAN, I WOULD LIKE TO MAKE IT CLEAR THAT IT WAS NOT OUR INTENTION TO ENTIRELY REPLACE PRIVATE SECTOR ACTIVITY. IN FACT WE HOPE THAT OUR LEGISLATIVE ACTIVITY IN THIS AREA WILL ENCOURAGE THE PRIVATE SECTOR TO CONTINUE THEIR EFFORTS TO DEVELOP COVERAGE FOR THOSE AREAS WE ARE UNABLE TO RESOLVE. FOR EXAMPLE,

THERE CONTINUES TO BE A TREMENDOUS NEED TO ADDRESS THE LONG TERM CARE NEEDS OF THE ELDERLY AND THE ACUTE AND PRIMARY CARE NEEDS OF THOSE UNDER AGE 65 WHO ARE UNINSURED OR UNDERINSURED. ALTHOUGH THIS BILL DOES NOT DEAL WITH EITHER OF THESE ISSUES, THAT DOES NOT MEAN WE ARE NOT GOING TO CONTINUE TO WORK ON SOLUTIONS, AND THE PRIVATE SECTOR WILL CONTINUE TO PLAY A KEY ROLE IN THAT EFFORT.

IT IS EQUALLY IMPORTANT TODAY TO KEEP IN MIND OUR PRIMARY FOCUS, AND THAT IS THE WORD

CATASTROPHIC. WE ARE NOT HERE TO CONSIDER BASIC BENEFIT CHANGES, BUT RATHER TO ADDRESS ONE OF THE MAJOR CONCERNS OF THE ELDERLY, AS RELATES TO CATASTROPHIC OUT-OF-POCKET EXPENSES. WE CANNOT SOLVE ALL THE PROBLEMS WHICH EXIST WITH THE MEDICARE PROGRAM IN THIS ONE BILL, AND EFFORTS TO DO SO MAY WELL WEIGHT IT DOWN TO SUCH A GREAT DEGREE THAT IT CANNOT PASS. I HOPE THAT IS NOT THE CASE. IF WE CAN PROVIDE SOME RELIEF TO THE ELDERLY, LIMITED THOUGH IT MAY BE, WE WILL HAVE MET ONE MAJOR

GOAL. I AM CONVINCED THE TIME IS RIGHT AND THAT OUR DELIBERATIONS OVER THE NEXT FEW DAYS WILL PROVE SUCCESSFUL.