spur of the moment, on this reconciliation bill, is an unwise, unfortunate, and unnecessary attack on all senior citizens.

The provision also violates the Byrd rule because it does not affect spending within the budget window. We eliminated this proposal 2 years ago, and Senator DURBIN's point of order should strike it from the bill again.

Mr. LAUTENBERG. Mr. President, I rise to support removing the provision on the increase in Medicare eligibility. I would like to see that removed. This provision, as we all know, calls for increasing the eligibility age for Medicare from 65 to 67.

Throughout our negotiations on the bipartisan budget agreement, there was no serious discussion—none—of increasing the eligibility age for Medicare. And, if there was, even the most casual discussion didn't wind up in the bill. So it wasn't believed in the contentious review that it would be appropriate. Nor has this issue been the subject of hearings or serious debate in the 105th Congress. There is nothing in the budget resolution that calls for dealing with the issue, as I said.

Nevertheless, the bill before us would increase the eligibility age for Medicare and would do so without protecting the seniors aged 65 and 66 to make sure that they will have access to affordable health insurance as they age. Typically corporations now have men aged 65 to offer retirement in many cases, and that is the vulnerable age. If there is an illness that befalls someone or they run into economic differences during that period of time, that is a very harmful experience. I think it would be a serious mistake to do that without making certain that the those aged 65 and 66 are protected.

Before going further, I want to acknowledge that the Senators who are responsible for this proposal are trying in good faith to confront the long-term problems facing the Medicare Program. They deserve real credit for that. I, too, would like to have a comprehensive review on Medicare.

I think we have made a good first step back when we finally had the policy behind the development. That was to add years of solvency to the Medicare Program while we engaged in a comprehensive review. So this is not the time, frankly, nor the place on our agenda to do that. So I disagree with their approach.

My concern is that if we simply exclude 65- and 66-year-olds from Medicare, what do these folks do? At that age private health insurance can be prohibitively expensive, if it is available at all. Without Medicare, these people may have nowhere else to turn.

Mr. President, I point out that more and more businesses are dropping health insurance coverage for their retirees. The trend has been accelerating in recent years, and it may well continue into the future.

I know lots of people who face retirement who want to engage in a business or continue to work productively. But in almost no case can they be assured that they are going to get private health insurance to take them over if they wanted to go beyond Medicare protection. So private insurance doesn't look like it is a real course for those in that 65–66 category.

It is a frightening prospect. I have never heard so many conversations from people about their concerns about health insurance. It is a continuing subject. Notice that in job opportunities very often the health insurance discussion is no longer one that is available. Lots of small companies can't afford to provide it, and they don't.

So people are worried about the prospect of bankruptcies as a result of a catastrophic illness, about being put out on a limb and not getting the coverage that they need. We know that hospital services in this area are expensive. We also know that there has been a major change in the psychology of our society; that is, people in their sixties no longer expect to be put out to pasture. They can do lots of good things. Take it from an expert here, they can do lots of good things. And they want to know that their health is protected.

So it is a scenario that could face millions of Americans if we are not careful.

If the Congress decides, Mr. President, that the Medicare eligibility age should be changed, there are ways to protect senior citizens in the process. Some have suggested allowing uncovered seniors to pay a reasonable premium in return for Medicare coverage. Others have suggested subsidizing private insurance or other options.

I am not advocating any single program at this point. My focus is that we should not pull the rug out from millions of Americans without ensuring that they have at least a basic safety net.

I also believe that a fast-track reconciliation bill is the wrong vehicle to be considering a fundamental change like this. For those who are not familiar with our terminology, ''fast track'' means get it done, try to zip it through the place—not undercover but to try to get it done. The reconciliation bill is one that kind of commands an enforcement mechanism for achieving the objectives that we set out for ourselves—in this case the balanced budget by the year 2002, to try to extend the solvency of Medicare, take care of legal immigrants who are here, to provide insurance coverage for children that are not ensured.

Those are the missions that we encompass in this bill. They were negotiated over a long period of time—several months. They were very difficult negotiations—difficult not because we were at each other's throat but because we tried to deal with reason and thought and arrived at a consensus that would take care of most of the needs that we provide for our citizens, including a massive infusion into our education programs to provide young people with opportunities for the future, and again to protect senior citizens who are perhaps impoverished and can't afford increased premiums. Suddenly this is a new factor introduced from the Finance Committee which is an amendment to the basic bill.

In addition to the limit on amendments to the reconciliation, it would be very difficult even for Senators to consider fully various options.

The proponents of rating the eligibility age in this bill argue that we must act now to give Americans adequate notice about a change that is coming in the future. However, I would note that this bill includes a commission to look at the long-term issues involving the Medicare Program. The commission is required to report within 1 year of this bill's enactment. If the commission determines that a delay in the eligibility age is required, Americans will have plenty of notice about that possibility to be able to respond with their community and with their organizations. They will be able to send in considered opinions. I think we must do that.

So I hope that my colleagues will support the effort to remove this provision from the reconciliation bill. It would be wrong to leave older Americans without health care coverage. We certainly shouldn't do so on something that is going to move as rapidly as this is without an opportunity for having adequate public input and a full debate.

So, Mr. President, again I salute the effort of those who are offering the change because they think that it is essential for the solvency and for the long-term survival of Medicare. But, on the other hand, if it is that important and that crucial, then we ought to make sure that we allow enough time and allow enough review to make certain that the step we are going to choose is the correct one.

Mr. President, I see nothing is going on at this moment. I therefore, note the absence of a quorum, and I ask that it be charged to both sides.

The PRESIDING OFFICER. Without objection, it is so ordered.

The clerk will call the roll.

The bill clerk proceeded to call the roll.

Mr. ROTH. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

MORNING BUSINESS

Mr. ROTH. Mr. President, I ask unanimous consent there now be a period for the transaction of morning business with Senators permitted to speak for up to 5 minutes each.

The PRESIDING OFFICER. Without objection, it is so ordered.

HOME HEALTH CARE PROSPECTIVE PAYMENT ACT OF 1997

Mr. HATCH. Mr. President, over the past several months, I have been developing legislation to dramatically reform the way Medicare pays for home health services. This effort builds on my work in the Finance Committee during 1995 where I strove to see a prospective payment system for home health services included in the Balanced Budget Act agreement.

The culmination of this year's efforts is a bill I introduced on June 16, the Home Health Care Prospective Payment Act of 1997 (S. 913). The Home Health Care Prospective Payment Act is intended to achieve three primary goals:

First, the bill will create incentives for providers to behave in a more cost effective manner.

Second, it will help assure that the federal government achieves the necessary savings it seeks in order to ensure the solvency of the Medicare program well into the next century.

And third, perhaps most importantly, my bill accomplishes these first two goals while protecting the quality and continuity of home health care services for beneficiaries.

As my colleagues are aware, I have been a strong supporter of home health care services ever since I came to this body. I have applauded changes that have made it easier to treat Medicare patients in the most cost-effective setting. The changes we have made to the system have benefited many patients who would otherwise have not received care. In other cases, these individuals would have had to wait until their health deteriorated to the point of having to be admitted to a hospital. This outcome was neither cost effective nor good health care policy.

We have learned a great deal about Medicare reimbursement since we passed the prospective payment system [PPS] for hospitals in 1983. We now know the value of a proper transition period so that providers will be able to manage their operations toward a permanent system.

We also know that we can model a payment system that encourages providers to manage costs and utilization better. We realize that moving to a new reimbursement system is a massive undertaking. The amount of data, time, and expense is enormous. It is especially important not to unnecessarily burden health care providers, Government, or patients with administrative requests.

My legislation proposes to begin a transition to a home health care PPS immediately, rather than waiting until fiscal year 2000. Instead of relying on cost limits, we can begin using predetermined rates in an initial PPS system during fiscal years 1998 and 1999.

The principle behind prospective payment is to shift the risk from the Government to providers. This is done by rewarding providers for keeping their costs below the rates—or having them absorb the loss if their costs are over the rates. Therefore, I propose we incorporate a limited shared savings plan during the initial 2 years of the PPS to encourage more cost effective behavior by health care providers.

In addition, there needs to be greater sensitivity to the data demands and consequences in our proposal. For example, there needs to be some discretion for the Secretary of the Department of Health and Human Services to designate a different base year for extraordinary situations that may arise in a particular case. There are other proposals that may be considered that might be good ideas in and of themselves. Some proposals, however, may impose data, time, or cost demands that are unnecessarily burdensome to providers, patients, or the Government—but may not be necessary for PPS implementation.

The changes I am proposing in my legislation are not new to the Senate, but merely reflect the information and legislative history we have gained through our consideration of Medicare payment reforms. My legislation will make home health care reform consistent with that history.

Mr. President, for the benefit of my colleagues I ask unanimous consent that a section-by-section analysis of S. 913 be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

SECTION-BY-SECTION ANALYSIS

Section 1. Provides a short title and a table of contents.

Section 2. Provides that amendments made by the Act are to the Social Security Act.

Section 3. Provides for the recapture of savings from the temporary freeze on payments for home health payments from 1994 to 1996 in updating home health costs limits for FY 1998 and subsequent years.

Section 4. Provides for the establishment of an initial prospective payment system for home health services beginning in FY 1998. Payments would be based on rates equal to the lower of—

Costs determined under the current reimbursement system (revised to limit costs to 105 percent of the median of visit costs for freestanding home health agencies and eliminating annual rate updates); or

An agency-specific per-beneficiary annual limit based on 1993 cost reports, multiplied by the agency's unduplicated patient census. Annual limits for new providers would be based on an average of limits applied to other home health agencies. Incentive payments would be available to agencies equal to 50 percent of the amount by which its year end reasonable costs are below its per-beneficiary annual limit.

Section 5. Provides for the establishment of a permanent prospective payment system for home health services beginning in FY 2000. Payments would cover all services included in the Medicare home health benefit, including medical supplies. In determining payment amounts, the Secretary of Health and Human Services would be required to determine an appropriate unit of home health service, to provide for adjustments based on variations in the mix of services provided, and to assure continued access to quality services. Payments would be subject to annual adjustments based on the home health market basket index. The Secretary would be authorized to develop a payment provision for outliers based on unusual variations in the type or amount of medically necessary services.

Initial payment rates for a permanent prospective payment system would be required to be developed in a manner that would assure the achievement of the scorable savings of the act.

Section 6. Provides for home health services to be reimbursed on the basis of the geographic location where the service is furnished.

Section 7. Provides for the elimination of periodic interim payments for home health services upon implementation of a permanent prospective payment system.

Section 8. Provides for limiting Part A coverage of home health services to the first 100 visits following a hospital stay. Clarifies coverage of intermittent and part-time nursing care. Provides for the exclusion of the costs of home health services from the calculation of Part B monthly premiums. Provides a new definition of the term ''homebound''. Authorizes the Secretary to deny coverage of home health services which are in excess of normative standards for the frequency and duration of care.

SKILLED NURSING FACILITIES PROSPECTIVE PAYMENT ACT OF 1997

Mr. HATCH. Mr. President, on June 16, 1997, I introduced legislation, S. 914, proposing to revise the present system in which the Medicare Program pays for services provided by skilled nursing facilities [SNF's]. This legislation builds on my work in the Finance Committee in 1995 when the committee included a proposal I authored to implement a prospective payment system for nursing home payments.

As currently structured under Medicare, seniors receive up to 100 days of skilled nursing facility services following a 3-day hospitalization stay. Currently, those services are reimbursed on a cost-plus basis. As Medicare has evolved, however, so have systems of cost-plus reimbursement.

For many years, I have worked with my colleagues in the Senate to provide seniors with the services they need in a skilled nursing facility setting. I have worked to modify the Medicare reimbursement methodology in order to provide economic incentives to SNF providers to provide the highest quality of care at a reasonable and affordable price to the Medicare Program.

My legislation will accomplish that goal.

Congress initially began requiring prospective payments for skilled nursing facilities in the early 1980's. However, the Health Care Financing Administration [HCFA] has not been able to identify an appropriate payment methodology, and how best to define the services provided to seniors in a comprehensive way. Nevertheless, we have come a long way since the mid 1980's in understanding the proper