MEDICARE EARLY ACCESS AND TAX CREDIT ACT

Title I: Help For People Aged 62 to 65

62–65 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, 2001, 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 $326 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 estimated to be about $4 per month in 2005 for someone that participated for the full three years. 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 as HR 2229) 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 $460 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. They can remain in that plan, paying 125% of the premium, until they are eligible for Medicare at age 65.

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 weed 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.

Title V: Tax Credits

Creates a new, federal tax credit equal to 25% of the amount paid by an individual for any of the three new programs described above.

THE FISCAL YEAR 2001 AGRICULTURE APPROPRIATIONS BILLS

HON. JAMES H. MALONEY

OF CONNECTICUT

IN THE HOUSE OF REPRESENTATIVES

Monday, July 24, 2000

Mr. MALONEY of Connecticut. Mr. Speaker, my Colleagues, I rise in opposition to H.R. 4461, the fiscal year 2001 Agriculture Appropriations bill. The provisions of this bill reflect the wrong priorities. The measure's total funding is $524 million less than it was last year. These cuts not only gravely impact the health of our children, but they also harm our environment.

Most importantly, the bill rejects funding for the Food and Drug Administration's tobacco program. Congress must give the FDA the authority to regulate tobacco. I have worked hard to protect our children from the dangers of tobacco, and I cannot support a bill that contains such an ill conceived provision.

In addition, the Agriculture Appropriations bill underfunds a number of important programs for children and families, the environment, and consumers. The Women, Infants and Children (WIC) program is cut substantially below the President's request. This essential program saves our most vulnerable children from disease and starvation by providing infants and children with nutritious food to help them thrive during critical years of development. Additionally, funding for state water quality grant programs received less than half of the requested funding level. Another underfunded program is the Food Safety Initiative, which would minimize contamination and ensure consumer food safety.

My Colleagues, it is up to us to make sure that programs that are important to the health and safety of the children and families we represent are safeguarded. The Agriculture Appropriations legislation has its priorities reversed. For that reason, I could not support H.R. 4461, the Fiscal Year 2001 Agriculture Appropriations bill in its current form.

LT. COMMANDER CHARLES A. SCHUE III RETIRES

HON. FRANK A. LoBIONDO

OF NEW JERSEY

IN THE HOUSE OF REPRESENTATIVES

Monday, July 24, 2000

Mr. LoBIONDO. Mr. Speaker, thank you for allowing me the opportunity to recognize the achievements of a great man, who, through his impressive leadership skills and dedication to both his country and the United States Coast Guard, has forever raised the bar of excellence for those who must follow in his footsteps.

July 21, 2000 marks the retirement of Lieutenant Commander Charles A. Schue, III, United States Coast Guard, as well as the Change of Command at the Coast Guard Loran Support Unit (LSU) in Wildwood, New Jersey. On July 21, 2000, Lieutenant Commander Schue will relinquish command of the unit he has so ably commanded for the last three years. He will then retire after more than 26 years of honorable and meritorious service with the United States Coast Guard.

After attending Coast Guard Boot Camp in Cape May, New Jersey, Lieutenant Commander Schue quickly rose through the enlisted ranks to become a Commissioned Warrant Officer in just 10 years. His tours of duty with the Coast Guard took him across the nation and the world, from Southern New Jersey to Alaska, from Marcus Island, Japan, to Monterey, California, and then, appropriately, back to Southern New Jersey. While serving on Long Range Aids to Navigation (LORAN) transmitter and control stations, Lieutenant Commander Schue helped provide vital radionavigation services to the United States and Asia.

Despite isolated tours of duty and numerous changes of duty stations, Lieutenant Commander Schue continued his professional growth and easily gained entrance to the Coast Guard Officer Candidate School. Not content to merely assume the trappings of being an officer, Lieutenant Commander Schue continued his professional growth, earning both a Master of Science Degree in Electrical Engineering from Naval Postgraduate School and a Master of Science Degree in Engineering Management from Western New England College. Lieutenant Commander Schue's superior engineering and leadership skills were formally recognized when he was named the Coast Guard's Engineer of the Year for 1999.

As Commanding Officer of the LSU, Lieutenant Commander Schue expertly led and motivated a team of office, enlisted, and civilian, and contractor personnel, which consistently produced results of the highest quality, as was highlighted when LSU received the Secretary of Transportation's Team Award for the Loran Consolidated Control System. Setting the standard for responsiveness, and using innovative engineering solutions despite the scarcity of parts and funding, he was instrumental in keeping 1960's and 1970's vintage Loran electronics equipment operational well beyond its planned lifecycle. The LSU's superb support of the $65.4 M North American Loran-C system resulted in a near 100 percent availability for this safety-of-life navigation system during his tour as the Commanding Officer.

Upon his retirement, his award citation from the Commandant of the Coast Guard noted that ''Lieutenant Commander Schue was the driving force behind the Loran Support Unit solidifying its position as the international leader in the Loran-C systems technology'' and further stated that ''Lieutenant Commander Schue's ability, diligence, and devotion to duty are most heartily commended and are in keeping with the highest traditions of the United States Coast Guard.''

I wish to extend my appreciation to Lieutenant Commander Schue for his service to the United States of America and I wish him, his wife Lori and their two children, Ian and Tia a wonderful future.

ON THE INTRODUCTION OF THE GERIATRIC WORKFORCE RELIEF ACT OF 2000

HON. GENE GREEN

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Monday, July 24, 2000

Mr. GREEN of Texas. Mr. Speaker, the complex health problems of aging require specially-trained physicians in order to adequately care for frail older persons. Geriatrics is the medical specialty that promotes wellness and preventive care; these specialists are first board certified in family practice, internal medicine or psychiatry and then complete additional years of fellowship training in geriatrics. With an emphasis on care management and coordination, geriatricians help patients maintain functional independence, thus improving their overall quality of life. An emphasis on coordination also limits unnecessary and costly hospitalization or institutionalization.

Despite the increasing number of Americans over age 65, there are fewer than 9,000 geriatricians in the United States today. In Texas, there are only about 225 geriatricians—and we are one of the top ten states nationally. Texas has four geriatric training programs; Baylor College of medicine in Houston, the University of Texas at San Antoino, the University of Texas Medical Branch at Galveston (where, I am proud to say, my daughter is a third-year student) and the University of Texas Southwestern.

The Baylor program, in my Congressional District, has been operating for over 15 years. It trains six fellows now and is unable to increase this number because of a Congressionally-mandated Graduate Medical Education (GME) cap. I am told that there are plenty of applicants interested in geriatrics who are being turned away because our Medicare program will not allow them to be funded.

Why is there a cap on the number of new geriatricians? The Balanced Budget Act of 1997 established a hospital-specific cap based upon the number of residents in the hospital in the most recent cost reporting period ending on or before December 31, 1996. Under the cap, the number of residents for direct graduate medical education payment purposes is based upon a three-year rolling average, except for Fiscal Year 1998, when a two-year average was used.

The implementation of this cap has adversely impacted geriatric programs in Houston and elsewhere. As geriatrics is a relatively new specialty, the cap has resulted in either the elimination or reduction of geriatric programs. Because a lower number of geriatric residents existed prior to December 31, 1996, these programs are under-represented in the cap baseline. Thus, new geriatric training programs are severely limited and existing training programs tend not to increase funding, or even decrease funding, for geriatric slots.

There is a well-documented shortage of geriatricians nationwide. Of the approximately 98,000 medical residency and fellowship positions supported by Medicare in 1998, only 324 were in geriatric medicine and geriatric psychiatry.

At the same time, the number of physicians needed to provide medical care for older persons has been estimated to be 2.5 to three time higher in 2030 compared to the mid-1980s, according to the federal Health Resources and Services Administration.

Unfortunately, the pace of training is not meeting this need. The actual number of certified geriatricians has declined, as approximately 50% of those who certified in 1988 did not recertify in 1998. This has occurred just as the baby boomers have started reaching the age of Medicare eligibility.

To correct this problem, I am introducing the Geriatric Workforce Relief Act of 2000 today to allow an increase in the number of person studying geriatrics at our medical schools. In order to be fiscally responsible, my legislation does not completely lift the cap. Instead, it allows hospitals to increase the cap by 30%. This will allow for a few more students at most programs. My legislation defines approved geriatric residency programs as those approved by the Accreditation Council of Graduate Medical Education.

My legislation, which will also be introduced in the Senate today by Senator REID, is modeled upon a similar provisions that was enacted last year for rural hospitals. It is a sensible and reasonable proposal and one that allows us to meet the needs of Medicare patients. I encourage my colleagues to support it.

HONORING ROBERT DOLSEN UPON HIS RETIREMENT AS THE EXECUTIVE DIRECTOR OF MICHIGAN'S REGION IV AREA AGENCY ON AGING

HON. FRED UPTON

OF MICHIGAN

IN THE HOUSE OF REPRESENTATIVES

Monday, July 24, 2000

Mr. UPTON. Mr. Speaker, I rise today to honor my friend, Robert Dolsen, upon his retirement after 26 years of dedicated service as the Executive Director of the Region IV Area Agency on Aging. Over the years, Bob has made a tremendous difference in the lives of thousands of elderly and their families in St. Joseph/Benton Harbor and surrounding communities. He has been a great community leader.

Bob established the Region IV Area Agency on Aging in 1974 as a small operation with a staff of four. Today, the Agency operates with a staff of 60 and a budget of over $10 million. Through the Agency, over 5,000 families are receiving the support services they need to maintain their independence through life's transitions and changes.

Bob has long recognized that one of the greatest challenges facing our community and our nation is the aging of our population and the need for long-term care services. He is providing great leadership on this issue. We are growing old—fast. Today, those 65 and over comprise 12 percent of our population. In just 30 years, those 65 and over will comprise nearly 20 percent of our population. One in five Americans will be a senior citizen. Rising to this challenge, Bob established the first demonstration project for Michigan's home-based long-term care system. It was successful and led to the State's initiation of a Medicaid waiver for home-based services and to the statewide replication of care management through Area Agencies on Aging.

Bob is recognized state-wide and nationally for his knowledge of aging issues, and especially long-term care. He has testified before Congressional committees on 9 different occasions, he is a frequent speaker and trainer at statewide and national conferences, and he was the 1992 recipient of the Harry J. Kelley Award from the Michigan Society of Gerontology for outstanding service in the development of policy and programs for older persons. He is a founding member of the Great Lakes Alliance, an interstate corporation to facilitate cooperation and communication on