EXTENSIONS OF REMARKS

DRUG COVERAGE MEANS EXTRA COST

HON. DOUG BEREUTER

OF NEBRASKA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, June 15, 1999

Mr. BEREUTER. Mr. Speaker, this Member commends to his colleagues an excellent editorial pointing out the need for realistic premiums to cover the additional cost that would result from including prescription drugs under Medicare coverage which appeared in the Norfolk (Nebraska) Daily News, on June 11, 1999.

[From the Norfolk Daily News, June 11, 1999]

DRUG COVERAGE MEANS EXTRA COST

PRESIDENT HAS A PLAN FOR INCLUDING PRESCRIPTIONS UNDER MEDICARE PROGRAM

President Clinton believes he has a plan for including prescription drugs under Medicare coverage that is superior to the one suggested by the co-chairmen of his 17-member advisory commission. The latter plan advanced by Sen. John Breux, D–La., and Rep. Bill Thomas, R–Calif., would provide the elderly participants under Medicare with a fixed amount for purchasing either a public or private health plan, which could include expenses for prescription drugs.

That had the advantage of simplicity, but a political disadvantage of not providing opportunity for presidents and members of Congress to get credit for periodic improvement of all kinds of health care benefits.

The Clinton plan, promised to be presented in detail later this month, proposes drug coverage for Medicare beneficiaries through the payment of an extra premium. It was predicted as being as low as $10 a month and certainly less than $25 a month.

In either event, it would be relatively cheap coverage, and appealing to those now covered by this government program whereby Social Security beneficiaries pay a $45.50 premium for health insurance. Inclusion of drugs in the program will boost costs, though White House advisers claim they will be offset by reducing hospital admissions and nursing homes, and reduce the need for home health care. The question is: Who will pay?

Today's wage-earners should not be saddled with extra payroll taxes to provide this new coverage; neither should employers who are partners in paying the payroll taxes.

The problems with future solvency for the systems that provide Social Security retirement and Medicare arise from a political inability to fix benefit limits. Any expansion of benefits—especially for prescription drugs—must be accompanied by a sound program by which those who are served share the extra expense.

Using a federal surplus—which accumulates because Americans are already taxed too heavily—to expand government benefits is a politically devious way to resolve solvency problems of a program already destined for insolvency on its present path.

Better coverage will cost more; and those costs ought to be paid largely through realistic premiums for those who wish and can afford the extras.

INTRODUCTION OF THE MEDICARE EARLY ACCESS ACT

HON. FORTNEY PETE STARK

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, June 15, 1999

Mr. STARK. Mr. Speaker, as this Congress debates Medicare reform, we need to ask ourselves what kind of reform do we want? Is Medicare a program that has worked for our nation's seniors? Is it something we should build upon or is it something we should tear down and start over?

I stand here today with 80 of my colleagues to say that Medicare is a program that works and that can and should be improved. In that vein, we are introducing the Medicare Early Access Act, legislation that was first introduced in the last Congress with the support of President Clinton. Rather than raise the eligibility age of Medicare like some in this Congress would seek to do, this bill would expand access to Medicare's purchasing power to certain individuals below age 65.

The Medicare Early Access Act is self-financed, through enrollees' premiums; it is not a publicly financed program. It simply would enable eligible individuals to harness Medicare's clout in the marketplace to get much more affordable health coverage than they are able to purchase in the private sector market that currently exists.

The bill would provide a very vulnerable population (age 55–64) with three new options to obtain health insurance:

Individuals 62–65 years old with no access to health insurance could buy into Medicare by paying a base premium (about $300 a month) during those pre-Medicare eligibility years and a deferred premium (per month, about $16 for each year of participation in the early access program) during their post-65 Medicare enrollment. The deferred premium is designed to reimburse the early access program for the extra costs for the sicker than average enrollees. It would be payable out of the enrollee's Social Security check between the ages of 65–85.

Individuals 55–62 years old who have been laid off and have no access to health insurance, as well as their spouse, could buy into Medicare by paying a monthly premium (about $400 a month). There would be no deferred premium. Certain eligibility requirements would apply.

Retirees aged 55 or older whose employer-sponsored coverage is terminated could buy into their employer's health insurance for active workers at 125 percent of the group rate. This would be a COBRA expansion, with no relationship to Medicare.

Through these changes, the Medicare Early Access Act would provide health insurance for some 400,000 people at a vulnerable point in their lives when the current health care marketplace is leaving them out. These are not people whom the current health care marketplace is scrambling to cover. Insurance companies don't want them and we are increasingly seeing employers drop coverage as well. It is time for the federal government to step forward and solve the problem of diminishing access for early retirees and workers who simply cannot buy adequate insurance in the private market.

In addition, the Medicare Early Access Act has only a small start-up cost that is fully financed through companion legislation to curb waste, fraud and abuse in Medicare that I am concurrently introducing today. In this way, we will expand coverage options to people between the ages of 55 and 64 at no cost to the American taxpayer.

The Medicare Early Access Act isn't the total solution for people age 55–64 who lack access to health insurance coverage. However, if passed, it would make available health insurance options for these individuals at much less than the cost of what is available today. This is a meaningful step forward in expanding health insurance coverage to a segment of our population that is quickly losing coverage in the private sector. It is a solution that has no cost to the federal government. The Medicare Early Access Act is legislation that we should be able to agree upon and to enact so that people age 55–64 have a viable option for health insurance coverage.

A more detailed summary of the Medicare Early Access Act follows:

MEDICARE EARLY ACCESS ACT OF 1999

SUMMARY

TITLE: HELP FOR PEOPLE AGED 62 TO 65

Sixty-two to sixty-five year olds without health insurance may buy into Medicare by paying monthly premiums and repaying any extra costs to Medicare through deferred premiums between ages 65 to 85.

Starting July, 2000, the full range of Medicare benefits (Part A & B and Medicare+Choice plans) may be bought by an individual between 62–65 who has earned enough quarters of coverage to be eligible for Medicare at age 65 and who has no health insurance under a public plan or a group plan. (The individual does not need to have exhausted any employer COBRA eligibility).

A person may continue to buy-into Medicare even if they subsequently become eligible for an employer group health plan or public plan. Individuals move into regular Medicare at age 65.

Financing: Enrollees must pay premiums. Premiums are divided into two parts:

(1) Base Premiums of about $300 a month payable during months of enrollment between 62 to 65, which will be adjusted for inflation and will vary a little by differences in the cost of health care in various geographic regions, and

(2) Deferred Premiums which will be payable between age 65–85, and which are initially estimated to be about $16 per month for each year or part of a year that a person chooses to enroll between age 62–65. For example, if one enrolls for only two years, the Deferred Premium will be roughly $32/month [2 x $16] between age 65–85. The Deferred Premium will be paid like the current Part B premium, i.e., out of one's Social Security check.

Note, the Base Premium will be adjusted from year to year to reflect changing costs

(and individuals will be told that number each year before they choose to enroll), but the 20 year Deferred Premium will not change from the dollar figure that the beneficiary is told when they first enroll between 62–65—they will be able to count on a specific dollar deferred payment figure.

The Base Premium equals the premium that would be necessary to cover all costs if all 62–65 year olds enrolled in the program. The Deferred Premium repays Medicare for the fact that not all will enroll, but that many sicker than average people are likely to voluntarily enroll. The Deferred Premiums ensure that the program is eventually fully financed over roughly 20 years. Savings from the anti-fraud proposals (introduced separately) finance the start-up of the program and protect the existing Medicare program against any loss (see Title IV).

TITLE II: HELP FOR 55 TO 62 YEAR OLDS WHO LOSE THEIR JOBS

55–62 year olds who are eligible for unemployment insurance (and their uninsured spouses) may buy into Medicare through a premium.

The full range of Medicare benefits may be bought by an individual between 55–62 who:

(1) has earned enough quarters of coverage to be eligible for Medicare at age 65,

(2) is eligible for unemployment insurance,

(3) before lay-off had a year-plus of employment-based health insurance, and

(4) because of the unemployment no longer has such coverage or eligibility for COBRA coverage.

A worker's spouse who meets the above conditions (except for UI eligibility) and is younger than 62 may also buy-in (even if younger than 55).

The worker and spouse must terminate buy-in if they become eligible for other types of insurance, but if the conditions listed above reoccur, they are eligible to buy-in again. At age 62 they must terminate and can convert to the Title I program. Non-payment of premiums is also cause for termination.

There is a single monthly premium roughly equal to $400 that will be adjusted for inflation. It must be paid during the time of buy-in; there is no Deferred Premium. This premium is set to recover base costs plus some of the costs created by the likely enrollment of sicker than average people. The rest of the costs to Medicare are repaid by the anti-fraud provisions (see Title IV).

TITLE III: HELP FOR WORKERS 55+ WHOSE RETIREE BENEFITS ARE TERMINATED

Workers age 55+ whose retirement health insurance is terminated by their employer may buy into their employer's health insurance for active workers at 125% of the group rate (this is an extension of COBRA health continuation coverage—not a Medicare Program).

This title is an expansion of the COBRA health continuation benefits program. If a worker and dependents have relied on a company retiree health benefit plan, and that protection is terminated or substantially slashed during his or her retirement, but the company continues a health plan for its active workers, then the retiree may buy-into the company's group health plan at 125% of cost.

TITLE IV: FINANCING

Titles I & II of the Early Access to Medicare Act are totally financed. Title III is not a Medicare or public program.

The existing Medicare program is protected by placing these programs in their own trust fund. The Medicare Trustees will monitor the program to ensure that it is self-financing and does not in any way burden the existing Medicare program.

Most of the cost is paid by the enrollees' premiums.

Payment of Start Up Costs: While the Deferred Premiums are being collected and for any costs not covered by premiums, a package of Medicare anti-fraud, waste, and abuse provisions has been introduced as a separate bill, the Medicare Fraud and Overpayment Act of 1999. This bill provides for a number of reforms, including:

(1) improvements in the Medicare Secondary Payment provisions,

(2) a reduction in Medicare's reimbursement for the drug EPO used with kidney dialysis so that Medicare is not paying much more than the dialysis centers are buying the drug for;

(3) Medicare payment for pharmaceuticals, biologicals, or parenteral nutrients on the basis of actual acquisition cost rather than the average wholesale price which is often far above the price at which the drug can really be purchased,

(4) setting quality standards for the partial hospitalization mental health benefit, so as to week out unqualified, abusive providers, and

(5) allowing Medicare to get a volume discount by contracting with Centers of Excellence for high volumes of complex operations at hospitals which have better than average outcomes.

TRIBUTE TO THE 1999 NOKOMIS HIGH SCHOOL GIRLS BASKETBALL TEAM

HON. JOHN SHIMKUS

OF ILLINOIS

IN THE HOUSE OF REPRESENTATIVES

Tuesday, June 15, 1999

Mr. SHIMKUS. Mr. Speaker, I would like to take this time to congratulate the 1999 Nokomis High School Girls Basketball team for winning the Illinois Class ''A'' State Title for the second straight year.

The team members are Jessica Aherin, Dee Eck, Bernadette Marty, Ashlee Keller, Va'Nicia Waterman, Lora Ruppert, Lyndsay Stauder, Heather Swanson Hayes, Janice Spears, Bonnie Meiners, Carrie Eisenbarth, Rochelle Detmers, Kassie Engelhart, Emily Heck, Jessie Hough, manager Tisha Morris and Head Coach Maury Hough.

I congratulate these young athletes and the people who were there to support them throughout this memorable season. The teamwork needed for this victory was not only seen on the court, but through the support and love of families and friends of the Nokomis High Girls Basketball team.

A TRIBUTE TO PATRICK KOSKE-MCBRIDE AND IRENE SORENSON

HON. JERRY LEWIS

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, June 15, 1999

Mr. LEWIS of California. Mr. Speaker, I would like to bring to your attention the fine achievement of Patrick Koske-McBride, an eighth grade student from Home Street Middle School in Bishop, CA. Patrick was a recent competitor in the National History Day Competition (June 13-17) at the University of Maryland. The competition involved students from across the United States who submitted projects on this year's theme: ''Science, Technology, Invention in History''

Patrick qualified for the national competition by first winning California State History Day competitions at the county and state levels. His essay, ''Evolution, an Idea of Change: How Darwin's Theory of Evolution Impacted Our World,'' investigated Darwin's life, his writings and the impact those writings have had on science, religion and society.

Patrick's outstanding accomplishments were undoubtedly guided by the leadership of his teacher, Mrs. Irene Sorenson. Irene is a past winner of the Richard Farrell Award from the National History Day as the 1996 Teacher of Merit. Also in 1995, 1996 and 1998, Irene has sent students to the national competition. Clearly, the dedication of young students like Patrick, and the guidance of teachers like Irene Sorenson, make our public school system the finest in the world.

Mr. Speaker, I ask that you join me and our colleagues in recognizing Patrick Koske-McBride for his fine accomplishment. To say the least, his fine work is admired by all of us. I'd also like to commend Irene Sorenson for her fine leadership and her devotion to such remarkable educational standards. Students like Patrick and instructors like Irene set a fine example for us all and it is only appropriate that the House pay tribute to them both today.

ELIZABETH BURKE

HON. WILLIAM J. COYNE

OF PENNSYLVANIA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, June 15, 1999

Mr. COYNE. Mr. Speaker, I rise today to recognize Ms. Elizabeth Burke, one of my constituents who has been chosen as one of the Robert Wood Johnson Community Health Leaders for 1999.

Each year, the Robert Wood Johnson Community Health Leadership Program recognizes ten individuals as Community Health Leaders for their efforts to provide better health care to communities which have historically been underserved. Community Health Leaders each receive $5,000 personal stipends as well as $95,000 in program support to finance their continued efforts to improve public health in their communities.

Ms. Burke will be recognized for her efforts to provide a comprehensive response to victims of domestic violence in the Greater Pittsburgh metropolitan area. Ms. Burke has worked as the Medical and Domestic Violence Advocate of the Women's Center and Shelter of Greater Pittsburgh to ensure that women who have been abused receive the medical care, prevention assistance, and other services that they need to end violent domestic situations.

Mr. Speaker, I commend Ms. Burke for her efforts in this important cause, and I congratulate her on her selection as one of the Robert Wood Johnson Community Health Leaders for 1999.