CATASTROPHIC HEALTH COSTS: BROAD PROBLEM DEMANDING EQUALLY BROAD SOLUTION

JOINT HEARING

BEFORE THE

SELECT COMMITTEE ON AGING
HOUSE OF REPRESENTATIVES

AND THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

ONE HUNDREDTH CONGRESS

FIRST SESSION

JANUARY 28, 1987

Printed for the use of the House Select Committee on Aging and the Senate Special Committee on Aging

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House Select Committee on Aging
Pub. Nbr. 100-618

Senate Special Committee on Aging
Pub. Nbr. 100-2

U.S. GOVERNMENT PRINTING OFFICE

72-476 WASHINGTON : 1987

For sale by the Superintendent of Documents, Congressional Sales Office
U.S. Government Printing Office, Washington, DC 20402

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CATASTROPHIC HEALTH COSTS: BROAD PROBLEM DEMANDING EQUALLY BROAD SOLUTION

WEDNESDAY, JANUARY 28, 1987

HOUSE OF REPRESENTATIVES,
SELECT COMMITTEE ON AGING,
AND
SPECIAL COMMITTEE ON AGING,
U.S. SENATE,
Washington, DC.

The committees met, pursuant to notice, at 2:05 p.m., in Room 345, Longworth House Office Building, Hon. Edward R. Roybal (chairman of the House Select Committee on Aging), and Hon. John Melcher (chairman of the Senate Special Committee on Aging) co-chairmen.

Representatives present: Representatives Roybal, Pepper, Biaggi, Bonker, Florio, Hughes, Lloyd, Synar, Skelton, Borski, Erdreich, Sisisky, Wise, Volkmer, Robinson, Clarke, Kennedy, Slaughter, Rinaldo, Hammerschmidt, Regula, Jeffords, Tauke, Wortley, Schneider, Ridge, Christopher H. Smith, Boehlert, Saxton, Bentley, Lightfoot, Fawell, Swindall, and Schuette.

Senators present: Senators Melcher, Chafee, Heinz, Durenberger, Simpson, Cohen, Wilson, Reid, and Shelby.

Staff present, Select Committee on Aging: Fernando Torres-Gil, staff director; Gary Christopherson, director, health legislation; Nancy Smith, professional staff member; Austin Hogan, communications director; Judith Lee, deputy staff director; Carolyn Griffith, Diana Jones, and Eric Anderson, staff assistants; Mary Wunderlich, press assistant; Deborah Jay, intern; Tom Puglisi, congressional fellow; Marcy Cohen, intern; Mary Jo Rinker, detailee (EPA).

Staff present, Senate Special Committee on Aging: Max I. Richtman, staff director; Susan Beecher, Bill Benson, Chris Jennings, Brian Lindberg, Jim Michie, Dianna Porter, Annabelle Richards, professional staff members; Jennifer Bonney, Craig Obey, legislative correspondents; Sarah Dodge, press secretary.

OPENING STATEMENT OF CHAIRMAN EDWARD R. ROYBAL

Chairman ROYBAL. The committees will come to order.

The purpose of this hearing ladies and gentlemen, is to explore the issues of catastrophic health coverage, to hear from Dr. Bowen, the Secretary of Health and Human Services, about his catastrophic health plans, and to examine also the responsibilities that the Congress may have in responding to this important issue.

As we begin the 100th Congress' effort to protect America's families from the financial ruin of catastrophic health costs, our resolve is bolstered by the many tragic stories we have heard about the devastating personal impact of catastrophic health costs. These victims would be the first to agree that the first priority of this nation should be a Catastrophic Health Initiative, a so-called CHI. Today I am issuing an urgent call for such a Catastrophic Health Initiative.

We are here today because we deeply care that 37 million Americans are uninsured—they are uninsured against basic and catastrophic costs and because we deeply care that there are over 200 million Americans that are underinsured against catastrophic acute or long-term care costs. America's conscience, I believe, is at the crossroads. We either commit ourselves to alleviating catastrophic health costs for all Americans or we commit millions of Americans to go without critical health care and millions of Americans to financial ruin. I strongly believe that America's conscience will choose the course of protecting all Americans. That is why I introduced the "USHealth" legislation, which is H.R. 200, on the first day of the 100th Congress.

[H.R. 200 follows:]

EDWARD R. ROYBAL
Chairman, House Select Committee on Aging

THE "USHEALTH" PROGRAM ACT: AN AMERICAN HEALTHPLAN

(H.R. 200)

A Bill to Contain Health Care Costs,
Maintain Quality and Ensure Access for All Americans

PURPOSE

This legislation, introduced by Representative Edward R. Roybal, is designed to control health care costs for all Americans whether they be individuals, employers, or the government; to maintain health care quality for all providers and patients, and to ensure financial access to health care and prevent financial disaster resulting from catastrophic illnesses.

BACKGROUND

From 1980 through 1985, health care costs rose at an average rate of 12.1 percent, or 4.0 percent faster than the Gross National Product. Health care costs continue to rise and are likely to reach a level of 11.3 percent of GNP by 1990 and over 12 percent by the year 2000. At the same time, the elderly are paying more and more of their limited incomes for health care even with the help of Medicare and Medicaid. Out-of-pockets costs are estimated to be as high as 18.5 percent of the elderly's income by 1991 -- substantially more than when the Medicare and Medicaid programs began. On top of the elderly's growing financial burden and in spite of the enactment of Medicare and Medicaid, many poor and near poor (37 million) still face major access problems due to lack of insurance. Many more -- about 85 percent of Americans -- are underinsured against catastrophic acute or long term illness.

BILL OVERVIEW

The provisions of this bill establish the USHealth program in 1992 which is designed to contain costs while maintaining quality and ensuring access. Health care cost increases will more closely match the increase in per capita Gross National Product -- a level which approximates the Nation's ability to pay. The provisions to ensure financial access for all Americans, including the poor, the unemployed, the uninsured, and the elderly are financed through the savings generated by the cost containment provisions, extension of the Medicare payroll tax to all incomes, beneficiary cost-sharing, an employer tax, an expanded cigarette tax, State revenues, a premium paid by the elderly approximating the "Medicare Part B premium", and a surcharge on corporate and individual income taxes. The provisions to maintain quality include the active involvement of providers and consumers, Peer Review Organizations or qualified state quality assurance programs, a national Council on Quality Assurance, and the qualification of Health Maintenance Organizations.

BILL SUMMARY

The "USHealth Program Act" is designed to control health care costs for all Americans whether they be individuals, employers or government; to maintain health care quality for all providers and patients, and to ensure financial access to health care and prevent financial disaster resulting from catastrophic illness.

Cost Containment. The health care cost containment program covers all services and patients. In the short term, the cost containment provisions include paying all health care providers prospectively where payments are developed in consultation with providers. Future increases are limited to increases in the per capita GNP. States may set up alternative payment programs. In the long term, a major vehicle for containing costs is through HMOs.

Cost sharing of 20% for health and skilled long term care and 25% for non-skilled long term care is required, but only up to the catastrophic limits described below. Cost sharing is optional for those enrolled in qualified HMOs. The poor (under 100% poverty) and those spending down into poverty are exempt from any cost sharing which prevents access to needed care.

The ceiling on total U.S. health costs is 12 percent of GNP under USHealth.

Access. Financial access is ensured by making every citizen and resident eligible for "USHealth."

Benefits. Beneficiaries are protected from the cost of catastrophic illness. Their financial risk is limited to paying coinsurance as follows: a. up to a maximum $500/person/year, pays 20% of health care and skilled nursing home and home health costs, and b. up to a maximum $1,000/person/year, pays 25% of non-skilled long term care costs. Both "maximums" are indexed to per capita growth in GNP.

Basic health benefits (similar to Medicaid "categorically needy" package) include: inpatient and outpatient hospital services, physician services, rural health clinic services, laboratory, x-ray services, EPSDT (for those under age 21), family planning (individuals of child-bearing age), preventive care, prescription drugs, physical therapy, occupational therapy, medical equipment, prosthetic devices, orthopedic shoes, nursing home services, home health services, respite care, adult day health care, speech-language pathology, audiology, outpatient mental health care, inpatient psychiatric hospital services, basic dental care, vision care and other medical or remedial care recognized under State law and specified by USHealth.

Quality. The current federal quality assurance system of Peer Review Organizations (PRO) is upgraded to place at least as much emphasis on quality assurance as on cost containment, cover all health care providers and consumers, cover all health services (hospital, physician, nursing home, home health), set up a national Council on Quality Assurance, add Consumer Boards to PROs, establish a patient bill of rights and create an ombudsman program. States have the option to develop their own qualified quality assurance system. Quality assurance is also addressed by federal HMO qualification.

Administration. The program is entitled **"USHealth"** and managed by the USHealth Administration (currently, Health Care Financing Administration) which is independent and off-budget. Most bill processing and review will be provided through contracts with private insurance companies.

Financing. Health care cost increases will closely match increases in per capita GNP -- approximating the Nation's ability to pay. The provisions to ensure financial access for all Americans are financed as follows: the savings generated by indexed prospective payment and capitation, beneficiary cost-sharing, an expanded cigarette tax, extension of the Medicare payroll tax to all incomes, a premium paid by the elderly (approximating the "Part B premium"), an employer tax based on compensation, State revenues covering 1/2 the cost of the poor, and a surcharge on corporate and individual income taxes sufficient for solvency of USHealth.

THE "USHEALTH" PROGRAM ACT -- BILL DESCRIPTION

In attempt to deal with the problems facing the American health care system, a series of changes are proposed. The provisions of this bill, if enacted, establish the USHealth program which contains health care costs for the federal government, States, employers, and consumers; improves financial access to needed services; helps maintain quality; and increases equity among health care providers and payers.

SECTION I: COST CONTAINMENT

This bill incorporates a series of cost containment measures. Greater incentives are provided for Health Maintenance Organizations. States are encouraged to implement state-wide cost containments programs as long as they perform as well as the federal program.

Health Maintenance Organizations

Medical care costs are contained through greater incentives for Health Maintenance Organization (HMO) development in general. The payment for HMOs is raised from the 95 percent of the Average Area Per Capita rate (AAPC) to 100 percent of AAPC as of 1992. The federal government initiates a national campaign to encourage beneficiaries to enroll in qualified HMOs. Employers are encouraged to encourage their employees to enroll in HMOs.

Federal and State Cost Containment Programs

The federal health care cost containment program includes all services and patients. The cost containment provisions take effect in 1992 and include the following:

- Inpatient hospital care is paid on the basis of Medicare's prospective payment system using the Diagnostic Related Groupings and adjusted for population differences (for example, based on a case severity or complexity index). Future payment increases are limited to increases in per capita Gross National Product.*
- Physician, nursing home, home health, hospice, ancillary and all other covered health services (including prescription drugs) are paid on the basis of a prospectively set, fixed fee developed in consultation with health care providers and adjusted for differences in patient population, service type, and input prices. Future payment increases are limited to increases in per capita Gross National Product.

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* Index is based on a 3-year moving average of increases in per capita Gross National Product.

- Exceptions to this payment system include payments to qualified Health Maintenance Organizations and payments in States with an approved state-sponsored cost containment program. Future payment increases for Health Maintenance Organizations and state-sponsored cost containment programs are also limited in effect to increases in per capita Gross National Product.
- Utilization review of all health and long term care services is conducted by the Peer Review Organizations and by insurance companies functioning as intermediaries/carriers. Intermediary/carrier review is strengthened to better control changes in bill practices, service delivery and service intensity.
- Payments to all providers are to be adjusted as necessary to ensure reasonable availability of health care services in rural areas, central city areas and for other "special need" areas or populations.
- The USHealth Board makes other adjustments in provider payments as necessary to maintain total program costs under 12 percent while ensuring that benefits are not reduced and out-of-pocket costs are not increased more than under current USHealth Program law.

States have the option to be exempt from the federal system and to implement their own alternative payment programs. In order to qualify for the exemption, the state program must meet or exceed the cost containment targets entailed in this bill and maintain access and quality equal to or exceeding the levels resulting from this bill. The alternative payment system must be mandatory for and equitably treat all types of providers covered under the State system.

For each State wishing to develop acceptable alternative payment programs, the federal government provides a three year development grant totaling between $1 million and $3 million. Those States with acceptable programs are eligible to have up to 50 percent of the savings (as compared to what would have paid under this amended law) added to reduce the state payment for the poor beginning in 1992. No additional state funds are needed to match this latter allocation.

Catastrophic Protection and Beneficiary Cost Sharing.

Beneficiaries are protected from the cost of catastrophic illness but are required to pay coinsurance as follows:

a. 20 percent of health care and skilled nursing home and home health costs up to a maximum of $500 per person per year (indexed to per capita GNP), and

b. 25 percent of non-skilled long term costs up to a maximum of $1,000 per person per year (indexed to per capita GNP).

Coinsurance payments are made directly to the Trust Fund. The above coinsurance provision is waived for individuals in families with incomes under the poverty level and for individuals whose health care costs require the family to spend down below the poverty level. However, a small copayment may be charged to the poor as long as it does not prevent access to needed health care.

SECTION II: INSURANCE SYSTEM

A. USHEALTH PROGRAM:

The following reforms take effect in 1992.

Administration:

Overall administration is by the federal government's USHealth Administration (currently, the Health Care Financing Administration) which is both off-budget and operates as an independent agency.

USHealth is overseen by the USHealth Board. The Health Board has responsibility for and control over the program subject to the law, or subsequent changes in the law, establishing the USHealth program. The Administrator of the USHealth Administration reports to the USHealth Health Board. Within the USHealth Administration, an Ombudsman office is established to represent beneficiary interests and help resolve beneficiary problems. The Administrator and the Health Board members are appointed by the President with the consent of the Senate.

Eligibility:

All U.S. citizens and residents are eligible for the USHealth program.

Financing:

Financing comes from several sources as outlined in Section V, "Financing of USHealth."

Benefits:

Beginning in 1992, the basic health benefits package, for all enrollees, are similar to Medicaid "categorically needy" package and include the following: inpatient hospital services, outpatient hospital services, physician services, rural health clinic services, laboratory, x-ray services, EPSDT (for those under age 21), family planning (individuals of child-bearing age), preventive care, prescription drugs, physical therapy, occupational therapy, prosthetic devices, orthopedic shoes, nursing home services, home health services (including homemaker/home

health aide services when part of physician plan of care and essential to person being maintained in the home), respite care, adult day health care (when part of physician plan of care and essential to person being maintained in the home), inpatient psychiatric hospital services, outpatient rehabilitation, hospice, alcohol and drug abuse rehabilitation, outpatient mental health (including community mental health centers), speech-language pathology, audiology, and other medical or remedial care recognized under State law and specified by the USHealth program. Dental (including dentures) and eyeglasses are added before the year 2000 unless total USHealth expenditures would exceed 12 percent of GNP.

More specifically, long term care (LTC) benefits are covered. Full coverage is provided with the co-payments made to the Trust Fund. The co-payment is waived for low income and for spend-down individuals. As part of the long term care benefit package, incentives are to be developed to encourage families to keep a LTC family member in their home. Strong utilization review is instituted by PROs and intermediaries/carriers to control costs.

For mental health services, the USHealth Board is to replace the current (Medicare) mental health limits on annual payments and covered days with an alternative system which better ensures access but contains costs.

Beneficiaries are protected from the cost of catastrophic illness but are required to pay coinsurance as follows:

a. up to a maximum of $500 per person per year (indexed to per capita GNP) for health care and skilled nursing home and home health costs, and
b. up to a maximum of $1,000 per person per year (indexed to per capita GNP) for non-skilled long term care costs.

Payments

Beginning in 1992, inpatient hospital care is paid using Medicare's prospective payment system using the Diagnostic Related Groupings and adjusted for population differences (for example, based on a case severity or complexity index). Future hospital prospective payment rate increases are limited to increases in per capita Gross National Product as described in the cost containment section above. Capital is no longer allowed as a pass-through and is added to the DRG payment. The adjustment to a particular DRG payment reflects the amount of capital required for that DRG. The mean ratio of total capital outlays to total non-capital DRG payments is not to exceed the mean ratio for the most recent three years.

Beginning in 1992, a fixed, prospective fee schedule is used to pay all providers in full for all non-hospital services (including physician, nursing home, home health, drugs, laboratory). The fee schedule is developed by the USHealth Administration in consultation with the respective provider organizations and consumer groups. In designing the fee schedule, adjustments should be made for differences in resource inputs and input prices. For example, physician payments should address current inequities among geographic areas, physician specialties, and types of service. To the extent possible and appropriate, the fee schedule should reward higher quality providers. For comparison purposes, the mean weighted fee cannot exceed the mean fee for a similar service paid under the current Medicare system as amended by this Act. Except for adjustments to reflect service delivery changes, future fee increases are limited to no more than increases in per capita Gross National Product. Such increases may be adjusted to reflect changes in service delivery and billing practices.

Beginning in 1992, the payment for HMOs is raised from 95 percent of the Average Area Per Capita rate (AAPC) to 100 percent of AAPC. The AAPC is adjusted by age, sex, enrollee type, and appropriate health status factors. (The federal government initiates a national campaign to encourage beneficiaries to enroll in qualified HMOs.)

Subject to guidelines established by the USHealth Board, all licensed individual health care practitioners may be reimbursed as health care providers.

Beginning in 1992, the approved health care provider fee is full payment.

Medical education is paid on the same basis as under current Medicare law.

This provision does not apply in States with federally qualified alternative payment programs.

The USHealth Board makes other adjustments in provider payments as necessary to maintain total program costs under 12 percent while ensuring that benefits are not reduced and out-of-pocket costs are not increased more than under current USHealth Program law.

The USHealth Board is responsible for conducting an education program for health care consumers and providers on the importance of holding down health care costs.

Delivery System:

HMOs are major providers of health care for beneficiaries. The USHealth Administration shall require participating HMOs (including HMOs, CMPs, and IPAs) to be qualified as specified under Title XIII of the Public Health Service Act beginning in 1992. HMOs must continue to be qualified on an annual basis. HMOs shall be penalized or removed from the program when they no longer meet the HMO qualification standards. The Office of Health Maintenance Organization's cost for carrying out the ongoing qualification process is covered by the Trust Fund. Quality assurance review for HMOs will be conducted by the Peer Review Organizations conducting review on non-HMO services.

Beneficiary Information:

Publications are provided which give side-by-side comparisons of HMOs in each area of the country. The use of HMOs is promoted, including the provision of a comparison of HMOs with the non-HMO providers in terms of quality assurance, covered services, and out-of-pocket costs to the elderly and disabled. (Information on the quality assurance system and the availability of a consumer hot-line are described in the quality assurance section.)

B. MEDICARE AND MEDICAID:

USHealth replaces the current Medicare and Medicaid programs and is built upon those two programs. All Medicare and Medicaid beneficiaries are entitled to enroll in USHealth.

C. PRIVATE INSURANCE:

The only private insurance which remains would be for benefits beyond those provided in USHealth. Any costs would not qualify for a tax deduction either for employers or for individuals.

Insurance companies are permitted and encouraged to perform intermediary/carrier functions under contract to the USHealth Trust Fund.

SECTION III: DELIVERY SYSTEM

As described above, Health Maintenance Organizations (HMOs) and similar delivery systems are to become a major vehicle for delivering health and continuing care services in the long term. This includes future delivery systems which differ from the current definition of HMOs but are initially and continuously qualified by the USHealth Administration, provide the full range of benefits, and perform as effectively in terms of quality, access, cost to the consumer, cost to the respective third party payer, and covered services.

Campaign to Promote HMOs

The federal government is to conduct a national media campaign to encourage the development of and enrollment in HMOs.

Financial Incentives for HMOs

This bill improves the HMOs' financial position relative to other delivery approaches by raising the payment rate to 100 percent of the Average Area Per Capita rate by 1992.

SECTION IV: QUALITY ASSURANCE SYSTEM:

The current Medicare quality assurance (QA) system of Peer Review Organizations is upgraded to cover all medical services (inpatient and outpatient) for all patients and all providers and to place at least as much emphasis on quality assurance as on cost containment. Most provisions are to be phased in as of January 1, 1991. A State has the option to obtain a waiver from this requirement if it establishes its own plan of quality assurance and as long as it provides at least the same level of protection as the amended federal plan.

Increased Emphasis on Quality Assurance:

This bill requires DHHS and, subsequently, the USHealth Administration to award, administer, and evaluate its PRO contracts under the stipulation that at least one-half of the PROs' level of effort is for the purpose of quality assurance as of January 1, 1991.

Extension to All Patients and Payers:

This bill requires the DHHS and, subsequently, the USHealth Administration and its contract PROs to conduct quality assurance for all patients.

Extension to All Medical Services:

This bill requires the DHHS, and, subsequently, the USHealth Administration and its contract PROs to conduct quality assurance activities on all medical providers including hospitals, physician offices, nursing homes, home health agencies, hospices and HMOs and other alternative delivery systems. The level of PRO effort expended on each type of provider reflects the proportion of national health care expenditures for this type of provider and the need for review. Similarly, membership on the PRO governing body and its composition reflect the range of health care providers reviewed by the PRO.

Hospital Discharge Planning:

This bill sets guidelines for discharge planning to protect against inappropriate discharges and to ensure a smooth and timely transition to post-hospital care. It also requires that hospitals have in place a discharge planning process that begins as close to the time of hospital admission as appropriate and that alerts nursing home and home health providers of a patient's anticipated need for post-hospital care at the earliest possible time.

Quality Assurance "Hot-line":

This bill requires PROs to have a 7-day-a-week hot-line for receiving questions and complaints from health care providers, consumers, and interested parties concerning health care quality problems. PROs are required to assist in the resolution of any legitimate quality related problems. The USHealth Administration, in coordination with each PRO, shall provide beneficiaries with the hot-line number for their PRO in a way that can be easily attached to their USHealth cards. The PRO hot-line is coordinated with the hot-lines operated by the Ombudsman program and any State quality assurance programs.

Home Care Quality Assurance Standards:
This bill sets home care quality assurance standards and requires compliance as a condition of participation under USHealth.

Plans of Care:
This bill requires that health and home care agencies have plan of care policies which identify services to be provided, provide a means for identifying additional client needs and include coordination mechanisms with other service agencies.

Health and Long Term Care Ombudsman:
This bill establishes a Health and Long Term Care Ombudsman Program to investigate and resolve health and long term care provider service complaints and to provide information on health and long term care provider services. The Ombudsman hot-line is coordinated with the hot-lines operated by the PRO and any State quality assurance programs.

Patient Bill of Rights:
This bill establishes a federal bill of rights for health care consumers under USHealth.

Local Consumer Board:
This bill requires each PRO to have a Consumer Board (CB) which conducts ongoing oversight of the PROs, provides input into the award and evaluation of PRO contracts, and can receive input from Medicare beneficiaries and other interested parties. The CB and the PRO are responsible for educating consumers on quality assurance and on the availability of assistance from the PRO and other agencies. The PRO makes available to the CB such information and staff as are necessary to carry out the CB function. This does not include information where either the individual health care provider or consumer can be identified.

The CB is required to prepare an annual report on the PRO's performance and submit that report to the respective Governor(s), to the national Council on Quality Assurance, and to DHHS and, subsequently, the USHealth Administration. CB input is to be utilized in decisions to award PRO contracts.

The CB consists of 5-7 volunteer members appointed by the respective Governor of the State covered by the PRO and representing organizations of the elderly, the disabled, the poor and other consumers.

In addition to the CB, each PRO has at least one health care consumer, who is not a health care provider, on its Board of Directors.

National Council on Quality Assurance:
This bill establishes a national Council on Quality Assurance (CQA) to provide oversight on the operations of the quality assurance system and make recommendations to DHHS and, subsequently, the USHealth Administration, and to the Congress for its improvement. Its oversight function includes the review of the administration of quality assurance, the overall performance of the PROs and waivered state plans, reports of the Consumer Boards, quality assurance studies and methodologies developed by DHHS, the USHealth Administration and others, the data needs of the PROs and input from interested parties.

DHHS and, subsequently, the USHealth Administration are required to provide such information as is needed by CQA to carry out its responsibilities. Based upon these reviews, the Council is to make recommendations annually for improving quality assurance to DHHS and, subsequently, the USHealth Administration, and to the Congress. DHHS and, subsequently, the USHealth Administration are required to take into account CQA input in its administration of the PRO program.

The Congressional Office of Technology Assessment (OTA) will provide for the appointment of the fifteen member Council consisting of equal numbers of health care providers, health care consumers, and experts in quality assurance. Subject to the review by OTA, the Council may employ staff as necessary to carry out these functions.

Studies and Reports:
The USHealth Administration shall prepare an annual report which assesses the performance of the quality assurance system and addresses the recommendations of the CQA and the concerns and recommendations of the CBs. DHHS and, subsequently, the USHealth Administration shall analyze the impact which the federal cost containment system, limitations on health care provider payments, and Health Maintenance Organizations have had on health care quality, access and beneficiary cost and submit an annual report to Congress. The USHealth Administration shall conduct studies on and develop improved methodologies for quality assessment and assurance for health care services including hospital, physician, nursing home, home health services, and hospice services. The USHealth Administration shall submit an annual report to Congress on the progress toward developing such methodologies.

Sanctions:
This bill requires that sanctions, including intermediate sanctions (e.g., civil penalties), be available to ensure compliance with quality assurance standards.

Financing:
As compared to current law and adjusted for inflation, the funding level for the PRO program is increased by 50 percent in FY 1992 (first year of implementation), by 65 percent in FY 1993, and by 75 percent in FY 1994 and in subsequent years. The funding for the CQA and

the PROs program will be made from the Trust Fund. For those States with their own federally qualified quality assurance plans, the USHealth Administration is authorized to make available funds up to the amount that would have gone to the respective PRO as authorized above.

Funding for the Health and Long Term Care Ombudsman is authorized at $50,000,000 for 1992. In each subsequent year, the amount will be the previous year's authorization increased to reflect increases in per capita GNP.

SECTION V: FINANCING OF THE USHEALTH PROGRAM

Much of the long term cost of expanding access and reducing costs for all beneficiaries comes from reducing health care cost inflation for all payers and all health care providers.

- Health care cost savings are expanded by holding cost increases down to per capita growth in GNP and by controlling utilization.
- Beneficiary cost-sharing applies to all services (but is limited by the catastrophic provisions).

In order to finance the USHealth program and to provide an orderly transition from the current system of financing health care, USHealth is financed through the following revenue sources:

- A premium approximating the cost of the "Medicare Part B premium payment" is charged to people over the age of 65. This premium may be waived for elderly with incomes under the poverty level.
- Employers pay a tax based on a percentage of employee compensation. The basis for setting that percentage is the aggregate amount which employers are paying under the current system for employee and retiree health benefits in 1990.
- The cigarette excise tax is raised by 16¢ and indexed to per capita GNP.
  The "Medicare payroll tax" is expanded to cover all income levels.
  States provide revenues equal on average to 1/2 cost of the poor (i.e., everyone under poverty level). Payment formula is as follows: (total cost of poor) X 1/2 X (State population / US population) X (State per capita income / National per capita income).
- An earmarked surcharge on all corporate and personal income taxes is made which equals the amount necessary to maintain the solvency of the USHealth Trust Fund. (Financing formula: Total USHealth expenditures minus cost sharing minus cost savings minus State share minus cigarette add-on minus the "Medicare payroll tax" minus the employer tax minus other revenue additions = Net revenue required from an X% surcharge on federal corporate and individual income tax.)
- Revenues are placed in the USHealth Trust Fund which is off-budget.
- Within 6 years, the Trust Fund should have an appropriate reserve for contingencies.

The USHealth Administration shall conduct studies of the USHealth financing system to determine if those with the ability to pay are paying at least the average cost of care for a USHealth beneficiary and, depending on the results, to recommend appropriate financing policy changes.

For more information on the "USHealth" Program Act, contact the House Select Committee on Aging (202-226-3375), Room 712, Annex I, Washington, D.C. 20515.

Chairman ROYBAL. While I believe that we have arrived at a consensus on the breadth of the catastrophic health cost problem, I also believe that we have a long way to go before we arrive at a consensus on the breadth of the solution. Though negotiations between Congress and the Administration will be difficult, we can and we must arrive at a consensus that protects both those Americans who are uninsured and those Americans who are underinsured. We are committed to a Catastrophic Health Initiative. We hope that the President is equally committed.

We believe, Mr. Secretary, that you are strongly committed. Your appearance here and your advocacy on behalf of all uninsured and underinsured Americans attest to your personal commitment and courage. I would like to, therefore, welcome you before these committees.

But before we proceed, I would like to take this opportunity to recognize two people who are in our audience and have a special perspective on the issue of catastrophic health costs; that is, Joyce Gordon and Carol Brock. Will those two ladies please stand just momentarily?

These are two courageous people whose families have personally felt the double catastrophic of major illness and huge health costs, but they are only two of millions. I want to personally thank them for being with us today.

Ms. Gordon is the mother of a 17-year-old child with a disabling brain injury. The Gordons choose to care for their daughter, Karen, at home rather than place her in a nursing home. They were told by Karen's doctor that her recovery would be slow and deliberate and could take as long as two years. Yet, the insurance companies terminated payment for costly hospitalization and follow-up care after five months because they judged her daughter as not making enough progress in recovery. To continue treatment, the Gordons have had to bear much of the cost of Karen's treatment.

Despite the fact that the Gordon's have always regarded themselves as middle class, they now view themselves as among the growing number of underinsured and continue to struggle with the financial as well as the emotional burden of Karen's care.

For the past six years, Mrs. Brock has cared for her elderly mother (Mrs. Bryan), a victim of Alzheimer's disease, and has borne the burden and cost of her mother's home and nursing home care. Since October, Mrs. Bryan has been hospitalized twice—and is currently in the hospital with a broken hip.

What Carol Brock and her husband face is a double catastrophe in attending to her mother's acute and long term care needs. On the acute side, Medicare will cover much of the hospital costs they face but will not pay for the post-hospital care and equipment Mrs. Bryan will need because she is not considered to have "rehabilitation" potential. Looking on the long term side, the picture is even more bleak. Although Mrs. Bryan receives monthly retirement and Social Security checks, her total income is not sufficient to cover the cost of extended home or nursing home care. Yet, she has been found ineligible for Medicaid assistance because of a home she owns but cannot sell in her disabled state. This Catch 22 has put the Brock's in the sad situation of having to pay for Mrs. Bryan's care at the expense of their children's education. In Mrs. Brock's

words, "We're having to ransom the futures of our seven children in order to provide my mother with the care she needs."

Out of choice and economic necessity, the Brocks—who must both stay fully employed to make ends meet—will continue to bear the burden and the cost of her mother's care at home once she is discharged. What angers Mrs. Brock the most is the fact that Medicare will pay over $1,000 per day to keep her mother in a hospital bed, but neither Medicare or Medicaid will pay a cent to keep her at home at less than half the cost.

This afternoon we are going to be rather limited in time, and I would like to be sure that every member of both committees is given ample time to ask questions. I would like to welcome the participation of the Senate Special Committee on Aging. Senator Melcher, chairman of the Senate Special Committee on Aging, here with us, as is Senator Heinz, the former chairman. There will be other Senators that will be coming in to also listen and to ask questions.

But in so doing, we are going to try to observe the 5-minute rule. Each one will ask questions when the time comes, and we hope that the question and the answer will not go beyond the 5 minutes. It is my understanding that Dr. Bowen will greatly appreciate it if we don't go on and on, his time being limited due to the fact that he has presented testimony practically all day today. So we hope that we can get Dr. Bowen out anywhere between an hour and a half and two hours; that is at least our goal.

[The prepared statement of Chairman Roybal follows:]

PREPARED STATEMENT OF CHAIRMAN EDWARD R. ROYBAL

As we begin the 100th Congress' effort to protect America's families from the financial ruin of catastrophic health costs, our resolve is bolstered by the many tragic stories we have heard. People like Newton Gann, Elsie Parsons, Joyce Gordon, Jim Strong, Maria O'Brien and Dr. Albert Sabin are not all well-known, but they all share a common concern -- **the devastating personal impact of catastrophic health costs.**

For several years, people such as these have come before my Committee. They have pleaded for Congress and the President to wake up and have the compassion and political will to put a stop to this financial devastation. **They would be the first to agree that the first priority of this nation should be a "Catastrophic Health Initiative", a so-called C-H-I. Today I am issuing an urgent call for such a "Catastrophic Health Initiative."**

America's **conscience is at the crossroads.** We either commit ourselves to alleviating catastrophic health costs for all Americans or we have committed millions of Americans to go without critical health care and millions of Americans to financial ruin. I strongly believe that America's conscience will choose the course of protecting all Americans. **That is why I introduced the "USHealth" legislation (H.R. 200) on the first day of the 100th Congress.**

On behalf of the millions of uninsured and underinsured Americans who can't be with us today, let me state why we are here. We are here because we deeply care that **37 million Americans are uninsured** against basic or catastrophic health costs. We are here because we deeply care that over **200 million Americans are underinsured** against catastrophic acute and long term care costs. We care so deeply that we will no longer tolerate inaction. Neither will the American people.

While I believe that we have arrived at a consensus on the breadth of the catastrophic health cost problem, I also believe that we have a long way to go before we arrive at a consensus on the breadth of the solution. Though negotiations between Congress and the Administration will be difficult, **we can and we must arrive at a consensus that protects both those Americans who are uninsured and those Americans who are underinsured against catastrophic acute and long term care costs.**

Rest assured that I and these two Committees are committed to alleviating the burden for all Americans. One need only note that it was this commitment that brought about this first joint hearing between my House Committee and Senator Melcher's Senate Committee.

We are committed to a **"Catastrophic Health Initiative."** We hope that the President is equally committed. We believe that his Health and Human Services Secretary, Dr. Otis Bowen, is strongly committed. **His appearance here and his advocacy on behalf of all uninsured and underinsured Americans attest to his personal commitment and courage.**

Today, we will receive testimony from Secretary Bowen. Our role is to carefully examine the Administration's catastrophic health proposal and assess its adequacy for all Americans.

PURPOSE: The Senate Special and House Select Committees on Aging are conducting a joint hearing on the President's plan for catastrophic health care. The purpose of the hearing is to examine the breadth of the catastrophic health problem and the adequacy of the position adopted by the President. **Health and Human Services Secretary Otis Bowen will be the Committees' only witness.**

BACKGROUND: Over the past year, a consensus seems to have emerged on the part of the public, the Congress and the Administration on the serious problem of un- and underinsured Americans. An estimated 37 million Americans are uninsured -- lacking even basic health care coverage. A total of 200 million people, over 85% of the American public, are underinsured when it comes to coverage for catastrophic acute and long term care. Concern for these millions of Americans is at the heart of what has become characterized as the "catastrophic health debate." While there is agreement on the breadth of the problem, there is not agreement on the solution -- a question under considerable debate.

Proposed solutions include DHHS Secretary Otis Bowen's own catastrophic health proposal that, along with alternatives submitted by the Council of Economic Advisors, has been under review by the President. Bowen's plan calls for what, essentially, is an optional public "medigap" program for acute hospital and post-hospital care financed by monthly premiums and covering Medicare deductibles and coinsurance rates after the first $2,000. These costs are now being payed by Medicare beneficiaries out-of-pocket or under private medigap insurance policies. On the long term care side, the Bowen proposal supports private rather than public financing options by providing incentives for personal savings and private long term care insurance. Other, legislative proposals have been offered that range from totally private approaches, to combined public and private options, to comprehensive systems of public protection against the costs of catastrophic acute and long term care.

FACTS - THE BREADTH OF THE PROBLEM

* **Over 200 million Americans** are either uninsured or underinsured against catastrophic acute or long term care costs. (Source: House Select Committee on Aging, 1986.)

* **Over 37 million persons** are uninsured for even basic health care. (Source: Census/Urban Institute, 1986.)

* **The vast majority of Americans** are underinsured for long term care costs. About 13% are underinsured for acute care. (Source: House Select Committee on Aging, National Center for Health Services Research.)

* **Over 17% of persons** under age 65 are uninsured. (Source: Census, 1986.)

* According to a 1982 study, **nearly 50% of the poor** are without any public or private health insurance. (Source: T. Joe, J. Meltzer, P. Yu, Health Affairs, Spring, 1985.)

* **The elderly will pay as much as 18.5% for their income** on health care by 1991, up from a 1977 level of 12.3%, and up from the level of 15% when Medicare and Medicaid began. (Source: House Select Committee on Aging, 1986.)

* A recent survey found that **2 out of 3 persons age 66 years and older** living alone would become **impoverished after just 13 weeks** in a nursing home. (Source: 1985 study by Harvard and Blue Cross/Blue Shield of Massachusetts for the House Select Committee on Aging.)

* **Up to 10 percent of all families** face health costs in **excess of 10 percent of their income.** (Source: National Center for Health Services Research.)

* **Only 28% of poor elderly** living alone receive some Medicaid assistance. Nearly **1 out of 3 have no other insurance protection** than Medicare. (Source: Louis Harris and Associates, Inc., 1986.)

* Even if private long term care insurance were readily available, **less than half of all elderly would be served by such policies and only 5% of Medicaid expenditures would be offset** by the year 2020. (Source: Preliminary findings, Brookings Institute, presented at Gerontological Society Meetings, 1986.)

* **Nearly 65% of the uninsured are employed adults** or their dependents. (Source: American Hospital Association.)

* **One million families** have at least one family member who was refused care because of inadequate funds. (Source: RWJ Foundation, 1982.)

* **Over 8% of all families** in 1983 did not obtain needed medical care for financial reasons. (Source: Louis Harris and Associates, Inc.)

* The proportion of **low-income Americans covered by Medicaid fell from 63% to 46%** between 1975 and 1983 due to changes in eligibility requirements. (Source: New England Journal of Medicine, May, 1986.)

* **Per capita health care costs** are projected to grow at **8.0% annually** between 1985 and 1990 while the costs of other goods will grow at only 4.8%. (Source: Health Care Financing Review, Spring, 1986.)

* The cut-off income level for **Medicaid eligibility fell below 55% of the federal poverty** threshold in 23 states in 1984. (Source: Business and Health, September, 1984.)

* **Nearly 80%** of older persons surveyed in 1986 were under the false impression that Medicare covers long term care. (Source: AARP.)

* On average, an older person or their family would need **$500,000 in assets producing about $40,000 a year** to cover nursing home bills. (Source: Business Week, March, 1985.)

Chairman ROYBAL. The Chair now recognizes Chairman Melcher, and he, in turn, will introduce his ranking minority member, Senator Heinz.

STATEMENT OF CHAIRMAN JOHN MELCHER

Chairman MELCHER. Thank you very much, Chairman Roybal. We are very pleased to have this joint hearing with you on what, I think, is perhaps the number 1 concern of the elderly. I believe without a doubt, that the biggest problem the elderly have is health care and how to pay for it, and that is a pretty big problem. On top of all of that is the fear that somehow the protection that they have through Medicare and whatever insurance policy they may have—to supplement Medicare—will run out and still all of the bills will not be paid. They live in that fear, and that is exactly why we are here today. We are attempting to remove or minimize the fear of the elderly, of not having catastrophic protection. We want to remove that from their minds.

Dr. Bowen, I am very pleased that you have broken the ice and have made your proposal for Catastrophic. The President last night, in his State of the Union message, stated that he was in favor of a bill. But whatever difference there might be in his bill as compared to your proposal is a little bit secondary to what we are about today. What we are about here today is to establish a beginning of congressional action on developing a bill to go as far as we can to cover Catastrophic for the elderly. I think it is a day we have long waited for. I think it is a good day for a start.

How far we will get we can't say today. But I want to assure the elderly we will go just as far as possible in this Congress to remove that fear. The fear of not being covered by health protection when Catastrophic strikes them, and the fear that in order to get long-term health care or whatever it takes to protect them that they would have to go broke, lose all their savings and go on welfare. That is not a very happy state to be in; but yet, that is the condition that the elderly are facing right now.

So I think our task is a real challenge. I welcome the opportunity to accept that challenge and to do what we can as quickly as possible.

Thank you very much, Mr. Chairman.

[The prepared statement of Chairman Melcher follows:]

PREPARED STATEMENT OF SENATOR JOHN MELCHER

Today, the House and the Senate have come together to hear from Otis Bowen, M.D., Secretary of the Department of Health and Human Services, about his proposals to remedy the frequent tragedy of costly catastophic illness. I welcome Dr. Bowen and congratulate him for taking a lead role in this debate through his report to the President on Catastrophic Illness Expenses. I am very pleased to join with the Chairman of the House Select Committee on Aging, Congressman Edward Roybal, and the members of our two Committess in conducting this important joint hearing. I hope this hearing is the first of many joint efforts between our two committees.

One of the newest buzz words on the hill is "catastrophic care." As Chairman of the Senate Special Committee on Aging, I intend to do more than just talk. In order to ensure that this issue is a top priority of the 100th Congress, I plan to rivet the attention of America on this tragedy that consumes the resources and dignity of many people, young and old alike.

For years, the Congress, the Administration, and the press, have simply blinked their eyes at the picture of financial and emotional devastation which reflects the lives of those who suffer from the extraordinary costs of catastrophic illness. While we can turn away from this awful picture, there is no turning away for the victims of catastrophic illness and their families.

On Monday, three impressive women testified before the Senate Committee on Aging about their experience when a loved one needs extended and costly medical care. Their stories cut across this country, to the core of what makes America great -- independence and pride. We heard these hard working, honest Americans talk about their day to day struggle to make ends meet. They're in a mess not because they didn't plan for the future or because they didn't pay their fair share, but only because they ran into the "double whammy" of poor health and costly care.

For example, we heard from Mrs. Edith Rieger, of Alva,

Oklahoma who, at age sixty-eight, has taken a job laboring as a cook. She now works fifty hours a week, so she can pay the medical expenses of her eighty-three year old husband. To save more money for her husband's care, Mrs. Reiger has not obtained necessary treatment for the torn cartlidge in her knee, nor does she take medication for her high blood pressure.

During the first week of the 100th Congress, Senator Kennedy and I introduced S. 210, which includes part of the Secretary's proposal. In return for a monthly premium of about five dollars, our legislation would place an annual out-of-pocket limit of $2,000 for all Medicare deductibles and coinsurance. I intend to use S. 210 as a starting point for dealing with the real catastrophic costs of nursing home care, home health, and prescription drugs, and other forms of essential care. The big gap in care is long-term health coverage and when the elderly run out of savings their only alternative is welfare. That is their big fear and it is degrading.

I am pleased that you favor doing something, Dr. Bowen, but the White House is dragging its feet. The President's budget does not include any of your catastrophic cost proposals, but instead includes proposals to increase the burden on older Americans.

For example, the Medicare budget proposal includes increases in the Part B deductible and co-insurance paid by Medicare beneficiaries. Further, the budget proposes to delay Medicare eligibility at age 65 for one month, leaving at least 10% of new beneficiaries without coverage. It appears that the Administration is still opening new gaps in health coverage for elders.

Medicare was enacted to provide adequate medical care for the elderly and the handicapped with some protection against financial ruin. Yet, older Americans are spending the same percentage or more of their income on health care today than they did over twenty years ago when Medicare was established.

Between 1980 and 1984, Medicare beneficiaries saw an enormous rise, 18 percent annually, in doctors' fees alone. Fewer doctors today are accepting assignment -- that is, the doctor's fee judged to be "usual, customary and reasonable" by Medicare. Consequently, patients have to make up the difference out of their own pockets.

Secretary Bowen and the Congress have started the debate on exactly who is responsible for picking up the costs of care when a person has little or nothing left. Before we go any further, however, I want to know why any citizen of this country should be flat broke to get help. Is this how we want to treat the very people who have made this nation great? I don't believe it is.

The Congress is eager to work with the Administration to solve the problem of catastrophic health care costs. We are, of course, pleased that the President mentioned in his State of the Union address that our nation's elderly should not have to choose between "bankruptcy and death," and that he would soon submit legislation to the Congress to free the elderly of the cost of catastrophic illness. I am certain that Dr. Bowen shares our view that we must also deal with the cost of catastrophic care for all of our citizens. I look forward to learning more about what the Administration plans to do about this issue, and appreciate having this opportunity to ask a few of the many questions I have.

I will also submit written questions to you following the hearing and will include your responses in the hearing record.

Chairman ROYBAL. Thank you, Senator.
The Chair now recognizes Mr. Rinaldo.

STATEMENT OF REPRESENTATIVE MATTHEW J. RINALDO

Mr. RINALDO. Thank you very much, Mr. Chairman.

Mr. Chairman, I am pleased to join with you and members of the Senate to re-examine the issue of catastrophic health insurance. I particularly want to welcome Secretary Bowen, and I want to also take this opportunity to commend him for his hard work and the tremendous efforts he has given to finding a solution to this extremely difficult problem that has caused many American families to go bankrupt, and has caused so many families to go from living a decent life of dignity into one of poverty.

First of all, I would like to tell Dr. Bowen that I agree with the major thrust of his report; and that is, that catastrophic coverage for the elderly is something the Government can and should provide. We have no less of an obligation.

I know, Dr. Bowen, that you have encountered some difficulties since the release of your report from some who think it represents an expansion of Government and should be left alone. I completely disagree with that kind of outlook.

The fact is that catastrophic illness for senior citizens and people of all ages is devastating. Where we can help, we shouldn't be afraid about providing an expansion of the Medicare program.

At the same time, Dr. Bowen, I think you have started the debate on providing more comprehensive long-term care coverage for the institutionalized, but it is clear from the report that you seem to feel that this area should be left far more to individual efforts, the States and the private sector. I am concerned with that approach because I feel it doesn't differ enough in its essentials from what has been our current policy. Obviously, we can't completely cover all cases, but I feel very strongly that we must do much more to actually help people who suffer from a catastrophic illness and their family. That is something that is long overdue in this country of ours, and I am hoping that this hearing will serve as the impetus for action by this Congress so that legislation can be enacted during this very historic 100th Congress.

I look forward to your testimony, and want to thank you once again for appearing here and for your very diligent efforts in this area.

Thank you, Mr. Chairman.

Chairman ROYBAL. Thank you, Mr. Rinaldo.

As has been agreed, I will be limiting opening statements to the two chairmen, Senator Melcher and myself, and to the two ranking minority members, Representative Rinaldo, who has just spoken, and the chair now recognizes Senator Heinz.

STATEMENT OF SENATOR JOHN HEINZ

Senator HEINZ. I might observe that in my recollection this is only the second time that the two Committees on Aging have had a joint hearing. The last one was under Claude Pepper's chairmanship and auspices, in 1983, on drug abuse among the elderly. So this is probably only the second time in 10 years, in a decade, and

it is a testament I think both to our witness and to the seriousness of this issue on catastrophic health insurance.

I would also like to recognize the fact that we have very good attendance in Senator Simpson, in Senator Durenburger, in Senator Wilson, who have expressed a great interest in the way we go about addressing this issue. I will make my comments very brief.

There are a lot of gaps in health insurance coverage, and those gaps range anywhere from loopholes in the fine print of Medigap insurance policies all the way to the black holes of long-term debilitating illnesses and most individual's inability to find a way to pay and insure themselves against that risk. We have been laboring in this country under a public misconception for a long time—the misconception that if you are 65, and eligible for Medicare, then virtually all your health care needs are taken care of. Secretary Bowen not only knows better, he has issued a very comprehensive report setting forth in great detail exactly how flawed that myth of the comprehensiveness of Medicare is, and I salute him for it.

And the second misconception or lack of direction we have had is that up until now there has been a lack of leadership. I think we in the Congress have to take responsibility, but also this is the first time that the executive branch in either this or the previous Administration of President Carter has seen fit to address the issue of catastrophic coverage and perhaps the issue of long-term care.

So, Mr. Chairman, I salute not only you and Congressman Rinaldo and my chairman, Senator Melcher, but I commend Secretary Bowen for having thrown a national spotlight on an issue that until now has caused so many Americans to be plunged into great darkness and despair, wondering how they are ever going to emerge from a stack of bills that they never in their lives dreamed they would have to encounter and somehow pay for. So I thank you, Mr. Chairman.

[The prepared statement of Senator Heinz follows:]

PREPARED STATEMENT OF SENATOR JOHN HEINZ

This is indeed an historic occassion, Mr. Chairman, that finds the Senate and the House Committees on Aging in joint session. In my six years as Chairman of the Senate Special Committee, we had only once such joint hearing--in June 1983--and that was on the issue of drug misuse among older Americans. We are here today to look at an even more critical issue: the short falls in our nation's health care programs--the potholes, the coverage "black holes" that put too many Americans of all ages at risk.

We stand today at a crossroads. We must decide whether to strengthen our commitment to essential health services for all Americans, or cave to compulsive budgeteers and program polemics who say we've done enough.

Mr. Chairman, I think the choice is clear. While the President stopped short of endorsing the Bowen proposal in his State of the Union address last evening, the Secretary deserves credit for ushering the debate over catastrophic coverage into the national spotlight. While there are problems with the Secretary's proposal, it fills an invaluable role as a backboard off which to bounce more comprehensive solutions.

Mr. Secretary, I have read your proposal in its entirety with great interest. You have already faced one Congressional firing line earlier today with your testimony before the Senate Finance Committee. As I told you then, you deserve an "A" for your leadership and courage, both for recognizing the devastating potential of a catastrophic illness and for putting forth a framework for change. Rest assured that your are not alone. Your concerns are echoed by a chorus from this Committee and from others across the Hill.

I have done a more detailed analysis of your proposal Mr. Secretary, which I would be pleased to share with you. This analysis begins with my premise that a truely comprehensive proposal for acute and chronic health care coverage must meet four critical criteria.

First, it must rely on a joint public/private approach for financing.

Second, it must provide for a full range of services, from community-based to institutional, from catastrohpic acute to long term chronic.

Third, it must make coverage accessible and affordable for all Americans.

And finally, it must be cost-effective, without threatening quality.

Based on these criteria, Mr. Secretary, I find several areas where I would improve upon your proposal. You thread the needle to darn the holes in America's acute and long term care coverage. But your thread isn't long enough, nor strong enough, to mend the full range of problems we face.

The biggest weakness in your proposal, as I see it, is the limited set of options you offer for long term care. Your recommendations for tax credits, for example, such as the Individual Medical Accounts (IMAs), by emphasizing institutional settings, invite care that is more expensive, perhaps inappropriate and even less desirable than care in a home or community. These long term care incentives, further, rely too heavily on solutions that are unlikely to help lower-income individuals and families.

When it comes to the elderly, your proposal would not really expand coverage beyond current services. For example, prescription drugs would remain an out-of-pocket expense. The proposal would not ensure access to coverage for those low-income individuals who do not get Medicaid and cannot afford the added Part B premium.

Mr. Secretary, again I commend you on what is a good beginning down the road to comprehensive health care coverage for Americans of every age and income. You can count on our support, I know, as we work together for a full solution to the problem.

Chairman ROYBAL. Thank you, Senator.

At this point all opening statements will appear in the record according to seniority.

[The prepared statement of Mr. Hammerschmidt follows:]

PREPARED STATEMENT OF REPRESENTATIVE JOHN PAUL HAMMERSCHMIDT

I WOULD LIKE TO COMMEND CHAIRMEN ROYBAL AND MELCHER FOR CONVENING THIS TIMELY HEARING ON THE ADMINISTRATION'S PROPOSAL FOR A CATASTROPHIC HEALTH INSURANCE POLICY. I WOULD ALSO LIKE TO THANK SECRETARY BOWEN FOR COMING BEFORE US TODAY TO DISCUSS THE PROPOSAL AND RESPOND TO OUR QUESTIONS.

IT IS IMPOSSIBLE TO QUANTIFY OR EVEN TO ADEQUATELY DESCRIBE THE PROFOUND EFFECT MEDICARE HAS HAD ON THE LIVES OF MILLIONS OF OLDER AMERICANS SINCE ITS INCEPTION IN 1965. THE MEDICAL CARE PROVIDED THROUGH THIS PROGRAM HAS IMPROVED THE QUALITY OF LIFE FOR MILLIONS OF OLDER PERSONS AND EXTENDED THE LIVES OF MILLIONS MORE. BUT WITH ALL ITS BENEFITS, IT WASN'T DESIGNED TO COPE WITH THE COSTS OF CATASTROPHIC ILLNESS. MEDICARE PAYS LESS THAN FULL COSTS OF THE FIRST 150 DAYS FOR HOSPITAL CARE AND THEN STOPS ALL REMAINING HOSPITAL PAYMENTS COMPLETELY.

THE MEDICAID PROGRAM WHICH IS DESIGNED TO PROVIDE MEDICAL ASSISTANCE TO LOW-INCOME OLDER PERSONS, AMONG OTHERS, IS REACHING ONLY THE VERY POOREST. THE CUT-OFF INCOME LEVEL FOR MEDICAID ELIGIBILITY FELL BELOW 55 PERCENT OF THE FEDERAL POVERTY THRESHOLD IN 23 STATES IN 1984. THERE ARE MANY ELDERLY PEOPLE WHO HAVE INCOMES ABOVE 55 PERCENT OF POVERTY BUT CANNOT AFFORD THE PREMIUMS FOR A PRIVATE SUPPLEMENTAL MEDIGAP POLICY.

IT IS CLEARLY TIME FOR CONGRESS TO CONSIDER PROPOSALS WHICH WILL SAFEGUARD THE ELDERLY FROM THE POTENTIAL FINANCIAL RUIN THAT CAN BE CAUSED BY CATASTROPHIC ILLNESS. I APPLAUD THE SECRETARY FOR DESIGNING A PROPOSAL THAT IS BUDGET NEUTRAL, LIMITS THE PAYMENT OF THE DEDUCTIBLE TO A MAXIMUM OF TWICE A YEAR, ELIMINATES PART A COINSURANCE AND ONLY EXTENDS THE PREMIUM THAT THE ELDERLY PAY BY AN ADDITIONAL $4.92 A MONTH.

[The prepared statement of Senator Glenn follows:]

Mr. Chairmen, I am pleased that the Senate Special Committee and the House Select Committee on Aging are holding this hearing on catastrophic health care costs. I have always felt that a priority issue for the Congress should be to protect our Nation's citizens against the bankruptcy that can be caused by catastrophic illness or injury.

This happened in my own family. My dad was a plumber. He and my mother owned their own home and had a modest amount saved for retirement. About two years after retiring, my dad came down with cancer, and it was a six-year downhill slide. Fortunately, he did not lack for medical care because I could help out. But all my parents' savings went in the first couple of years -- everything. And if they had not had other family members who were able to help -- and many people don't -- I hate to think what would have happened.

Catastrophic expenses are those which cause a great financial burden on individuals and families. For most of the estimated 37 million Americans under the age of 65 without health insurance, any illness or injury could be catastrophic. Other groups particularly vulnerable to today's high health care costs are people with inadequate insurance, retirees under age 65 and their dependents who are not yet eligible for Medicare, and the 60 percent of low-income Americans who do not meet Medicaid's eligibility requirements.

For older Americans living on a small retirement income, the Medicare hospital deductible could be a catastrophic expense. And for many elderly people, the lengthy list of health care services not covered by Medicare -- such as out-patient prescription drugs, eye and dental care, physical examinations and long-term care at home or in an institution -- makes the cost of health care the greatest financial threat they face in retirement.

In an attempt to reduce their out-of-pocket costs, more than two-thirds of Medicare beneficiaries have purchased private, supplemental insurance. However, in most cases, these "Medigap" policies do not cover services that are not covered by Medicare. Rather they pay the Medicare premiums, deductibles and co-payments. A recent General Accounting Office (GAO) study shows that their ratio of payouts to premiums is quite low, and further regulation of the Medigap insurance industry is needed. Confusion about what Medicare covers and concern about rising medical costs have created a climate where many older Americans fall prey to unscrupulous insurance salesmen who sell them multiple, unnecessary policies. For these reasons I welcome Congressional consideration of proposals to cover the current cost-sharing in Medicare through an additional Medicare premium.

A major catastrophic expense for the elderly, particularly the "old-old", is the cost of long-term care; and most people are surprised to learn when a family member needs custodial care at home or in a nursing home, that it is not covered by Medicare or private health insurance. Medicaid, which pays over 40 percent of our nation's nursing home bill, is increasingly becoming a program for middle income Americans who spend down to Medicaid's eligibility levels. It is estimated that one-half of all current Medicaid nursing home residents were not initially poor, but spent down their income and assets to Medicaid levels while institutionalized.

Many proposals have been put forward to expand health insurance coverage -- through the Federal and State governments, private employers and individuals themselves -- to protect against catastrophic health care costs and to ensure access to health care for all Americans.

At the same time that we are looking at ways to increase protection, we must fight the Administration's most recent budget proposals which seek to reduce Medicare and Medicaid expenditures. The proposed cuts in Medicare would increase out-of-pocket health care costs for the elderly, and would reduce payments to hospitals providing care to the uninsured. And the proposed Medicaid "cap" -- which I will oppose in the 100th Congress as I have in the past -- would make it difficult for the States to provide health care to low-income citizens and the growing number of elderly persons in need of long-term care.

Two days ago, the Senate Aging Committee heard from several witnesses who came to Washington, D.C. to tell us about the devastating impact on their lives of the high cost of medical care, and the gaps in public and private health insurance. Also at that hearing a representative from the Health Insurance Association of America (HIAA) gave his recommendations for improving current Medigap policies and for expanding protection for all Americans against catastrophic health care costs.

Today, look forward to hearing from the Honorable Otis Bowen, Secretary of the Department of Health and Human Services, who, at the President's request developed recommendations to protect against the bankruptcy that can be caused by catastrophic illness. I commend Secretary Bowen for bringing attention to this issue -- which I believe should be at the top of our domestic agenda -- and I look forward to learning the details of the Administration's legislative proposal for meeting the challenge of providing catastrophic illness protection to all of our citizens.

As a member of the Senate Aging Committee and a long-time advocate of catastrophic health insurance, I am pleased that attention is being given to this issue by the Congress and the Administration. We must work together to ensure that all Americans receive the full range of health care services they need without the threat of financial ruin. I anticipate that today's hearing will be helpful in our efforts, and I look forward to Secretary Bowen's testimony.

[The prepared statement of Senator Reid follows:]

Mr. Chairman, in recent years, the escalating costs of hospital and medical care have brought to the forefront a pressing need for the creation of a comprehensive catastrophic health insurance program. I am pleased to be able to participate in today's hearing and listen to Secretary Bowen's testimony in hopes that it will help those of us on the House and Senate Special Committees on Aging develop a workable solution to the problem of catastrophic health care costs.

As a former member of the House Select Committee on Aging's Subcommittee on Health and Long-Term Care, I am acutely aware of the fact that in the 20 years since Medicare was enacted in the United States, the cost of health care has increased three times as fast as the cost of living. These increased costs have been passed along to the consumers of health services and to the taxpayers, especially the elderly. While Medicare does an adequate job of helping seniors pay for costs associated with episodes of illness requiring hospitalization, virtually no coverage is available under the Medicare program or most private insurance policies, for that matter, to help senior citizens when a chronic catastrophic illness strikes. When private insurance coverage is available, it is often too expensive for those who need it most.

Along with five other members of the House Select Committee on Aging, including Rep. Claude Pepper, I introduced H.R. 4287, Medicare Part C: The Catastrophic Health Insurance Act of 1986, during the 99th Congress. Our legislation sought to create a new optional "Part C" of Medicare to cover the gaps or coinsurance and deductibles seniors must pay for hospital and physician services under Parts A and B of the Medicare program and to provide comprehensive long term care services, including care for the chronically ill in their homes or in nursing homes, dental care, eye care, hearing care, and biannual physical exams. Unfortunately, this measure did not reach the floor of the House prior to adjournment.

With the opening of the 100th Congress, we are afforded new opportunities to scrutinize this and other proposals in an effort

to develop the best catastrophic health insurance program possible. I realize that the availability of government coverage will not necessarily solve the affordability problem. Both the Bowen proposal and a Medicare Part C would be accompanied by increases in the current Medicare insurance premiums. Even without this additional expense, many beneficiaries already face the problem of increases in Medicare premiums and a proposed increase in the Medicare Part B deductible that exceed the 1987 Social Security Cost of Living Adjustment. Questions have also been raised as to practicality of Individual Medical Accounts, another component of the Bowen proposal, in light of the fact that many of those who can not afford private supplemental insurance on their own are unlikely to be able to afford the annual contributions entailed. There are still more concerns about the fairness of tax subsidies to encourage the purchase of private insurance.

I would like to compliment both chairmen for taking the leadership in scheduling these hearings early in the session. This will allow us the time to provide policy alternatives to the committees with legislative jurisdiction and, hopefully, complete congressional action on a catastrophic health insurance bill during the 100th Congress.

[The prepared statements of Senators Shelby and Grassley follow:]

The unexpected thief -- he can strike anyone at anytime, and steal a lifetime's worth of savings. For many of us, the thief we fear most is a major illness -- an illness that is physically devastating and financially ruinous. An illness that is catastrophic in every sense. This thief is undiscriminating. But like others of his kind, he discovers his most vulnerable prey is the elderly.

Our efforts to devise a plan of protection against the calamaties of major illness must begin with America's seniors. This will be the greatest challenge; but one which will reap the greatest reward. To avoid a response would be to betray the value of our nation's seniors and compromise the future of America's working people.

The dilemma of how to finance catastrophic health care protection deserves thoughtful study. Who will pay? What mechanisms will help us pay for a comprehensive program? These are the toughest questions we face.

Recommendations should be gathered from every source -- private insurers, seniors' groups, policy makers, Administration officers, medicare officials -- and from these responses we can devise a consensus approach, a fair, sound funding policy.

Responding with compassion to that which steals away one's health and one's savings is not a partisan issue. It is not a conservative or liberal cause -- it is an American cause. The dread of catastrophic illness and its costs need not be the elderly's nightmare if we act now, together to create a catastrophic health care plan Americans can be proud of.

PREPARED STATEMENT OF SENATOR CHARLES E. GRASSLEY

THANK YOU SENATOR MELCHER AND CONGRESSMAN ROYBAL.

I COMMEND YOU FOR HAVING THIS EARLY HEARING ON THE PROBLEM OF CATASTROPHIC HEALTH CARE EXPENSES. CLEARLY, THERE IS A GREAT DEAL OF INTEREST IN IT NATIONALLY AND HERE IN THE CONGRESS. IT IS ALSO THE CASE THAT IT IS A COMPLEX TOPIC AND WE OUGHT TO GIVE IT THE TIME AND CAREFUL TREATMENT IT DESERVES.

I HOPE THAT THESE TWO COMMITTEES WILL HELP US ARRIVE AT A CONSENSUS ON THE NATURE AND DIMENSIONS OF THE PROBLEM. IT MAY BE MORE DIFFICULT TO ARRIVE AT A CONSENSUS ON HOW TO PROCEED, BUT WE SHOULD CERTAINLY TRY TO DO SO.

I HOPE THAT WE PROCEED CAREFULLY, ESPECIALLY AS CONCERNS THE CREATION OF NEW FEDERAL BENEFIT PROGRAMS. IN THE FIRST PLACE, WE STILL HAVE A MAJOR DEFICIT PROBLEM, WHICH, AS FAR AS I CAN TELL, THE CONGRESS, THE ADMINISTRATION AND THE AMERICAN PEOPLE ARE COMMITTED TO ELIMINATING. SECOND, EVEN IF SUCH NEW FEDERAL BENEFIT PROGRAMS ARE STARTED AS SELF-FINANCING, WE HAVE TO TAKE INTO CONSIDERATION THE PROBABLY INEVITABLE LATER POLITICAL PRESSURES TO USE GENERAL REVENUES TO PAY FOR THE BENEFITS WE PROMISE.

WE NEED TO BE CAREFUL THAT WE DO NOT PROMISE THINGS TO THE AMERICAN PEOPLE THAT WE MAY NOT BE ABLE TO DELIVER. THE RECENT FINANCING CRISIS IN THE SOCIAL SECURITY RETIREMENT PROGRAM, ALTHOUGH WE HAVE REPAIRED THAT PROBLEM FOR THE FORESEEABLE FUTURE, AND THE CONTINUING FINANCING PROBLEM IN THE MEDICARE PROGRAM, HAVE HELPED TO CREATE LACK OF CONFIDENCE ON THE PART OF THE AMERICAN PEOPLE IN THE PROMISES THEIR ELECTED REPRESENTATIVES MAKE TO THEM. MORE UNDELIVERABLE PROMISES CAN ONLY CREATE MORE DISAFFILIATION AND POLITICAL DISCONTENT. SO WE HAD BETTER BE ABLE TO GUARANTEE DELIVERY IF WE ARE GOING TO PROMISE NEW BENEFITS.

I AM PLEASED THAT THE COMMITTEE IS SEEKING OUT THE PERSPECTIVE OF PRIVATE BUSINESS PEOPLE WITH RESPECT TO WHAT THEY CAN OFFER TO THE SOLUTION OF THIS PROBLEM. IT SEEMS CLEAR, AT LEAST TO ME, THAT, GIVEN OUR DEFICIT PROBLEM AND THE UNPOPULARITY OF A GENERAL INCREASE IN INCOME TAXES, WE WILL NEED THE HELP OF THE PRIVATE SECTOR IN SOLVING THIS CATASTROPHIC HEALTH CARE EXPENSE PROBLEM.

THAT IS AT I HAVE TO SAY FOR THE PRESENT, MR. CHAIRMAN. I LOOK FORWARD TO THE TESTIMONY OF OUR WITNESSES.

Chairman ROYBAL. Our sole witness today is a distinguished physician and Secretary of the Department of Health and Human Services, Dr. Otis Bowen, who will present the Administration's recommendations, and his personal recommendations on the issue of catastrophic, acute and long-term care.

Dr. Bowen, we not only welcome you before this committee but are awaiting your testimony and the answers that you will be providing to members of this joint committee.

Would you please proceed in any manner that you may desire?

STATEMENT OF THE HONORABLE OTIS R. BOWEN, M.D., SECRETARY, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Secretary BOWEN. Thank you very much, Chairman Roybal, Chairman Melcher, and members of both the House Select Committee on Aging and the Senate Special Committee on Aging.

I realize that it is both a unique and a special occasion when your two committees join together to examine an issue. This issue—protecting our elderly against the devastating effects of catastrophic health care costs—has been at the top of my agenda as Secretary of Health and Human Services.

The subject for today's hearing is one which I know is of the utmost mutual concern. I commend you, Chairman Roybal, Chairman Melcher, Senator Heinz, Congressman Rinaldo, and the many, many others of the two committees who have shown such great leadership on this issue.

I am hopeful this hearing will mark the outset of an open dialog, as we work together to find the appropriate private and public sector solutions to a very pressing problem.

Be it through our personal experiences or those of family or friends, we certainly have all seen how a devastating illness can destroy the financial security of a family.

I think President Reagan deserves the thanks of Americans for recognizing this need. He has been a long-time supporter of catastrophic coverage, first as Governor of California and now as President. Without his leadership, I doubt that we would be having these discussions. That is why the President asked me last February to report options to him on how the private sector and government can work together to address the problems of affordable insurance for those whose life savings would otherwise be threatened when a catastrophic illness strikes.

My report provides a good starting point to begin the debate of how to address the various problems associated with catastrophic health care coverage. In conducting this study, at the outset we recognized that the catastrophic illness problem is both large and complex. The possible solutions to this problem are numerous, and there is no single policy that will reduce the catastrophic burden for everyone. So let me highlight what we have been doing in the year since the President asked for a study of the issue.

Many people and organizations contributed to our work. But one prong of our efforts was a Private/Public Sector Advisory Committee that I established to actively solicit information from all interested parties throughout the country on their concerns and their ideas as to how to solve the catastrophic health problem. This com-

mittee was chaired by Jim Balog, who is vice chairman of Drexel-Burnham-Lambert, a major New York investment brokerage firm. We selected a blue-ribbon panel representing a broad spectrum of the American public, including representatives of the aging, physicians, insurers, business, and elected officials from all levels of government.

The committee held eight public forums and heard from over 100 organizations and individuals. Last August, the Private/Public Sector Advisory Committee's efforts culminated in its report to me, synthesizing these numerous points of view.

In addition to the committee's work, the other prong of our efforts was a detailed technical analysis of policy options for catastrophic illness. Our Department staff consulted technical experts from all over the country to ensure that no major option and no major argument was omitted. All told, over 50 options were analyzed in three technical reports covering 1600 pages.

There are far too many policy options that were considered to allow full discussion here. However, these are discussed in detail in the report which was provided to you shortly after it was sent to the President.

To understand the catastrophic illness problem, three groups of people must be considered. That is, the elderly who are facing acute care expenses; the elderly facing long-term care expenses; and the general population under the age of 65. The chance that a catastrophic illness event will strike a member of these different groups occurs at different rates and frequencies. Elderly Americans require more medical care than younger persons and are more apt to suffer the consequences of an acute illness or need long-term care.

Of the more than 28 million elderly Medicare beneficiaries, approximately 1.2 million will incur personal costs for acute care of $2000 or more in 1987. This can be a heavy burden for those elderly living on $6000 to $7000 in social security benefits. Virtually all elderly have acute care insurance protection under Medicare. Nearly two-thirds also have private supplementary insurance called Medigap. But there still may be significant gaps in coverage.

As you are aware, Medicare hospital coverage is limited. After 60 days, a Medicare patient begins to make increasingly costly payments. There is also a required 20 percent copayment for all physician services covered by Medicare. Medigap insurance helps for the 65 percent of the elderly who buy it, but even with Medigap, an individual may face significant out-of-pocket costs. The State-operated Medicaid program may also help with about 13 percent of the elderly, but there are limits on the kinds of services provided.

To improve catastrophic protection for the elderly facing acute care expenses, my report suggested three options. First, that Medicare be restructured to provide catastrophic protection financed by an actuarially sound additional premium of $4.92 per month. Second, that Medicare be restructured to provide for catastrophic protection with increased cost sharing related to income. And third, that Medicare be restructured to include catastrophic coverage with increased cost sharing unrelated to income.

Long-term care ranges from informal, unpaid care provided by family and friends to full nursing home care. It is not typically as-

sociated with specific diagnoses, but rather the need for assistance in activities necessary for daily living. There is limited private insurance coverage of long-term care, and the only major Federal program that covers such care is Medicaid, of which eligibility is restricted to low-income and medically indigent patients.

Most long-term care is provided free of charge by relatives and friends. Strong family and community support for the elderly is one of the finest aspects of American life. But in addition, 1.4 million elderly currently receive care in nursing homes every day. The expense averages $22,000 a year. These expenses are not covered by Medicare, nor are they usually covered by private insurance. Unfortunately, many seniors believe that nursing home expenses are covered by Medicare or medigap, and the truth often comes as a shock and these individuals find all their savings consumed by a stay in a nursing home.

The urgency of long-term care as a policy problem is increasing as the population ages. Within the next 45 years, the number of people living to age 85 and beyond will quadruple. By the year 2030, 8.6 million Americans will be over the age of 85, compared with 2.7 million in 1985. These are the people in need of long-term care, and these are the people who should begin now, in their middle age, to make provisions for that care.

Obviously, we need to look far down the road for any approach to long-term care. Changes in the system would be very costly and won't come over night. Among the report's many options, two approaches, which were developed prior to tax reform, would, first have encouraged personal savings for long-term care expenses. One idea we had before enactment of the Tax Reform Act was to consider tax incentives, such as individual medical accounts. This could be coupled with insurance and be an effective method, not only for coverage, but also for prevention of thousands of Medicaid enrollments.

The second approach would have encouraged the development of private long-term care insurance. There is clearly a need for more innovative and affordable policies of this type. Again, before enactment of the tax bill, we had considered some approaches using the Tax Code. The President's tax reform initiative eliminated many of the Tax Code's incentive features that narrowed the tax base, substituting lower tax rates for our citizens. With the enactment of tax reform there are other options being considered that would not narrow the tax base.

One action about which there is widespread agreement is to educate the public about the costs of long-term care and the lack of coverage for those costs under Medicare and medigap insurance. The Federal Government can work with private industry and other levels of government to help people understand what is not covered under existing insurance, and to encourage them to make provisions for their future needs.

Finally, I would like to mention catastrophic protection for those under the age of 65. The majority of non-elderly persons have private insurance coverage, most of which is employment-related, and much of which provides solid protection against catastrophic expenses.

A significant amount is also provided by Medicare for those who are disabled, Medicaid for the low-income families with dependent children, and other government insurance for members of the armed forces. It has been estimated that some 30 million people under the age of 65 have no health insurance at all and 10 million have inadequate coverage for catastrophically high expenses. About three-quarters of the uninsured live in families where an adult is employed all or part of the year.

How many people under the age of 65 actually incur catastrophic expenses? Well, it is estimated that 28.3 million persons use $5000 or more in health services in a year. Much of these expenses are paid by insurance; however, some 2.8 million pay $5000 or more in out-of-pocket costs after insurance coverage.

To improve catastrophic protection for the general population, there were two possible approaches included in the options report. The first would encourage State innovation and initiative in the management of health programs affecting their residents. Their understanding of the needs and problems of local areas enables States to foster catastrophic health insurance in innovative ways. States and localities could integrate the approach with existing programs for uncompensated care. For example, States—the level of government traditionally responsible for the regulation of insurance—could consider mandating catastrophic protection in employer-provided insurance, formation of State risk pools, loan guarantees, health insurance requirements for vehicle registration, and greater flexibility in operating their Medicaid programs.

Second, tax deductions for health insurance were considered for all employers who include catastrophic protection in their plan. As mentioned, the President's tax reform initiative eliminated many of the Tax Code's incentive features that narrowed the tax base, substituting lower tax rates for our citizens.

In closing, let me emphasize that my report put forth a range of options for your consideration, a guideline or starting point for what we expect will be a continuing dialogue with Congress. We also urge the Congress to proceed with some caution. The problem is important, it is complex, and potentially costly to solve. It is important that we not create new problems nor aggravate old problems while solving this one.

In addition, we caution that congressional bills should not displace the private insurance market. To help ensure consideration of costs, we urge Congress to consult CBO and the Administration to have their options priced and thoroughly worked out between the private and public sectors, between all levels of government and between users and medical providers.

I think it is possible to craft a proposal within those guidelines, and I believe it is necessary that we do so. And I look forward to working with the Congress.

Thank you, again, Mr. Chairman, for allowing me to present our views on catastrophic health coverage. At this time, I would be pleased to attempt to respond to your questions. To assist me, at the table, I would like to introduce Mr. Tom Burke, my chief of staff, who is a medical economist; and, to my right, Assistant Secretary for Legislation, Dr. Ronald Docksai.

Chairman ROYBAL. Thank you, Dr. Bowen.

We will now go into the question and answer period. The Chair will limit each question and answer to no more than 5 minutes. I will, as chairman, not ask a question at this time, in order to make time available to the other members. As you can see, there is a large attendance, and for each one to make an opening statement and still have five minutes for questioning, would mean that we would probably be here until midnight, and I don't think we want to do that at this time.

So I will then recognize the ranking minority member from the House side, Mr. Rinaldo.

Mr. RINALDO. Thank you, Mr. Chairman.

Dr. Bowen, The Washington Post seems to indicate that the White House has not endorsed your recommendations. Can you tell the committee what the White House's objections are to your report?

Secretary BOWEN. I am not sure I know who you mean by the "White House."

Mr. RINALDO. Well, what the Administration's objections are to your report?

Secretary BOWEN. I am not trying to be facetious.

Mr. RINALDO. Neither the Administration nor the President has endorsed your report during his State of the Union speech. Certainly the President didn't endorse it last night. He endorsed a form of catastrophic health insurance, but I didn't hear him mention your particular report. If they are opposed to it, I would like to know what the objections are, if you know what they are.

Secretary BOWEN. Let me say that I know the President is very sensitive to this issue and desires to solve the problem of the need for catastrophic coverage for devastating health expenses. As you say, you have read about it in the paper and it is no secret that there are those who object to the plan we have put forth. I think the main objection is that of displacing, or potentially displacing private sector activity. Other concerns include expanding the Medicare program and questioning costs, not only of the $4.92 premium, but also whether cost containment can be continued over a long period of time.

Mr. RINALDO. Yet, according to a lot of the news accounts that I have read, the Administration wants to ensure that first, any catastrophic health plan is voluntary; second, not an entitlement; and, third, budget neutral. And according to your testimony and my reading of your report, your recommended options meet all these criteria. It provides for an actuarially sound Part B premium increase while Part B remains voluntary.

Do you agree with this assessment?

Secretary BOWEN. That is my assessment. The $4.92 figure has been studied by the best actuary around, our actuary for HCFA. He insists that he has gone over this and over it and that this is the proper figure—and you can keep it that low because of the fact that 30 million beneficiaries would be included. So, we say it is a "pay-as-you-go" plan and it will be budget neutral.

And as far as being voluntary: yes, Part B itself is voluntary, although most people do elect it. So I guess there would be some question as to how voluntary the Part B part of the program is.

As to assertions that it would remove the private sector from the area, it would be my judgment that it would not do this. The $2,000 cap could still be insured against as well as the things that Medicare has never paid for, such as drugs, eye care, and dental care. I think it would also be natural for private insurance to expand into the long-term care insurance business.

Mr. RINALDO. Yet, despite those facts, the Administration still seems, to put it mildly, reluctant to adopt your recommendations. I would like to know whether or not ongoing discussions are continuing between HHS and the Administration or has your plan been shunted aside and overruled already?

Secretary BOWEN. Let me say that I have had the opportunity on three occasions to present my report to the Domestic Policy Council, and I have had two additional occasions to present it before the Cabinet, and in front of the President. I think they all know that this is our report with our name on it. There are preferences that I recognize. And as I said at the outset, we are presenting three options. Even though I think ours are good and satisfactory, even if they are not adopted, the discussion and debate eventually lead to something that is worthwhile and solves the problem—then my feelings wouldn't be hurt because of pride of authorship.

Chairman ROYBAL. The time of the gentleman has expired.

Chairman Melcher?

Chairman MELCHER. Dr. Bowen, you have testified that 1.4 million elderly currently receive care in nursing homes. Now can you tell me, of that number, how many are currently covered by Medicaid?

Secretary BOWEN. Yes. I can tell you that about 50 percent of all of expenditures in nursing homes are paid for by Medicaid. So it could be about 50 percent of the people. And 1.4 percent, some say 1.7—and I guess it is someplace between those two—of costs are paid by private insurance. The rest is out of individuals' pockets.

Chairman MELCHER. So, then for about half of those that are in nursing homes, the bill is paid by Medicaid, by the Government and less than 2 percent of the others that are in nursing homes are actually covered by some type of insurance?

Secretary BOWEN. That is right.

Chairman MELCHER. Well, that I believe is the biggest fear of the elderly when we talk about catastrophic coverage. I am not overlooking that many of the elderly are at home but require nursing care and medical attention there, which is their preference, and by all means the best solution. It is better than nursing home care if they can remain in their own homes and get the proper care there.

I believe that we are looking at the problem, or at least I am looking at the problem as the elderly are looking at it. I think this is the biggest fear they have, and the reason that many wonder whether their savings will hold out long enough to pay all the bills, I think that is an area that I am particularly interested in broadening in your proposal. I am not going to belabor the point now, but the fact that your proposal does not get into this area, I believe, would be considered the greatest shortcoming of it.

But I will repeat again, as I said at the outset, Dr. Bowen, you have broken the ice. You have got people interested in catastrophic coverage. And when the public is interested, perhaps we can get

the votes here in Congress to bring it to reality. Thank you very much.

Secretary BOWEN. Thank you. I might add just one point. For everyone who is in a nursing home, there are four others who potentially could be in a nursing home, but are cared for at home by family and friends.

Chairman MELCHER. Yes. And I think that is why, if the elderly can be cared for at home, that is by far the best choice.

Secretary BOWEN. It is the most ideal.

Chairman MELCHER. Best or ideal for them.

Chairman ROYBAL. Thank you, Senator.

The Chair recognizes, Mr. Pepper.

Mr. PEPPER. Thank you, Mr. Chairman.

Dr. Bowen, we all commend you and the President for the initiative you have manifested in this critical area. Our only concern is that it is too feeble a step forward.

I ask you, what percentage of the elderly would be benefited if your program as proposed were adopted by the Congress and the country?

Secretary BOWEN. Eventually I would hope all of them would be included, but I would admit that the long-term care part of our program would be a few years down the road. However, it is not as far down the road as many people would suggest.

Mr. PEPPER. Well, your program relates only to continued stay in a hospital, doesn't it?

Secretary BOWEN. No, it has three parts, sir.

Mr. PEPPER. Beg pardon?

Secretary BOWEN. We have it divided into three parts.

Mr. PEPPER. Would it cover long-term care?

Secretary BOWEN. That is one type of care it would cover, but coverage would be farther down the road. It would not be immediate. It would be in 3 parts.

Mr. PEPPER. Well, my information is that your program would only benefit about 3 percent of the elderly. We had this morning in this building a hearing of a subcommittee of this committee, and we had 3 witnesses. One of them started off with $160,000 in assets and liquid capital, wound up desperate, with 4 insurance policies and still not getting any coverage. Another one had $150,000, wound up the same way. Another one had $140,000. A man named Ed Howard testified here that he thought he was all right. He had several insurance policies. He was a good strong man. He had a good job. And he had $140,000 in liquid assets. Then he had a stroke. His wife had cancer and one ailment after another visited him, and here he was at the end, no aid from his insurance policies, his money exhausted, crying out pitifully, What am I going to do?

In 1946, President Truman recommended a national comprehensive insurance program to cover the people of this country. My Senate Committee on Wartime Health and Education made a similar recommendation about the same time. In all those 40 years, about all we have done is to pass Medicare—good, but limited—and Medicaid—very restrictive in the people it benefits.

How much longer are we going to have to wait in America to give the people in this country, through intelligent planning by the

Congress and the private enterprise system—the two basic principal insurers—the kind of protection and coverage that their situation demands? How much longer are we going to have to wait?

The President disappointed everyone, including me, and I have a high regard for the President, at the meagerness of his statement on the subject last night. He offers little hope to the American people.

May I ask, do you consider that the investigations, commendable as they are, that you have made would afford Congress the technical data upon which to enact a proper covering program protecting people against catastrophic illness?

Secretary BOWEN. The answer to that would be a definite "yes."

Mr. PEPPER. Did you deal with the topic of how it could be financed?

Secretary BOWEN. Yes, we did deal with that. I think there is a little misunderstanding about our report.

Mr. PEPPER. And did you deal with the problem as to how it could be administered?

Secretary BOWEN. Yes.

Mr. PEPPER. Well, some of us have thought maybe we should set up another commission of 15 members, bipartisan in character, the President to have the chairmanship and the Democrats to have 8 of the 15 members, and let them have a period of six months in which to study the whole problem and advise the Congress of the basis upon which it could enact a program.

Are you saying to us—and I hope you are—that you have already plowed that ground and we don't need to appoint another inquiring authority?

Secretary BOWEN. Well, I don't believe that another commission is necessary. But, if in your wisdom you feel that it is, and one is appointed, we would be glad to work with them.

There is a little misunderstanding concerning our report. Our report covers three separate groups of people, each with different problems, and each with different solutions, because one solution would not cover all of the areas.

Chairman ROYBAL. The time of the gentleman has expired.

The Chair recognizes Senator Heinz.

Senator HEINZ. Mr. Chairman, I think because I had an opportunity to question Secretary Bowen earlier today, I am going to yield my time to Senator Wilson of California.

Senator WILSON. Thank you very much, Senator Heinz. Thank you, Mr. Chairman.

Mr. Secretary, first, my congratulations to you for what has been described as your "ice-breaking" report. You are addressing a profound problem.

In the interest of time, let me invite your attention to the first chart over here, farthest to your left. The one that says Medical Expenses of Elderly With Over $2000 in Annual Out-of-Pocket Costs. That pie-shaped chart clearly indicates that the vast majority of expenditures fall within the category of nursing home care, and it is indicated that it is over 80 percent.

In your report to the President, as you have outlined the several options in a discussion of private health insurance, at the bottom of page 12, after relating considerable statistical enforcement your

concluding sentence is that private health insurance covered only a tiny proportion of the nursing home bill, 1 percent of the total expenditures on nursing home care.

In developing the various options, you obviously were in contact with the private health insurance industry. And earlier this week, we have been told by some representatives that they were somewhat skeptical of the approach of simply increasing the premium. They thought that perhaps the private sector might have a larger role.

Now it seems clear from this sentence that describes 1 percent of the total expenditures and 80 percent of the out-of-pocket costs of the elderly that there is an enormous gap in Medigap insurance between what is being covered and what isn't. And this is, as you have pointed out, the most likely to grow into enormous costs as the population ages, with, as you put it, four times the population in 2030 that we now have over the age of 85.

When you talked to the people in the private health insurance industry did they indicate to you any optimism or enthusiasm about their ability to deal with this problem? And if so, what did they tell you would be necessary in order for them to do so? Did they say that the States should mandate a pooling of risk? Did they say that there would have to be tax incentives? What was their response to the proposal for a voucher system?

Secretary BOWEN. First, I think that you are confusing two different sections of our report, one on long-term care and the other on acute care. But yes, the insurance industry——

Senator WILSON. Let's just talk about the long term.

Secretary BOWEN. All right. In order to develop long-term care insurance policies, which essentially the industry has not done; one has to first educate the public as to the need for long-term care and as to what Medicare and medigap pays for and what they don't. And second, if I understood insurance industry representatives correctly in the meeting that I had with them, the insurance industry would appreciate some incentives to develop these types of programs. They feel there should be some incentives for people to buy them, and the incentives they were talking about were tax incentives.

Senator WILSON. Any comment from them on the voucher proposal?

Secretary BOWEN. I recall no comment from them. But I was only with them for a very short time at one meeting. There were other meetings that I did not attend.

Senator WILSON. Thank you, Mr. Chairman. I should point out that you are losing the Senate members of this joint meeting because we just began a vote. So excuse me.

Chairman ROYBAL. Thank you, Senator. It is my understanding that there is a vote on the floor of the Senate, and it is necessary for the Senators to leave. Some of them will be returning.

The Chair now recognizes Mr. Biaggi?

Mr. BIAGGI. Thank you, Mr. Chairman.

First, permit me to congratulate you, Mr. Secretary, for your initiative. It was most heartening to hear the President last night address the question of catastrophic illness, but that is a subject that has been a principal concern of ours for a considerable period of

time. I recall most vividly, under the Carter administration, when Secretary Califano was in your position, where the proposal was catastrophic illness with some enhancements. What occurred then, and I point this out for a very significant reason, and that reason is for all of the persons who are concerned about comprehensive care. The proposal then was catastrophic plus some enhancement. There are two schools of thought for that one, catastrophic and cradle to the grave, and they are intractable in their positions. And because of their intractability, we got nothing. So the notion of catastrophic illness insurance, or coverage is critical. Very much like the fact that social security in 1935 scarcely resembles the social security we have today. We have enhanced it over the passage of time with experience.

So it is important that this whole undertaking be given one paramount note. Get something and then build on it. That is critical.

I think, second, Congressman Rinaldo talked about the President's proposal and yours, and he pre-empted what I was going to ask you. But let me ask you. My main question relates to a very personal catastrophic health care crisis in which I find myself, but I am sure many others find themselves in the same position. It involves my wife of some 43 years. She was diagnosed as having Hodgkin's disease and spent several weeks in the hospital undergoing tests and treatment, and Medicare was responsive to that. She was discharged and now receives her treatment on an outpatient basis. Yet, part of her care in the home requires two full-time nurses, which Medicare does not cover.

My question is, in your proposal you call for a cap on out-of-pocket costs for catastrophic illness costs in an exchange for an increase in premiums. Would this cap include those services that relate directly to the illnesses that are provided in the home?

Secretary BOWEN. The answer would be "yes." There are no coinsurance charges for home health care. Home health care is covered by Medicare following acute care, not for long-term, custodial-type of care. And home care visits are unlimited, really, so there wouldn't be anything to count against the $2,000 if there were no charges for services.

Mr. BIAGGI. Well, that says something very significant for the proposal. I am sure it will never affect me personally, but there are countless cases out there where this kind of problem devastates families.

I have nothing further to say except I will continue to listen, Mr. Chairman. And I admonish—I admonish all of those advocates of general health care to bear in mind what I say. You have nothing. Get what we can get. Fight for as much as we can. Don't be a bull in a China shop and wind up in the same fashion we wound up in some 10 years ago, with nothing.

Chairman ROYBAL. Thank you, Mr. Biaggi.

The Chair recognizes Mr. Hughes.

Mr. HUGHES. I, too, want to echo the sentiments of my colleagues in congratulating you on plowing this extremely valuable ground. I think that you have made a tremendous investment, and I am sure it is going to pay dividends.

I have a couple of areas of concern, but time won't allow me to get into all the areas. In your statement dealing with the general

population, apparently your study group was looking at tax incentives. But then with the tax reform bill of 1986, that became rather moot, and you suggest that you are looking at other alternatives, other options—on page 14 of your statement. I wonder if you can share with us what other options you are pursuing for the general population.

Secretary BOWEN. You are talking about the statement I made just a few minutes ago, and not in our report?

Mr. HUGHES. Yes, your statement today. You indicate that with tax reform legislation now enacted, you are looking at other options. Page 14, at the bottom of the statement.

Secretary BOWEN. Yes; I am aware of it.

Mr. HUGHES. I wonder if you can just share with us your insights into what other options you might be looking at.

Secretary BOWEN. I am unable to do that, because the other options are being considered elsewhere.

Mr. HUGHES. Are being considered within the Administration in other areas?

Secretary BOWEN. Yes.

Mr. HUGHES. Can you share with us who that would be? Is that in the Office of Management and Budget, or where would that be?

Secretary BOWEN. It is a combination of those who disagree with my plan.

Mr. HUGHES. So it is hither and there.

Can we assume that part of it is in the Office of Management and Budget?

Secretary BOWEN. If you care to. I am not trying to be facetious, but I really don't know the exact individuals.

Mr. HUGHES. But you have no specific options that you are looking at?

Secretary BOWEN. We have outlined them all in our reports here, and we have some that we studied which were considered as non-options, so to speak, in the 1600 pages of our technical work group report.

Mr. HUGHES. When you suggest that other options are being considered, then what you are saying is that you are not considering any other options, but that others within the Administration are considering other options.

Secretary BOWEN. Yes, sir.

Mr. HUGHES. Is that what you are saying there?

Secretary BOWEN. That is correct.

Mr. HUGHES. Okay. My colleague, Mr. Biaggi, touched just briefly upon home health care. And I wonder if, in your studies, you have looked at the myriad of other options that bear upon that category of long-term care. I don't think a week goes by that I am not aware of somebody within my own congressional district—and I suspect my colleagues are all in the same position—who really is unable to care for himself at home but yet wants to stay at home. It is too very expensive for them to go to an extended care facility, and they don't really need that type of skilled care to begin with, but they can't find the assistance at home. Often there are no viable options.

Intermediate care is another area where people really don't need skilled nursing care. They need something between skilled care and hospital care, but they can't find that.

Are you looking at those options as part of the overall effort to deal with the problems of the elderly and long-term care?

Secretary BOWEN. Our Department is studying that particular issue from two angles: one, quality of care, it must be comparable to what one would receive in a hospital or a nursing home; and two, the cost of care. We do have, under our Medicaid programs, a Medicaid waiver for optional home care which each State may provide rather than only providing care in an institution. So we have that start, and we are continuing to hold conferences on that particular issue. And we also have a home care study underway.

Mr. HUGHES. Well, my time is up, but that is for another time. Thank you.

Chairman ROYBAL. Mr. Tauke?

Mr. TAUKE. Thank you, Mr. Chairman.

Mr. Secretary, I know that a lot of people have talked about this issue in the past, but until your initiative came forward there was little prospect that legislative action would be taken. So I want to commend you for this initiative. At the same time I have to say to you something that I am sure you already know, and that is that this is another patch on a system that has a lot of faults in it. And I don't know if it is another commission we need, but we certainly do need a much more comprehensive look at the future of our health care system and the way we are going to deliver care to individuals in the nation.

Let me ask about one question on each of the three segments of your report. First, on the acute care for those over age 65. The most popular recommendation on Capitol Hill, if my reading of the tea leaves is correct, is the recommendation for a $4.92 increase in the premium for Part B. However, there is some concern that if we increase the Part B premium $4.92 we will have fewer elderly taking that option. More will opt out of Part B. Did your study look at the issue of how many elderly citizens might choose not to participate in Part B of Medicare if we increase the premium $4.92?

Secretary BOWEN. I believe that the opposite effect would occur. Older people worry about two things: their health and their finances, and which one will run out first. For $4.92, you could buy peace of mind, even for those who think that they can't quite even afford another $5. But I have heard from a lot of people who say, "I would be pleased to pay that or much more and not run the risk of losing all of my savings." So I don't believe there would be many who disenroll.

Mr. TAUKE. You would need a little education effort.

Secretary BOWEN. Pardon?

Mr. TAUKE. You would need a little education effort. I mean, if you just hit citizens with a $5 increase in their bill, and they have the option of paying or not paying, it seems to me some are going to decide not to pay unless there is an effort to educate those who are eligible for Medicare.

Secretary BOWEN. The Lou Harris poll, which I understand was done a month or so ago, stated that the vast majority of Americans would be in favor of this proposal.

Mr. TAUKE. The second question relates to the long-term care segment. You indicate that part of the solution is private insurance. Did your study find out why it is that there is so little private insurance available for long-term care? What is the obstacle?

Secretary BOWEN. Well, I believe the obstacle is the insurance companies fear to come forth with a plan until they could be certain that they wouldn't lose their shirts on it.

Mr. TAUKE. Does your report say how we overcome that obstacle?

Secretary BOWEN. The report stresses the need for an education program for Medicare-eligible beneficiaries instructing them what Medicare covers and what Medicare does not cover. A large percentage of them, about 2 out of 3, according to AARP's, recent poll, thought that Medicare and medigap combined would cover long-term care, and they are utterly shocked when they find out that it is not covered. So an educational program is first, and then the insurance industry feels that incentives to develop these programs would be very helpful.

Mr. TAUKE. The third relates to the under 65 group. I guess I am a little disappointed that the report didn't look at the way we spend dollars now at the Federal level. I know it is not popular to look at tax breaks as expenditures, but a little story may help illustrate the problem.

In my own district, in fact, in the church I go to, a few years ago there was a family of a mother and father in their early forties and nine children. The father had a very well-paying job at John Deere. Unfortunately, he suffered a heart attack and died, so there is a mother with nine children.

When the father was alive, the Federal Government contributed a lot to the health insurance coverage of that family because they had insurance through John Deere. When John Deere participated, they took a tax break. But once the father was dead, there was no help from the Federal Government, the State government or the local government for a family of 10, with no father, no wage-earner in the family, nine children, $14,000 income. And there wasn't any place you could get any assistance from government to provide health insurance.

So it seems to me that for the under 65 group, it isn't that we are spending too little money or making too little contribution from the Federal level. The problem is that we have distributed it so poorly. And I guess that I don't think your report speaks to that issue.

Would you care to comment?

Secretary BOWEN. I am glad you did bring up the point that the Federal Government is contributing tremendously to the uninsured and the underinsured. I have a list of things that we do cover: Medicaid and Medicare; the remaining Hill-Burton free-service requirements; the block grants that go to the States; community health centers and migrant health programs; Indian Health services; the National Health Service Corps; and the disproportionate share adjustment in Medicare. Then, there is the Federal legislation requiring that group-rated employment-based insurance continue for laid-off individuals and for the widow of the individual who passed away, that would have been a solution, or part solution to the prob-

lem that you mentioned * * * then, DOD and VA also cover a tremendous amount of these things. But there is still a gap, yes.

Chairman ROYBAL. The time of the gentleman has expired.

The Chair will try to call on members according to seniority on the committee. At this time I will regain the time that I had given up with regard to questions by the chairman. I would like to ask the distinguished doctor just one question.

We are the only industrialized nation in the world, except South Africa, that does not have a national health plan. Now wouldn't a national health program such as Canada's or better than Canada's, but one that is proposed in my health bill—USHealth (H.R. 200)—provide the protection against catastrophic long-term care that we are now discussing?

Secretary BOWEN. I don't believe I would want to go quite as far as Canada and some other countries. I think that each individual should have considerable responsibility to prepare for his or her own future health and therefore, we should not have, essentially, a Federal program of "cradle-to-grave" care. Individual responsibility is very important.

Chairman ROYBAL. But you do agree, then, that there is definitely a need for a national program that will provide protection for people that are in the particular situation of needing long-term care?

Secretary BOWEN. We need a method whereby the elderly, or anybody, for that matter, receives adequate health care. I am hopeful that method would be more through private coverage than through Federal coverage. But the Federal Government does need to make sure that all the gaps are closed.

Chairman ROYBAL. Doctor, I wasn't fishing to try to get you to endorse my bill. But what I was trying to get from you is whether or not the bill does, in fact, provide the type of care that we are talking about. Whether we want to go that far or not, that is something else. But you agree that it does provide that type of care, do you not?

Secretary BOWEN. It is a very comprehensive plan.

Chairman ROYBAL. Thank you, Doctor.

Secretary BOWEN. It goes a little farther than I would desire.

Chairman ROYBAL. Thank you, Doctor.

The Chair recognizes Mr. Bonker.

Mr. BONKER. Mr. Secretary, you state, on page 15: "We caution that congressional bills should not displace the private insurance market." My question is, why not? In 1965, when Medicare was first implemented, the senior citizens were promised by the Congress that it would cover 80 percent of health-related costs. Today, it covers no more than 48 percent. And so people are forced to purchase private insurance, which incidentally, was not envisioned when the legislation first passed the Congress. So how are private insurance companies doing with Medigap insurance?

Last October, at the request of the House Ways and Means Committee, the GAO reported to the Congress that older Americans got back only 60 cents for each $1 in premiums they paid to commercial health insurance in 1984. Now most health policies sold to large businesses averaged over 90 cents in benefits for each $1 in premium.

This committee has conducted a number of hearings on medigap insurance. The ripping off that takes place for senior citizens, the excessive charges, and the redundant policies that have plagued the senior citizens of this country.

Your concept is fine; that is, to give people the option of the higher premium and expanded coverage. Most people would probably take up the offer, however we ought to expand that option. Today I am introducing legislation, H.R. 784, that incorporates the part of your proposal that deals with premium payments, but goes further to give Medicare beneficiaries the option of purchasing expanded coverage under both Parts A and B, thus eliminating the need for medigap insurance. Further, it provides an extended option that would cover all drug and related costs presently not covered by Medicare or medigap insurance.

This would provide a savings of billions of dollars for senior citizens; and it would significantly eliminate the vexing paperwork that many people find more painful than the illness that is being covered by Medicare and medigap. Now I maintain that your proposal, which again is sound, would still require people to purchase Medigap insurance, and so they are paying an additional amount beyond the $400 or $600 a year they have to pay for premiums and they still have, or they are still exposed to a liability of up to $2,000 a year, based on how many times they have to go into the hospital.

My proposal would give them greatly expanded coverage, not only under Part A as yours would do, but under Part B as well. It would do away with Medigap insurance and the liability would be only $800 a year.

So I ask you, why do we have to necessarily involve private insurance when Medicare is sufficiently established and, according to GAO and other reports I have seen, is doing a fine job at administering the program? Why not expand the coverage, do away with the paperwork, save billions of dollars for senior citizens, and still give them the option of going into expanded coverage with higher premiums or going with private insurance if that is their desire?

Secretary BOWEN. As you are aware, our plan would increase the premium. This would amount to about $59 a year, in contrast to whatever the charges of the medigap policy would be. The potential savings would be between the $59 and the cost over medigap. However, the individual who did not buy the medigap would still be at risk for the $2,000. That would be the choice that he or she would have to make.

I certainly do not condone "rip-offs." I have heard a lot of the same stories you have—elderly with multiple policies and this type of thing. Those should be prevented by law or regulations, or other action. I have not seen the GAO report. It was made available fairly recently, in October of 1986.

Mr. BONKER. That is the same one to which I referred that made reference to the return elderly people are getting, even with Medicare coverage, vis-a-vis those in the private sector.

Secretary BOWEN. Some of the plans, though, are returning 80 and 90 cents, but not very many of them. The average, I believe is 60 cents.

Mr. BONKER. And there are some that go down to 47 cents.

Secretary BOWEN. I know there are some that go way down in thier payout ratio. The Baucus amendment that was enacted in 1980 has done a lot to help correct that, and maybe some strengthening of that might be in order.

Mr. BONKER. Well, Mr. Secretary, I would just conclude by inviting you to consider this option. I think you are sufficiently flexible, and I wouldn't foreclose the idea of making it possible for people to have full Medicare coverage, with the additional premium, and not rely on medigap insurance. It is insufficient. It is expensive, and the paperwork, as I said earlier, is proving very painful to people who have to deal with it every time they go into the hospital.

Thank you.

Chairman ROYBAL. The time of the gentleman has expired.

The Chair recognizes Senator Cohen.

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

I have a brief opening statement.

Chairman ROYBAL. Without objection, it will appear in the record at this point.

[The prepared statement of Senator Cohen follows:]

PREPARED STATEMENT OF SENATOR WILLIAM S. COHEN

I commend the Chairman of the House Select Committee on Aging and the Chairman of the Senate Special Committee on Aging for holding this timely hearing. The specter of catastrophic health care costs haunts the nation's elderly, threatening to drive them into poverty and welfare. The toll that catastrophic health care costs too often take upon individuals and their families is tragic.

Medicare has done much over its more than 20 years to secure for the elderly of this nation access to the medical care necessary to their health and well-being. Indeed, the nation's senior citizens have come to rely on Medicare so much that many do not realize that Medicare does not "take care of everything." Still other senior citizens, who have taken the precaution of purchasing so-called "Medigap" health insurance as a supplement to Medicare coverage, do not have the protection against catastrophic health care costs they may think they are buying. Medicare, often even when supplemented by additional health insurance coverage, leaves senior citizens vulnerable to a financial nightmare that can accompany a serious illness, a long convalescence, or extended nursing home care.

At today's joint hearing, the House and Senate Aging Committees will hear the testimony of the Honorable Otis Bowen, Secretary of Health and Human Services. Dr. Bowen, at the request of the President, has put forward proposals for the provision of protection for all Americans against overwhelming acute health care and long-term care costs. I congratulate Dr. Bowen for his success in advancing public awareness and discussion of the problem of catastrophic health care costs and I look forward to his testimony.

Catastrophic health care expenses can strike anyone -- young and old alike. Indeed, Dr. Bowen's proposals address the need of all Americans for insurance against ruinous health care expenses. However, it is Dr. Bowen's proposals for providing the nation's elderly with protection against catastrophic expenses of acute health care through the expansion of the Medicare program that have attracted the most interest -- and controversy. I know that members

of the House and Senate Aging Committees will be especially interested to hear Dr. Bowen comment on this aspect of his overall proposals.

By far the most common financial "catastrophe" to befall the nation's elderly is the financial burden of long-term care. Again, although many senior citizens may think otherwise, neither Medicare nor private Medigap insurance policies cover the costs of nursing home care under most circumstances. The nation's nursing homes are full of indigent elderly driven to the Medicaid program after the costs of long-term care have claimed most of their income and assets. A comprehensive effort to address the problem of catastrophic health care expenses cannot succeed without addressing this, the most prevalent financial threat to our growing elderly population.

There is much that the federal government might do, and much that it should do, to help senior citizens to face the financial burden of long and serious illness. Whether such efforts should entail encouraging changes in private sector practices, an expansion of the Medicare program, or both, I am pleased that the House and Senate Aging Committees are responding to the needs of the nation's elderly for security from the threat of catastrophic health care costs.

Senator COHEN. Dr. Bowen, if I could just ask a couple of questions of you, and I apologize for not being able to hear your opening statement. I would like to know why, in your judgment, the private sector is being so adamant in its opposition to your type of proposal.

Earlier this week, at a Senate Aging Committee hearing on catastrophic health care costs, a witness indicated, on behalf of the insurance industry, that there really is no problem. That the problems of catastrophic health care expenses is being greatly exaggerated and that the current combination of private and public dollars is serving the public well, and if it is not broke, then don't fix it. Why is there such opposition to your proposal if, in fact, the insurance industry has never taken advantage of its ample opportunity to provide the type of catastrophic health care cost protection that you are advocating?

Secretary BOWEN. To the best of my knowledge, they are opposed simply because they believe that it is removing something from the private sector and replacing it with something in the public sector.

Senator COHEN. What is being removed? Is the coverage being removed?

Secretary BOWEN. I have a different viewpoint from some of the others. I don't think the program that we have put forth would reduce the opportunities for insurance. It would even enhance these opportunities, simply because the $2000 upper limit would still be available for which people could get insurance. There are other items that Medicare has never paid for—eye care, dental care, and drugs—and these could be insured against. It would also be logical they would go right on into long-term-care-type of insurance. So I think that it would stimulate the industry. They may have to sharpen their pencils and rearrange policies a little, but I believe it would not be as harmful as some have indicated.

Senator COHEN. Apparently you touched upon this issue prior to my coming in, but if I might ask in a different way. You obviously explored a number of alternatives to the proposal that you have made. A number of different funding mechanisms and programs. And I would like to know if you could state for me now or at some later time for the record what are the pros and cons, in your opinion, if increasing catastrophic health care cost protections for the elderly via an insurance voucher system?

Secretary BOWEN. I would like to ask Mr. Burke to answer that, if you would, please.

Mr. BURKE. We intend to propose again this year a "voucher" bill. We are supportive of a voucher concept.

Senator COHEN. I am sorry. When you say we, whom do you refer to?

Mr. BURKE. The Department and the Administration.

We also believe that the recommendations in the report would go farther toward fostering and making more attractive the privatization of Medicare via a voucher mechanism. We say that for this reason: Reinsurance provisions would be needed for high catastrophic expenses incurred by private health plans and this could be covered with the $4.92 premium. This, therefore would make the marketing of a voucher easier.

Senator COHEN. I am a bit confused. I was asking the Secretary what his opinion of the pros and cons of a voucher is. Mr. Secretary, are you advocating a voucher system?

Secretary BOWEN. Yes, we are advocating it as an alternative to the traditional Medicare system as a whole, but not for the catastrophic component.

Senator COHEN. Would you clarify for me, then? Is your proposal being accepted and endorsed by the Administration?

Secretary BOWEN. It is being considered by the Administration.

Senator COHEN. Well, would you clarify for me in terms of what is the opposition to your proposal within the Administration?

Secretary BOWEN. There are a couple of oppositions: one—that it would be removing something from the private sector and placing it in the public sector; and sector, the fear that the $4.92 rate is not the right figure or that it would go up; and that the the costs of any Federal program once started tend to escalate.

The $4.92 rate has been figured by the best of actuaries—figured and refigured, and it can be kept that low simply because of the 30 million people over which it is spread. The argument of taking it out of the private sector and putting it into the public sector, I think I have mentioned; but the $4.92 premium and the $2,000 cap, would be indexed to future medical inflation, in order to keep it a pay-as-you-go plan.

Further, the safeguards we have to help to keep the costs down, of course, are the Gramm-Rudman-Hollings law, the DRG system of payment, and the Peer Review Organizations we have, which keep watch over admissions, discharges, costs, and appropriateness of care. In addition to that, we are heading as much as possible toward capitation-like programs which would help keep costs down.

Chairman ROYBAL. The time of the gentleman has expired.

The Chair recognizes Mr. Florio.

Mr. FLORIO. Thank you very much.

Mr. Secretary, let me just say I think the report has served a very important public service purpose. But nevertheless, there is still an awful lot of confusion out there among American people. I think when people listened to the President's speech last night and little comments about our starting to address catastrophic illness, most people don't make the distinctions between acute care and chronic care. Those are things that I think have to be emphasized, though. Because in some respects we are holding out the prospect of people having their problems dealt with when, in fact, there really isn't any imminent intention to deal with the problems that are most impacting upon people.

Is it fair to say that any legislative proposal that the Administration will submit in the foreseeable future, the immediate future, is going to be exclusively an acute care catastrophic illness proposal?

Secretary BOWEN. I cannot answer that, because I don't know.

Mr. FLORIO. It is my sense and what is a little bit disconcerting is that your relatively modest acute care proposal, that is the section of your report that deals with acute care, apparently is not being met well with a lot of enthusiasm by some in the Administration, and that, of course, means that we are not even addressing the serious problem, all these are serious, but in terms of the problem

area that has the most direct and costly impact on American aging people is the long-term care aspect of the catastrophic illness.

We have had Congressional hearings in my area, this committee has, I have had people that have come and told me about Alzheimer's disease, long-term stroke, being advised that they have to spend down in order to qualify for medicaid, literally put themselves into a state of poverty before they would have any governmental assistance to deal with those costs.

Do you have any intention or do you know if the Administration has any intentions of submitting legislative proposals that will deal with long-term chronic medicare proposals?

Secretary BOWEN. The only answer I could give you, sir, is the statement the President made that shortly, he will send legislation to Congress to deal with the catastrophic issue. That, in my judgment, would mean all three areas: acute care for the elderly; long-term care; and catastrophic care for those under the age of 65.

Mr. FLORIO. That is pretty much what the President said last year. Do you have some sense of when we can expect particularly the long-term care legislative component of that proposal? This year?

Secretary BOWEN. Whatever the definition of "shortly" is, that is when it will be.

Mr. FLORIO. I am sorry, I didn't hear you.

Secretary BOWEN. Whatever the definition of "shortly" is, that is when it will be. I don't know.

Mr. FLORIO. I don't mean to be disrespectful, Mr. Secretary, but I think we are entitled to a little bit more of a specific response than that. Are we talking about six months?

Secretary BOWEN. I don't want to be disrespectful either, but I don't know. I would tell you if I knew.

Mr. FLORIO. Let me ask one last question, then. I thought I heard in your initial presentation the suggestion, I am not sure exactly what you were suggesting, the suggestion that the States ought to require in employment based health programs some long-term care component.

Did I hear that, and if I did, isn't there some desirability for having that done on a national basis rather than State by State, so as to allow States to end up making determinations not on the basis of health care, but maybe economic incentives to locate in different States?

Secretary BOWEN. It would probably be desirable to have a uniform system, but I am not familiar enough with the expected differences in how State-by-State passage or Federal passage of a bill would affect employment based health options.

I don't know.

Mr. FLORIO. I must have misunderstood. Didn't I understand you to suggest in your preliminary remarks that State-by-State mandating of employment-based coverage would be an optional—desirable option?

Secretary BOWEN. Yes, that was in my testimony, but I thought you were asking whether it should be national or State-by-State. We have suggested State-by-State in the report.

Mr. FLORIO. You suggest State-by-State?

Secretary BOWEN. Yes, we do.

Mr. FLORIO. Is there a philosophical reason as to why it should not be done uniformly, the same approach, but uniformly across the country rather than very different systems in different States?

Secretary BOWEN. As I understand it, insurance has been governed almost totally at the State level rather than at the Federal level. That would be one good reason why it should be State-by-State.

Chairman ROYBAL. The time of the gentleman has expired.

Mr. FLORIO. Thank you.

Chairman ROYBAL. The Chair recognizes Senator Chafee.

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

It is clear, Dr. Bowen, that the deepest concerns of the elderly is the fear of a devastating illness with the consequences of financial impoverishment. In your proposal, that covers the long-term care in a hospital, and you are moving on something we will follow along as I understand from you, dealing with long-term non-hospital care.

You indicated that will be the next section, as it were. I would like to ask about what you might call an in-between group, let's take the case of somebody who is suddenly stricken with a stroke, rushed to the hospital, and stabilized, and it appears that that person is not going to get better, and is so immobilized that he or she will require long-term care, let's say, in a nursing home.

We have the situation where under the prospective reimbursement and DRG setup, some people are moved out of the hospital before really they are, or before they should be. I don't say that harshly, but just that that is what occurs.

What I am thinking about in the case of this particular person, where the person is not in the condition that they would be once they got into the nursing home, but required a bit of intensive extra assistance.

That is an in-between case between the long-term situation and the in-hospital situation. Is there anything in your proposal now that would cover that situation?

Secretary BOWEN. No, we recommended nothing specific to cover that. The individual you were talking about would go from the hospital and potentially could be put into a skilled nursing facility for some time.

Senator CHAFEE. Let me make the case, they are going home, let's say, and being cared for at home, but they require an initial period at home, greater assistance than they will require once the case gets stabilized.

That is perhaps a better illustration. Now, is there any plan or thought given to giving that person or the family, while he or she is at home in this initial period, a little extra help?

Secretary BOWEN. Home health care is available in the acute care cases. I think that this individual would probably qualify for that, for at least a short period of time. That is already built into the program. But the answer is "no," we have nothing in our program that would take care of that situation.

Senator CHAFEE. And that is built in absent medicaid, we are not assuming that the person had to spend down.

Secretary BOWEN. That is right, and in Medicaid situations, there is more chance of home health care in many States, simply because

we have a Medicaid waiver program that can give the States the opportunity to have home care versus institutionalization.

Senator CHAFEE. I am interested more in the non-medicaid patient who had not had to spend down in that situation.

Thank you, Mr. Chairman.

Chairman ROYBAL. Thank you.

The co-chairman this afternoon is Senator Melcher, who will now take over the chairmanship, and I ask him to proceed under the five-minute rule.

Chairman MELCHER [presiding]. Thank you, Mr. Chairman.

The Chair now recognizes Mr. Saxton.

Mr. SAXTON. Thank you, Mr. Chairman.

Dr. Bowen, one of the previous members of the House Aging Committee questioned you relative to whether or not potential beneficiaries in the long-term care program would actually be anxious to participate.

I would like to assure you from my travels and visiting with senior citizens around New Jersey that there is a great deal of excitement about the proposal, particularly when the cost to the individual is mentioned.

When I have been able to explain in general terms what I know about the plan and what I believe the expected cost to be of $60 or thereabouts, or a little less, a year, people are very anxious to see the proposal enacted into law.

In fact, they ask me when it is going to happen, so I can take advantage of it? My question relates to $4.92 a month. Let me preface my question by saying this: Over the years, the cost to the social security program has been thought to be stabilized on numerous occasions, and because it is a benefit to people, and because Congress wants it to work well, the cost has escalated over the years to the point where people pay many times more today for the program than they did at its inception.

The same has been true of the medicare program as it exists today. When Medicare was first instituted in 1965, there was a level of benefits that were expected to be provided, and a level of payment to be expected to be paid by participants in the program. Through the last 20 years, that level of payment has risen and the level of benefit has decreased.

Now, we are in the process of convincing people that we have a good program for $4.92 a month. My question is, how sure are we that it is going to be $4.92 a month? How long do we expect it to stay at $4.92 a month, and do the actuarial facts that you have indicate that we are in fact on safe ground with that number for some time to come?

Secretary BOWEN. I can only state that $4.92 is deemed very adequate for this year's prices, this year's cost of living, and so forth. I can't guarantee what inflation rates will be, but we have stated that the $4.92 should be indexed to the medical inflation rate to keep it cost-neutral.

But again, I am well aware of the fact that when Part B went into effect back in 1966 it was $50 and had that $50 been indexed, today I believe it would have been about $200.

So, everything is relative.

Mr. SAXTON. Perhaps the answer to this is that there are a relatively few number of people who would actually benefit from this program directly. Now, there are many people who would benefit from having a safe and secure feeling about their future by paying the premium into the program, but am I correct in assuming that there are a relatively few number of people who would actually benefit from this expanded program, and is that the reason that the cost is relatively low?

Secretary BOWEN. About 3 percent, I believe, would benefit directly, as you say, but the other 97 percent would worry a lot less.

Chairman MELCHER. The time of the gentleman has expired.

I now recognize Senator Reid.

Senator REID. I have no questions, Mr. Chairman.

Chairman MELCHER. I now recognize Congressman Swindall.

Mr. SWINDALL. Mr. Secretary, is your $4.92 figure based on a voluntary or compulsory system?

Secretary BOWEN. It would be attached to the Part B premium. Part B, by law, is voluntary, but the vast majority of people elect it. I don't know what the percentage is, but it is well up in the nineties.

Mr. SWINDALL. By definition, your $4.92 figure is speculative, because you must speculate as to how many will actually participate.

Secretary BOWEN. I think Part B is considered to be one of the best bargains in government. I doubt very much that there would be anybody who would disenroll.

Mr. SWINDALL. Except for one basic fact, and that is the fact sheet says that nearly 80 percent of all older persons surveyed in 1986 were under the false impression that Medicare covers long-term care already.

Why would somebody spend $4.92 to get something they presumably already have?

Secretary BOWEN. This is where the education program has to be effective.

Mr. SWINDALL. Next question is what, what is the dollar return on Medicare?

Secretary BOWEN. The what?

Mr. SWINDALL. The dollar return on Medicare?

Secretary BOWEN. Between 97 and 98 cents.

Mr. SWINDALL. And my next question would be have we given any thought or consideration to the prospect of mandating coverage in much the same way that States mandate no-fault insurance or insurance coverage, or whatever, and then leaving the private sector basically under presumably free market, competitive conditions to provide the insurance?

Secretary BOWEN. I have not considered any such mandate, no.

Mr. SWINDALL. Why would that not even be considered as an alternative?

In other words, it would broaden your pool so that you no longer end up only with high-risk individuals opting out, and presumably the costs would be very, very low if everyone was required to participate, but you would get the positive aspects of free market, competitive, private sector industry providing the coverage.

It would seem to me that should at least be considered.

Secretary BOWEN. We can consider it, but I guess I am a little sensitive to the word "mandate."

Mr. SWINDALL. In effect, aren't we mandating a system when you, as we did in 1965, actuarily soundly presume that it is going to be a certain cost, and now we find it is 8 to 10 times what the original assumptions were? We were mandating through tax-paid dollars a higher cost than we did when we went into it, supposedly with our eyes open; is that true?

Secretary BOWEN. I would have to say it is true, yes. But the benefits have also been increased.

Mr. SWINDALL. But, again, it is a matter of how we define voluntary or compulsory?

Secretary BOWEN. Right.

Mr. SWINDALL. Thank you.

Chairman MELCHER. The Chair now recognizes Senator Shelby.

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

Mr. Secretary, I was absent and didn't hear all of your testimony, but I am very interested in your plan. I would like to go over, if I could, if you would indulge with me a few minutes, some of the costs and see if I have these cost proposals that you all have done right.

Is it $4.92 a month increase over the Medicare premium of $17.90, or $59 a year total increase; are those your basic numbers?

Secretary BOWEN. It would be added to the regular Part B premium, which, I believe, is $17.90, at the present time. It was about $15 until the first of the year.

Senator SHELBY. That is correct.

Secretary BOWEN. So, it would be $4.92 a month, for each month, which totals $59 a year.

Senator SHELBY. How much money would that bring in, Mr. Secretary?

Secretary BOWEN. About $1.7 billion.

Senator SHELBY. A year?

Secretary BOWEN. A year.

Senator SHELBY. Okay. Do you think that—do your studies show that that would be adequate financing starting out?

Secretary BOWEN. Our actuary has been over it, and over it and over it, and he says, "yes." That is even with the assumption that there would be a little increased utilization.

Senator SHELBY. For one, I believe that the time has come, if it hasn't already passed us, when we needed this. I want to salute you for approaching this.

I don't know what method we are going to go, what road we are going to go down, but whatever road we go down, we ought to make sure that, one, it is financed right. If there is or could be some private participation in a big way, we ought to look at that. But the American people, and I know in my home state of Alabama, they are crying for it. It is an issue that transcends both parties, I think, and a lot of us in the Senate and House want to work and get this done just as you do, Mr. Secretary.

Secretary BOWEN. I appreciate your comments.

One of the dangers I think we face is that of over expectation, that the $4.92 will cover everything, long-term care and all——

Senator SHELBY. Explain what that $4.92 would cover?

Secretary BOWEN. The $4.92——

Senator SHELBY. Especially Part B; wouldn't it?

Secretary BOWEN. Yes, once the cap is reached, it would cover Part B services, and Part A services, and, in fact, essentially unlimited hospital days in a year, an unlimited amount of covered medical care, plus the home health care benefit already in Medicare, and the skilled nursing home provisions. But the individual would still be at risk for a maximum of $2,000.

Now if an individual continued taking medigap coverage—the $2,000 would obviously be covered, but the choice for the individual would be between, "do I want to be at risk for $2,000 and take the chance of not being sick and my maximum would be $2,000 out-of-pocket? or do I want to purchase an additional medigap plan which would cover the $2,000 plus the things that Medicare has never covered, eye care, dental care and drugs?"

Senator SHELBY. Without a legislative initiative you are going to see thousands and thousands, and millions of people at risk for everything, aren't you?

Secretary BOWEN. That is right.

Senator SHELBY. Thank you, Mr. Secretary.

Thank you, Mr. Chairman.

Chairman MELCHER. The chair now recognizes Congressman Wise.

Mr. WISE. Thank you, Mr. Chairman. I will be very brief.

I think many of the details have been covered. Mr. Secretary, I want to commend you on, at least, initiating the discussion. You mentioned medigap insurance, and that has been one of my concerns, particularly the solicitation.

Let me ask in somewhat a facetious spirit, if you do institute this program, I request that you pledge not to put it out by competitive bidding, or to anyone else, to retired actors, to solicit on television coverage here.

Could I get that pledge? I like the program a whole lot more with that pledge.

The only other requirement is if you do put it out for bid that way, I would ask that there be a provision in the law stating that that actor who is compensated for his appearances, must he himself use that insurance policy or this coverage, that it be the only insurance policy that covers him, so he is totally dependent on that as are the poor suckers he is luring into it. I would ask that, also.

Thank you very much. I yield back the balance of my time.

Chairman MELCHER. The chair now recognizes Congressman Ridge.

Mr. RIDGE. Thank you, Mr. Chairman.

I want to echo and congratulate my colleague from West Virginia for his remarks.

Dr. Bowen, you are very confident that the $4.92 figure is actuarily sound. Might you, for purposes of the record, submit to us the assumptions that your actuary used including the patient population, the inflation factor, the cost factor, so we might be able to examine them independently and hopefully reach the same conclusion that you do?

Secretary BOWEN. We would be glad to submit that for the record.

Mr. RIDGE. I would appreciate that.
[The information follows:]

METHODOLOGY OF ESTIMATING CATASTROPHIC COVERAGE PREMIUM

To determine the catastrophic coverage premium, a computer model was constructed. The model projects the medical expenditure of each individual in the sample from the base year to the target year. Beneficiary's out-of-pocket liabilities under the present law benefit structure and under the catastrophic coverage proposal were then determined. The difference between these two out-of-pocket liabilities represents the additional cost arising from the new and restructured Medicare benefits. By aggregating the additional costs for all beneficiaries in the sample and then expanding it by the right proportion to represent the entire Medicare population, the total added cost was determined which is to be funded through a premium paid by all enrollees in the Part B program. Such a premium is obtained by dividing the total additional cost by the number of Part B enrollees. Note that the premium so determined is the benefit premium. It does not include any increase in the ongoing administrative expenses associated with the new benefits. Nor does it include any cost needed to set up a new, or to modify the existing data collection and processing system to monitor the restructured benefits.

The data file used is a one percent sample of Medicare enrollees who received benefits in calendar year 1983. It includes records for 196,300 individuals. Each record contains certain demographic information along with utilization data of medical services in 1983, such as number of hospital admissions, number of inpatient days, amount of Part A reimbursement, amount of Part B reimbursement, etc.

In projecting the base year data to the target year, changes in the Medicare program that took effect during or after the base year which had significant impact on reimbursement or utilization were taken into consideration. Time trends in utilization and unit cost of major types of medical services were also reflected in the projection. These adjustments were determined in such a way that in the aggregate the projected values of certain major parameters closely match those in the 1986 Trustees' Report.

Liberalization of benefits always carries the risk of encouraging utilization of services, either because of beneficiaries' own initiatives or because of providers' behavior, especially when beneficiaries' out-of-pocket expenses are near or over the cap. However, trying to estimate the extent of such induced utilization because of behavorial changes is inherently difficult. To compensate the potential of induced utilization, a small margin of five percent was added to the rate.

The final premium for the Bowen proposal was $4.92 a month for calendar year 1987. If the proposal is not implemented until 1988 or later, the premium will be higher.

To illustrate the approach described above, the derivation of the $4.92 monthly premium is persented below.

	1987 projection
1. Number of Part A deductibles under present law	8,156,600
2. Number of inpatient coinsurance days	2,776,200
3. Number of lifetime reserve days	1,057,300
4. Number of SNF coinsurance days	4,901,800
5. Part A out-of-pocket expenses under present law $-(1)\times 520+(2)\times 130+(3)\times 260+(4)\times 65$	$5,196,000
6. Part B out-of-pocket expenses under present law	[1]$9,228
7. Combined out-of-pocket expenses under present law	[1]$14,424
8. Combined out-of-pocket expenses under catastrophic proposal	[1]$12,906
9. Reduction in beneficiaries' out-of-pocket expenses $(=(7)-(8))$	[1]$1,518
10. Estimated cost for 365-day inpatient benefit	[1]$240
11. 5% margin	[1]$88
12. Total net cost $(-(9)+(10)+(11))$	[1]$1,846
13. Number of Part B enrollees	31.5
14. Net annual premium $(=(12)/(13))$	$59
15. Net monthly premium $(=(14)/(12))$	$4.92

[1] Million.

Mr. RIDGE. When you talked about improving protection, particularly in the area of acute care expenses, you also discussed an option involving restructuring, to provide for protection with increased cost sharing related to income.

Now, that is the first time, to my knowledge, that any type of cost sharing related to income would be considered as part of the medicare program.

I realize it is an option, but I thought I might inquire as to whether or not it was an option that involved the escalation or reduction of the cap, escalation or reduction of the premium based on income—would you care to elaborate or would you elaborate?

Secretary BOWEN. I don't believe we have discussed the exact method of figuring, unless Mr. Wirk has more knowledge of it than I. I would emphasize that what is catastrophic for one individual certainly is not catastrophic for another; therefore, some evaluation of income before you set a price sounds reasonable, but it would also increase the administrative problems of the Medicare program tremendously.

Mr. RIDGE. I figured it could conceivably have a down side to it. For instance, you might be required to file separate forms to determine income eligibility and the like. But I look forward to further development of at least that option in some of our future discussions.

With regard to the long term care portions of your report, I noted that, and was not surprised, that the insurance industry sought incentives, Government incentives, to attract people to use private sector insurance. But I thought in terms more of the home health care approach.

Are there any incentives to be considered—and let's go outside the area of tax credits for the time being, that would include recipient care or day care outside the home, so that those spouses or those sons and daughters who chose to care for a family member at home rather than putting that loved one in an institutional setting would be provided some assistance or relief? Is there any discussion, have you discussed or considered providing any expansion of day-care facilities?

Secretary BOWEN. We did not in our report, no. Obviously those things are always brought up and discussed, but you have to draw the line somewhere. Our report was the extent of it; it can be added to or subtracted from. This is a starting point at least, and I don't have the pride of authorship so much that I think this is the only way to go. If something can come out of the debate or discussion as a result of this that is worthwhile for our people who find themselves in those situations with catastrophic expenses, then I think it would all have been worthwhile.

Chairman MELCHER. The time of the gentleman has expired.

Mr. RIDGE. Thank you, Mr. Chairman. Thank you, Doctor.

Chairman MELCHER. The chair now recognizes Congressman Smith of New Jersey.

Mr. SMITH. Thank you very much, and Dr. Bowen, welcome again to the committee. First of all, Mr. Chairman, I would ask that my opening comments be included in the record.

[The prepared statement of Mr. Smith follows:]

PREPARED STATEMENT OF REPRESENTATIVE CHRISTOPHER H. SMITH

MR. CHAIRMAN, I WOULD LIKE TO THANK YOU FOR CONVENING THIS IMPORTANT HEARING TODAY. I WOULD ALSO LIKE TO WELCOME SECRETARY BOWEN. THANK YOU, MR. SECRETARY, FOR TAKING THE TIME TO APPEAR BEFORE THIS PANEL TO ADDRESS THE ISSUE OF CATASTROPHIC ILLNESS AND CATASTROPHIC HEALTH CARE COVERAGE.

MR. CHAIRMAN, NEARLY 16 MILLION AMERICAN FAMILIES, OR ABOUT ONE FAMILY IN FIVE, INCUR "CATASTROPHIC" OUT-OF-POCKET MEDICAL COSTS EACH YEAR, ACCORDING TO A RECENT STUDY FUNDED BY THE NATIONAL CENTER FOR HEALTH SERVICES RESEARCH. THE STUDY FOUND THAT PEOPLE SUFFERING CATASTROPHIC COSTS (GREATER THAN 5 PERCENT OF THE FAMILY'S GROSS INCOME) WERE OF TWO TYPES: THOSE WHO HAD GOOD HEALTH INSURANCE BUT HAD VERY LARGE COSTS BEYOND THEIR COVERAGE, AND FAMILIES FOR WHOM RELATIVELY SMALL OUT-OF-POCKET EXPENSES REPRESENTED A HIGH PERCENTAGE OF THEIR INCOME DUE TO A COMBINATION OF LOW AND INADEQUATE OR NONEXISTENT HEALTH CARE COVERAGE.

IN MANY CASES, MR. CHAIRMAN, CATASTROPHIC MEDICAL COSTS STEM FROM LONG TERM CARE FOR AN ELDERLY PATIENT. AN ESTIMATED 6.6 MILLION AMERICANS 65 AND OLDER REQUIRE LONG TERM CARE. OF THE ELDERLY OVER 84 YEARS OF AGE, 22 PERCENT ARE INSTITUTIONALIZED. MOREOVER, THE ELDERLY POPULATION IS INCREASING IN RECORD NUMBERS. LIFE EXPECTANCY AT BIRTH HAS REACHED A NEW HIGH OF 74.6 YEARS.

IN GENERAL, AMERICA'S FAMILIES ARE SHOULDERING THE BURDENS OF PAYING FOR LONG TERM CARE WITH THEIR PERSONAL FINANCIAL RESOURCES. IN FACT, 40 PERCENT OF NURSING HOME CARE IS PAID FOR FROM PRIVATE SOURCES. INSURANCE POLICIES FOR LONG-TERM CARE ARE AVAILABLE, BUT ONLY A SMALL FRACTION OF AMERICANS HAVE TAKEN ADVANTAGE OF THEM.

THIS MAY BE BECAUSE MANY OLDER AMERICANS MISTAKENLY BELIEVE THAT MEDICARE COVERS NURSING HOME CARE. A 1983 SURVEY BY THE AMERICAN ASSOCIATION OF RETIRED PERSONS, FOR EXAMPLE, SHOWED THAT 79 PERCENT OF THOSE WHO THOUGHT THEY MIGHT ENTER A NURSING HOME ERRONEOUSLY BELIEVED MEDICARE WOULD PAY ALL OR PART OF THE BILL.

THE FACT OF THE MATTER IS, MR. CHAIRMAN, THAT MEDICARE PAYS ONLY FOR SHORT-TERM STAYS (UP TO 100 DAYS). IT DOES NOT COVER "CUSTODIAL" LONG-TERM CARE. MEDICAID, THE JOINT FEDERAL-STATE HEALTH PLAN FOR THE POOR, DOES PAY FOR NURSING HOME CARE.

BUT MEDICAID WAS DESIGNED TO HELP ONLY THE TRULY NEEDY. BEFORE IT WILL PAY, PATIENTS MUST BE POOR ALREADY OR "SPEND DOWN" THEIR ASSETS TO MEET STRICT ELIGIBILITY STANDARDS. SADLY, ONCE A PERSON IS IN A NURSING HOME, THAT PROCESS DOES NOT TAKE VERY LONG.

MR. CHAIRMAN, OUR COMMITTEE FOUND THAT 63 PERCENT OF OLDER AMERICANS WITH NO SPOUSE IMPOVERISH THEMSELVES AFTER ONLY 13 WEEKS IN A NURSING HOME. ACCORDING TO THAT SAME STUDY, 83 PERCENT BECOME IMPOVERISHED WITHIN A YEAR.

HAVING REALIZED THE MAGNITUDE OF THE PROBLEM OF PAYING FOR LONG TERM CARE, CONGRESS, THE WHITE HOUSE, AND THE PRIVATE SECTOR ARE SEEKING APPROPRIATE MEANS TO PAY FOR CATASTROPHIC HEALTH CARE. THE U.S. CHAMBER OF COMMERCE HAS FORMED A TASK FORCE TO STUDY PRIVATE SECTOR ALTERNATIVES. MR. BOWEN'S PLAN WAS RELEASED IN NOVEMBER OF LAST YEAR IN RESPONSE TO A MANDATE BY THE PRESIDENT. IN ADDITION, BUDGET RECONCILIATION LEGISLATION THAT BECAME LAW IN APRIL CALLED FOR AN 18 MONTH STUDY BY A NEW TASK FORCE TO RECOMMEND LONG TERM CARE POLICIES TO CONGRESS AND STATE GOVERNMENTS.

PROPOSALS IN CONGRESS RANGE FROM EXPANSION OF MEDICARE COVERAGE TO INCLUDE AN OPTIONAL PART "C"; TO MEDICAL IRA'S; TO TAX DEDUCTIONS FOR THE CARE AT HOME OF CHRONICALLY ILL, ELDERLY FAMILY MEMBERS. MOST OF THESE PROPOSALS ARE VEHICLES FOR DISCUSSION OF POSSIBLE WAYS THE PRIVATE AND PUBLIC SECTORS CAN MEET THE VAST NEED FOR A CATASTROPHIC ILLNESS POLICY.

ONCE THE VARIOUS TASK FORCES COMMISSIONS AND PRIVATE SECTOR GROUPS HAVE COMPLETED A COMPREHENSIVE EXAMINATION, INCLUDING STUDY BY THE SELECT COMMITTEE ON AGING THROUGH SUCH FACT-FINDING FORUMS SUCH AS THE HEARING TODAY, I BELIEVE THERE WILL BE A CONSENSUS HERE IN CONGRESS TO TAKE ACTION ON THIS VITAL ISSUE.

MR. CHAIRMAN, IN HIS STATE OF THE UNION ADDRESS YESTERDAY THE PRESIDENT REAFFIRMED HIS COMMITMENT TO SOLVING THE CURRENT CRISIS FOR THOSE FAMILIES AND INDIVIDUALS WHO ARE OR WILL SOON BE FACED WITH A MEDICAL CATASTROPHE. IT IS OUR RESPONSIBILITY, AS REPRESENTATIVES OF THE PEOPLE, TO REMAIN FIRM IN OUR COMMITMENT AS WELL BY TAKING RESPONSIBLE, VIABLE STEPS TOWARD FINDING A SOLUTION TO THE PRESENT PROBLEM.

I COMMEND YOU, MR. CHAIRMAN, FOR ARRANGING THE HEARING TODAY AND I LOOK FORWARD TO THE INSIGHT MR. BOWEN WILL PROVIDE ON WAYS TO ADDRESS THE CURRENT GAP IN MEDICAL COVERAGE FOR MANY AMERICANS.

Mr. SMITH. Mr. Chairman, Dr. Bowen, you indicated that 50 percent of the people in nursing homes are on Medicaid. We all, I think—in our districts, and I know my own family—have has situations where family members have been literally drained once they have gone into the nursing home, and over a period of time their income has gotten down to the point where they are indigent.

Do you have any tables or any figures that you would share with this committee as to how many elderly couples remain indigent through nursing home expenditures?

Secretary BOWEN. I believe about 500,000 per year, and it takes about 3 to 6 months to spend down—for the average family to get down to the Medicaid level.

Mr. SMITH. You say there are two people, a couple. What happens to the family member who is not in the nursing home?

Secretary BOWEN. Well——

Mr. SMITH. Have those people been tracked?

Secretary BOWEN. I don't know how many of those 500,000 have spouses.

No, but we can try to find out.

Mr. SMITH. That would be helpful in establishing the record not just on those in the nursing home, and what their quality of life is or has become, but those that are surviving.

Secretary BOWEN. I presume of those 500,000 though, if they were down to the Medicaid level, that the spouse would be Medicaid eligible and would be taken care of at home rather than——

Mr. SMITH. Well, then, one more reason to have the early intervention would be to prevent that other person from suffering the consequences. I was listening to my friend and colleague, Mr. Saxton, addressing the $4.92 per month additional premium. I, too, had a number of questions about how sound that figure will ultimately be and how long it will last. I was wondering since even under the provisions of Gramm-Rudman it takes more than one government agency, OMB and CBO, to come to a conclusion as to what the deficit will be at any given time. Did any other agency, GAO, OMB, or CBO, look at that figure and determine whether or not it was accurate? Will they be second-guessing so to speak?

Mr. BURKE. They are welcome to our data to analyze if they would like, but they have not.

Mr. SMITH. I think it would be helpful.

Mr. BURKE. Yes.

Mr. SMITH. Since the low cost certainly is one of the necessay features of catastrophic insurance, as Mario Biaggi indicated, we may have to settle for something less than total comprehensive catastrophic illness health insurance rather than going for broke.

If the figure on which we base our assumptions is not accurate, that could be a fine line.

Mr. BURKE. The $4.92 figure, even if it were off is such that it is actuarially sound. So, if it were off this year, and it is $5.10, the difference between the amount—and what it might be that year would have to be added to the next year's premium, plus the indexing. So, over time, there would be no general revenues going into this fund.

Mr. SMITH. Understood. But again for those who will be footing the bill, those paying into the fund through the premiums, it would

be helpful to know as far as reasonable possibility, whether it is accurate. I have become in my three terms, now in my fourth term, very skeptical about so many figures emanating from all branches of Government including our own CBO, because 6 or 12 months down the line, time and time again, they prove not to be accurate.

That is not to cast any aspersion on your work. As a matter of fact, I am proud to say the mayor from my own home town, Jack Rafferty, was very much a part of the Commission, which worked to develop this plan.

Secretary BOWEN. You would have the opportunity to request a CBO budget study on it, too.

Mr. SMITH. Thank you.

Chairman MELCHER. The time of the gentleman has expired. The chair now recognizes Congressman Kennedy.

Mr. KENNEDY. Dr. Bowen, thank you for being here and for reviving this issue. Last night we listened to President Reagan talk about the fact that he was against the national debt. He was going to oppose any new taxes. He was going to continue the deficit build-up, and I just wonder—the program that you are bringing in is going to cost someone an additional $1.7 billion, whether or not you feel a little bit like a red herring this afternoon or in fact whether or not this proposal has any realistic hope of being passed by this Congress and approved and not vetoed by this Administration.

Secretary BOWEN. The proposal we will put forth is a pay-as-you-go plan and would be of no increased cost to the Federal Government, so I don't think that really should be an issue.

Mr. KENNEDY. So we can raise revenues as long as we don't raise taxes; is that what you are understanding of the President's position is?

Secretary BOWEN. No, I don't want to second-guess what his position is.

Mr. KENNEDY. I am not trying to—what I am really trying to find out is whether or not this is a serious hearing this afternoon about a program, by every chart and by everyone's story, it is vitally necessary. You have obviously done work to know that it is a vitally necessary program across this country and whether or not you feel that we are really just playing a game here this afternoon or whether there is a sincere effort on the part of this Administration to come to grips with national health insurance or come to grips with catastrophic health insurance or to just grab some headlines?

Secretary BOWEN. I have spent my life in this particular area and I have had two personal experiences, so I can assure you that I am very serious. My first wife spent many months in a hospital dying of cancer, and I know what acute care expenses are.

My mother is in her third year in a nursing home now. My father was a school teacher with five children, and they didn't have the savings or income for this kind of expense. So I come at this from two angles; there could be no one more serious than I am.

Mr. KENNEDY. I certainly didn't mean to imply that you were not the one serious about this. I do think that there is a question that it would be interesting to have you answer as to whether or not you think this Administration which you are here today represent-

ing, is in fact serious about getting catastrophic health insurance passed this year?

Secretary BOWEN. I believe I can answer that with a very definite "yes," I think the President is intensely interested in doing something to solve the problem. The question is the method of solving it——

Mr. KENNEDY. But we are not here to play some word games back and forth. We are not diplomats. What we are trying to get to is whether or not he is going to be willing to pay $4.92 per person, $60 a year to get catastrophic health insurance.

Secretary BOWEN. I cannot answer that. He said he would be coming out with the Administration's program shortly.

Mr. KENNEDY. And doesn't the Administration look to you to develop that program?

Secretary BOWEN. I was charged with the study and preparing a report as to how the private and public sectors could work together to solve the problem of catastrophic expenses for illnesses in all age groups.

Mr. KENNEDY. How do you interact, then, with your own administration?

Secretary BOWEN. I have had the opportunity three times to present our report to the Domestic Policy Council, at which time it received considerable discussion. I have had two opportunities to present it to the President and the Cabinet, where it received further discussion. The final decision will be made at a level higher than mine and the report, as you saw last night, said this will be done shortly.

Mr. KENNEDY. Shortly. Well, I hope we can all work together to make certain that the message gets through this time; that this program is needed and there are members of this Administration that recognize it is vital. Thank you.

Chairman MELCHER. The chair now recognizes Congressman Clarke.

Mr. CLARKE. Thank you, Mr. Chairman. Thank you, Dr. Bowen, for coming. I just have one quick question. In view of the $2,000 gap which you estimate individuals suffering catastrophic illness must make up, and the need for medigap policy in many cases, do you foresee the need for continued Federal standards for what are called medigap policies?

Secretary BOWEN. Yes, I do. The Baucus amendment that was put into effect in 1980 did a lot to improve the quality of medigap policies, and yet, I suspect there is room for further improvements. This is, however, administered at the State level because insurance is handled at the State level instead of at the Federal level.

Mr. CLARKE. You feel there should be Federal standards for those policies, though?

Secretary BOWEN. Federal guidelines for it, yes.

Mr. CLARKE. Thank you very much. Thank you.

Chairman MELCHER. Dr. Bowen, I want to return just briefly to the area of the harshest catastrophe for the elderly and that is the area where an individual or a family has exhausted all of their life savings and find themselves broke, yet the care for the person must continue. So if they can retain their dignity and not be on welfare and thus eligible for Medicaid, they are going to have a

little broader coverage than what is in your proposal as it exists now.

Referring to the charter over there, the first one with the pie-shaped graphic shows that of those elderly who have medical expenses exceeding $2,000 annually, that that is 81 percent of the expenditure.

Now, a large portion of that, of course, is spent in nursing homes and your testimony—we discussed this very briefly at the outset. Your testimony reflects that almost a million and a half Americans are in nursing homes now, and half of them are covered by Medicaid. Dr. Bowen, I am going to ask you to do one more thing for us today, and that is to provide whatever information you can on what it would cost either from the Government or a combination of Government and private insurance to say to those in the nursing home that are on their own funds yet, they are not broke. "You are covered. Your expenses are covered after some threshold," and I would suspect that $2,000 is a low threshold, so I will ask you for about $6,000 to be fully covered in the nursing home.

This is after they have spent $6,000. One time.

Secretary BOWEN. The question, then, is "What would it cost the government and private insurers, together with a $6,000 threshold, to cover these 1.4 million who are in the nursing homes?"

Chairman MELCHER. And who are not already covered by Medicaid.

Did I understand you correctly earlier in the day when you said that the expenses of approximately half of the people now in nursing homes are paid by Medicaid?

Secretary BOWEN. Yes, you are right. We spend about $32 billion a year on nursing homes, which would mean around $16 billion in Medicaid money going to that type of care.

Chairman MELCHER. So the point of my question is, can we take another step to say to the elderly that at this point you can still have a few thousand dollars left in your savings, and you won't have to go broke to have the rest of the costs paid for?

Secretary BOWEN. I would like to have Mr. Burke answer.

Mr. BURKE. For purposes of costing that out, I think you need additional information. You will have to assume there is no new increase in the nursing home population; is that correct?

Chairman MELCHER. Yes.

Mr. BURKE. Secondly——

Chairman MELCHER. And let me point out I don't think any of the elderly prefer to be in the nursing home. I think they would prefer to stay at home.

Mr. BURKE. And this would be a person who comes in in the first year, since it is on average a $22,000, cost per year; after they have incurred $6,000, you would have the remainder of the $16,000 paid for from some third party.

Is that your question?

Chairman MELCHER. The combination of the Government and the insurance.

Mr. BURKE. For those not covered by Medicaid or for all?

Chairman MELCHER. That is right. I think there are almost 2 percent now in the nursing homes that are covered by private insurance.

Mr. BURKE. The remaining 98 percent?

Chairman MELCHER. That is right.

Mr. BURKE. Okay.

Chairman MELCHER. Dr. Bowen, on behalf of both the House Aging Committee and the Senate Aging Committee, I want to express our gratitude to you for appearing today. We hope you can feather out of the proposals that are before Congress, and I am confident that we are going to start with your proposal, how much further we can go, and that this Congress does have the heart and compassion to go a long stride forward on catastrophic coverage.

Thank you very much.

Now, the hearing record will remain open for two weeks to permit anyone caring to submit testimony to us to be part of this hearing record.

Chairman MELCHER. The hearing is adjourned.

(Whereupon, at 4:10 p.m., the hearing was adjourned.)

APPENDIXES

Appendix 1
THE WHITE HOUSE

Office of the Press Secretary

FOR RELEASE AT 9:00 P.M. (EST)
TUESDAY, JANUARY 27, 1987

THE PRESIDENT'S INITIATIVE ON
CATASTROPHIC ILLNESS COVERAGE

FACT SHEET

The President recognizes that catastrophic illness can debilitate individuals and families financially, emotionally and physically. In proposing new initiatives to protect against the financial costs of catastrophic illness, the President is looking for ways to protect the millions whose present coverage is either non-existent or inadequate.

Coverage Under Present System

The American health care financing system is a broad network of private insurance mechanisms and public programs which, taken together, protect the majority of persons from the financial costs of catastrophic illness. Many people, however, still fear that potential devastating illnesses can destroy their financial security.

In addressing the catastrophic illness problem in the United States, there are three groups of people to consider: the general population under age 65; the elderly facing long-term care expenses; and the elderly facing acute-care expenses. The risks that these groups face are different, and programs to deal with their problems must vary accordingly.

1. General Population Under Age 65

The majority of the general population is covered by employment-related group health insurance with costs borne by employers as one component of fringe benefit packages. A large number of persons who do not work are covered for health expenses by Medicaid, a program designed for the elderly poor, the blind, disabled persons, and poor families with dependent children.

There are, however, an estimated 30 million people under the age of 65 who have no health insurance at all, and 10 million who have inadequate coverage for catastrophically high expenses. Many are self-employed or are employees of firms that do not offer group health insurance to their employees. Federal, State, and local governments annually spend several billions of dollars to care for the uninsured.

2. Elderly Americans Under Long-Term Care

The urgency of long-term care is an increasingly important policy issue. By the year 2030, an estimated 8.6 million Americans will be over the age of 85, compared to 2.7 million in 1985.

About 1.4 million elderly now receive care in nursing homes, at an average expense of over $22,000 a year. These costs are not covered by Medicare or private insurance, although many elderly are under the impression that they are. Of the $32 billion in 1985 nursing home costs, less than 2 percent was paid by private insurance. Of the remainder, half was paid out of savings of patients and their families and the other half was covered by Medicaid.

--MORE--

3. Elderly Under Acute Care

Virtually all elder Americans are entitled to acute care coverage under Medicare. Nearly two-thirds also supplement their coverage with so-called "Medigap" policies purchased in the private insurance market.

Medicare is designed as an acute care coverage program. Much of the costs of physician services and of hospital stays under 60 days are covered. Longer hospital stays are not fully covered and prescription drugs are not covered at all. Some Medigap policies cover these additional expenses, but many do not.

The major source of fear for the elderly is that they could be faced with expenses that are not covered either by Medicare or Medigap. In addition, confusion often exists over what acute care coverage the elderly have and do not have. Some elderly buy too much insurance, while others believe they have more coverage than they actually have.

Administration Proposal

The President's Initiative on acute care Catastrophic Illness Insurance for the elderly is based on the following guidelines:

- We must provide meaningful protection against out-of-pocket expenses that substantially threaten family savings;
- The importance of Medicare, Medicaid and Medigap should be maintained and we should not encourage excessive use of services;
- Any catastrophic illness coverage should be voluntary, not a new government entitlement; and
- The proposal must be fully budget-neutral, without the explosive potential of program expansions.

The President, in his 1987 State of the Union Address, spoke of the "specter" facing older Americans -- that of often having to make an "unacceptable choice between bankruptcy and death." The President will submit legislation shortly to free the elderly from the fear of not being able to meet the costs of catastrophic illness.

# # #

Appendix 2

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

The Honorable Edward R. Roybal
Chairman
Select Committee on Aging
House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

The Secretary appreciated the opportunity to testify before the January 28 joint meeting of the House Select Committee on Aging and the Senate Special Committee on Aging on the Catastrophic Illness Expenses report.

As you know, the issue of catastrophic illness coverage is one of the Secretary's and the Administration's highest priorities. The Department is certainly happy to work with the Committee to provide expertise in this area.

I have enclosed the responses to questions forwarded by you as a follow up to the January 28th hearing. If you have additional questions or need further clarification of the enclosed questions, please feel free to call on me.

Sincerely yours,

Patricia Knight

for Ronald P. Docksai
Assistant Secretary
for Legislation

Enclosure

FOLLOW-UP QUESTIONS FOR DHHS SECRETARY, DR. OTIS BOWEN

1. At long last, there seems to be a consensus on the extent of catastrophic health problem -- thanks in large part to your personal commitment to this issue. Yet, there is not a consensus on the solution. In fact, you have acknowledged that your own catastrophic proposal is not a panacea but a first step toward a solution. Let me now ask three related questions.

   o **Question:**
   Are you personally still committed to addressing the problem of the medically indigent and of Americans facing costly long term care?

   Answer:
   I believe a broad range of private financing strategies can assist persons in paying for long-term care, attract broad participation and help limit out-of pocket expenditures. The President has called for studies by the Department of the Treasury and others to assess the potential of private solutions and to evaluate the need for a public role in assisting people who need formal care and cannot afford private means of protection.

   o **Question:**
   What do you personally believe is the long term solution to protecting the millions of Americans of all ages who are at financial risk of acute and long term care? Ideally, wouldn't a national health program such as Canada's and such as that proposed in my "US Health Bill" provide this protection at the lowest cost?

   Answer:
   I believe that we can already see movement in the most promising direction for providing protection from an acute illness--filling in the gaps through such initiatives as state-sponsored risk pools, plus enactment of carefully tailored mandates on employers. As for long term care, among the various proposals mentioned in my recent report on catastrophic illness protection, the most important looks to the development of widespread demand for and supply of long-term care insurance.

   In my view, a national health insurance plan such as Canada's or that proposed in the USHealth Bill would be entirely unsuitable for this country. The truth is that we are not that far from a goal of universal access to care. We must continue to progress, but experience and common sense tell us that we should build on strength. It would be entirely contrary to

the long run interests of our citizens to abandon the mix of public and private institutions and programs that today satisfy 90 percent of our needs efficiently and flexibly, and put in their place a monolithic government plan dependant on massive Federal regulation and tax financing for its viability.

o **Question:**
What should be done in the short term to protect the 37 million medically indigent Americans who have no medical insurance and to adequately protect Americans of all incomes against the financial catastrophe of long term care?

Answer:
An estimated 35 million Americans have no health insurance at some point during the year; roughly one-half are uninsured all year, while the remainder are uninsured for some period during the year. However, it is also important to point out that being uninsured does not mean that these people are without access to health services; for example, states can provide Medicaid coverage to persons who would not normally be eligible because of their income and assets but have large medical bills, state and local governments finance free care (especially for the indigent as is their legal responsibility), certain free services are made available using Federal grant funds, and health care providers provide charity care.

These populations are made up of sub-groups with diverse economic, social, and demographic characteristics. No single insurance mechanism or coverage design can adequately meet their varying needs and circumstances. This Department is participating in efforts directed at exploring means for increasing the availability of health insurance for the working uninsured, the medically uninsurable, young people transitioning away from parental coverage, early retirees, and persons in other similar groups. It would be premature to point to particular options as having been conclusively proven to be both effective and efficient.

With respect to long-term care, I believe that our citizens need to plan during their working years for the risks of needing long-term care services. This will reduce pressure on our public programs (especially Medicaid) which will in turn free up some of these public funds for improved protection for those with very low incomes and resources.

2. **Question:**
If enacted into law, to what extent will the incentives in

your proposal for private long term care insurance and medical IRA's primarily benefit higher income persons and what do you see as government's responsibility to the millions of poor and near-poor who cannot afford these options but do not qualify for Medicaid?

Answer:
We expect that a significant number of middle income families could benefit from the Administration's proposals and, depending on how well the long-term care insurance market develops over the next five to ten years, could also benefit persons of fairly limited means as well. The President has directed the Treasury Department to study the cost and feasibility of a number of proposals which are designed to increase the affordability of long-term care insurance to persons in a broad economic range.

Our analysis of the possible impact of Individual Medical Account (IMA's) is based on the nations's experience with Individual Retirement Accounts (IRA's), since no IMA plans are currently in force. The latest information on IRA savers is for 1984 and is shown in the attached table, "Tax Returns with IRA Contributions by Adjusted Gross Income Class, 1984".

As the table indicates, the proportion of tax returns with IRA contributions in 1984 was 15.4 percent, with higher participation rates in the higher income groups. However, while the **percentage** of middle and lower income groups who took advantage of IRAs was smaller, the relative **number** of middle and low income IRA holders is very high. Almost 6 million of the total 15.4 million tax returns that showed an IRA contribution in 1984 had adjusted gross incomes of less than $30,000; and over 9 million (close to 60 percent of those with IRA contributions) had adjusted gross incomes of less than $40,000.

Even if a lower proportion of persons opt for IMAs than for IRAs, as we expect will be the case, still a significant number of families will save and those funds will be available to pay for long-term care costs. In addition, projections of income indicate that a larger proportion of persons will be able to save in such accounts in the future, and the reduction in the availability of other tax shelters may encourage higher participation.

While the existing system of financing long-term care has shortcomings, it nevertheless is extensive. Resources currently available to families include personal savings, assets (including home equity) and income; Federal, State and local programs that provide services through the Older Americans Act, the Social Security Block Grants the Veterans Administration and locally-developed community service programs; and, when other resources fail, the Federal/State

Medicaid program. As you know, Federal, State and local governments are already significant partners in sharing the costs of long-term care -- paying almost half of all costs through Medicaid and other financial assistance programs. (Chart Attached)

3. **Question:**
How do you respond to the preliminary findings of the Brookings Institute that show that private options such as long term care insurance and medical IRA's will serve only a small portion of the nation's elderly and will do little to offset Medicaid expenditures?

Answer:
The model developed by the Brookings Institution represents an important tool in understanding the potential impact of various long-term care financing mechanisms but it provides no certain or immutable predictions about the future. One key reason for caution is that the model projects forward nearly 40 years based on past behavior and assumptions about that behavior.

It must also be recognized that the IRA proposal developed by the Brookings Institution is predicated on different assumptions than those of IMA/insurance proposal developed in the Secretary's report to the President. The Administration's proposal emphasizes the role of multiple solutions to the future long-term care needs based on the fact that no single financing solution is likely to fill all of these needs.

Critical to meeting this Nation's long-term care need is the recognition of the vital role of improved public information about the risk of long-term care and the scarcity of private financing mechanisms. The President's proposal includes a recommendation to mount a public information campaign. Increased public awareness will most assuredly affect the demand for any private financing product.

4. **Question:**
Looking at the "Catastrophe" of Medicaid spend-down, what is your personal view of the idea of building in protections for the spouses of nursing home patients to prevent them from depleting all their assets to the point where they must continue to survive in the community alone and well below poverty?

Answer:
Medicaid is fundamentally a welfare program, with eligibility rules and thresholds based on Aid to Families

Table 3-1

Tax Returns with IRA Contributions by
Adjusted Gross Income Class, 1984

AGI Class ($000)	Tax Returns (000)	Percent	Tax Returns with IRAs (000)	Percent	IRA Returns as a Percent of all Tax Returns
Less than $10	33,659	33.8	714	4.6	2.1
10-15	14,081	14.1	952	6.2	6.8
15-20	11,522	11.6	1,286	8.4	11.2
20-30	16,486	16.6	2,968	19.3	18.0
30-40	11,105	11.1	3,155	20.5	28.4
40-50	5,996	6.0	2,306	15.8	38.5
50-100	5,733	5.8	3,267	21.3	57.0
100-200	771	0.8	550	3.6	71.4
200 and over	252	0.3	160	1.0	63.6
Total	99,605	100.0	15,359	100.0	15.4

SOURCE: Department of the Treasury, Office of Tax Analysis, from the Statistics of Income 1984 Advanced Data.

with Dependent Children (AFDC) and Supplemental Security Income (SSI). Assistance in all three programs is targeted to persons or families at very low subsistence levels.

- Middle class persons or families seeking Medicaid to help cover catastrophic medical expenses, including long-term institutional care, must, as a general rule, first use the resources they have in excess of welfare-related levels. Assets considered include savings, mutual funds, or other investments; usually the home is not affected.

Raising the levels of income and/or assets allowed for the maintenance needs of middle class groups while leaving levels for other groups, such as mothers with young children, at welfare levels raises serious concerns about the resulting inequity.

Rules on how much Medicaid recipients and their families are required to pay for long-term care are very complex and sometimes create arbitrary results. For example,

- If one spouse is institutionalized, his or her income and assets must meet eligibility standards before he or she can qualify for Medicaid. In cases where legal claim to the couple's income and property rests exclusively or mainly with the institutionalized spouse, even through the non-institutionalized spouse can continue to live in the home, limited amounts of his income will be made available to support the spouse at home.

- By contrast, if the spouse at home has substantial income and resources, these are ignored in determining the eligibility of the institutionalized spouse for Medicaid. If the institutionalized spouse has no income or assets of his/her own, Medicaid pays the full nursing home bill and no contribution is generally required of the well-to-do spouse.

This sort of situation is essentially an unintended outgrowth of linking State Medicaid eligibility procedures to those of Federal SSI.

- Permitting the spouse at home to retain all the couple's income and assets would essentially create an expensive new entitlement program.

- Increases in the amounts families could keep for personal use would have to be made up, dollar for dollar, by increases in Medicaid expenditures. This subject is very complex and has far-reaching implications. Consensus may be difficult to reach, and the subject deserves extensive consideration before action is taken.

5. **Question:**
What steps are being taken by the Administration to not only protect Americans form the costs of acute and long term catastrophic care, but to ensure that care is provided in the setting that is most appropriate for the individual - be it in an HMO, the home, nursing home, community service centers, or alternative residential settings - and not simply funneled to hospitals?

Answer:
As this question suggests, there is a continuum of medical, institutional and community support services to serve elderly individuals with short-term acute and chronic long-term care problems. Medicare, of course, covers the former and several facets of the program ensure that beneficiaries are served in the most appropriate, effective setting. At the most basic level, Medicare conditions of participation for hospitals, nursing homes and home health agencies require that these settings indeed provide the level of care indicated by their title. Further, Medicare PROs, intermediaries and carriers conduct medical reviews to ensure that beneficiaries are served in the proper setting. If providers are directing beneficiaries to inappropriate settings, Medicare has several options to change this behavior including education, payment denials, civil monetary penalties and sanctions.

Guidelines covering Federally qualified HMOs also require certain quality of care assurances which cover issues such as care delivered in the most appropriate setting. In addition, Medicaid programs cover many of the long-term care services needed by elderly. Most states have 1915(c) waivers concerning home and community based services for the elderly and other populations. These waivers often include a coordination component that ensures that the elderly have access to community services outside the traditional Medicaid service package.

Several programs funded by the Older Americans Act and the Social Services Block Grant support community services for the elderly, such as meals on wheels and community service centers. These programs often include case management and broker support that also provide protection in terms of the most effective services delivered in the most effective setting.

Finally, several sections of OBRA 1986 expand Medicare PRO review beyond the inpatient hospital setting to skilled nursing facilities, hospital outpatient departments, home health agencies and HMOs. As the Administration implements these mandates, additional opportunities for coordination will be pursued.

6. **Question:**
What is your view of the preliminary recommendation of your internal task force on long term health care policies that the Administration develop an alternative for Medicare's three-day prior hospitalization requirement for nursing home coverage? Is this not also a part of the catastrophic problem?

Answer:
The three-day prior hospital stay is used in the Medicare program to assure that care provided in a skilled nursing facility is an extension of an acute stay, as provided for in the original Medicare statute. The three-day prior hospital stay provides a simple basis for ensuring that a patient's nursing home fare is medically necessary and related directly to the acute care focus of the Medicare program.

The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) requires the Secretary to provide skilled nursing facility coverage under Medicare without regard to the three-day prior hospital stay, if the Secretary determines that this step will not lead to an increase in cost and will not alter the acute care nature of the benefit. The Department has not been able to find an alternative that would meet those criteria.

The Task force on Long-term Health Care Policies, which is responsible for making recommendations for the development, marketing, and regulation of private long-term care insurance, has tentatively agreed to recommend that we continue to press for an alternative screening device. The concern of the Task Force is that private long-term care insurance companies have adopted this mechanism to control induced demand, and in the absence of a better test of medical necessity, this test will continue to be used.

Induced demand is an even greater problem for long-term care insurance than for the Medicare program. Long-term care insurance not only covers skilled nursing care, but intermediate care and, in some cases, home health care. One insurance company has offered insurance both with and without a three-day prior hospitalization requirement, and the cost differential is substantial. Some individuals, however, may have illnesses -- such as Alzheimer's disease - that require long-term care but do not require

hospitalization; these individuals would be excluded from private long-term care insurance benefits by this test.

7. **Question:**
The latest work form the economists is that medical expenditures will continue to rise dramatically despite cost containment efforts (such as DRG's). Given this, what short of a national health program, will allow us to successfully "cap" the nation's health care bill for everyone (government, employers, individuals) without further restricting access and compromising quality?

Answer:
One of the most important factors behind increased expenditures on health care is the aging of the American population. Since spending on health is correlated with age, as we live longer, our spending on health care will go up as a percentage of Gross National Product despite our best efforts at cost containment. However, what we can realistically hope to accomplish is to slow the projected rate of growth and to obtain increased value, in terms of improved health outcomes, for our expenditures.

The Administration favors competition and capitation (i.e., consumer choice and managed care programs) as the best approach for restraining health care cost growth without restricting quality and access. The incentives in the traditional payment system are to increase utilization because someone else pays the bill. In managed care programs, the organization which pays the bill has a say in the delivery and structure of the health care services.

Further, to the extent that educated consumers share some of the purchasing responsibility in an environment with choices to be made, utilization incentives are in the proper direction.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

The Honorable John Melcher
Chairman
Special Committee on Aging
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

The Secretary appreciated the opportunity to present testimony on the Catastrophic Illness Expenses report before the joint meeting of the House and Senate Aging Committees on January 28.

I know the Secretary is pleased to work with the Special Committee on Aging on the issue of catastrophic health insurance coverage, because of your active interest in seeing that catastrophic coverage be fully debated before Congress. Your devotion to issues which better the lives of our Nation's elderly deserves applause.

I have enclosed the answers to your February 17 correspondence. If you should need additional information or need any of the responses further clarified, please call on me.

Sincerely,

Ronald F. Docksai
Assistant Secretary
for Legislation

enclosure

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

The Honorable John Heinz
Special Committee on Aging
United States Senate
Washington, D.C. 20510

Dear Mr. Heinz:

The Secretary appreciated the opportunity to present testimony on the Catastrophic Illness Expenses report before the joint meeting of the House and Senate Aging Committees on January 28.

As a follow-up to that hearing you requested that the Department answer several questions for insertion into the hearing record on the subject of catastrophic health coverage. I have enclosed the responses to those questions.

We are pleased to work with you on this issue as it is a priority of the President.

Sincerely,

Ronald F. Docksai
Assistant Secretary
for Legislation

enclosure

Question 1

What information does the Department of Health and Human Services have concerning problems with the Medicare supplemental ("Medigap") insurance market? Please provide any and all supporting documentation.

Response

As part of the study mandated by P.L. 96-265, DHHS (under contract with SRI International) conducted a survey of beneficiaries in six States. Among other things, they were surveyed regarding their experiences with health insurance transactions whether or not transactions resulted in a purchase. Two things should be kept in mind in reviewing these results: (1) the age of the data - the survey was conducted in mid-1982 and circumstances may have changed; and (2) The consumer survey was able to examine only perceptions of sales abuses and problems, rather than actual incidents, among persons interviewed. Both memory lapse and subjective interpretations of events may have affected the responses to the survey. For agent contacts without a purchase (see Table 1), the two most common problems reported were pressure exerted to buy a policy (ranging from 11 to 42 percent in the six States) and agent claims that the policy would pay for everything Medicare did not cover (ranging from 12 to 44 percent). The abuse that the agent claimed to represent the Federal Government was the least common; it was reported by only 2 to 7 percent of respondents in the six States. Lower levels of agent abuses and problems were reported for policies actually purchased (see Table 2), never exceeding 25 percent. Approximately half of the sample beneficiaries in all States had received and read unsolicited mail about health insurance policies. Reported incidence of mail abuses and problems were higher than agent abuses, ranging from 12 to 59 percent depending on the type of abuse. However, respondents were asked about any mail they had ever received but only about the latest agent encountered. Again, lower levels of mail abuses and problems were reported for policies actually purchased (Table 3) than for policies not purchased (Table 4).

P.L. 96-265 established Federal criminal penalties for certain fraudulent or abusive marketing practices. Criminal sanctions are provided for: (1) furnishing false or misleading information for the purpose of obtaining certification, (2) misrepresenting oneself as an agent of the Federal government for the purpose of selling insurance to supplement Medicare, (3) selling insurance which substantially duplicates benefits of another policy held by the purchaser, and (4) knowingly advertising, soliciting, or offering for sale mail order policies in a State without the approval of the State insurance commissioner. There have been no

Federal convictions under the law. During fiscal years 1982-84, HCFA received 63 complaints of misrepresentation or sale of policies duplicating coverage under another policy. HCFA

policies duplicating coverage under another policy. HCFA referred 8 complaints to HHS Inspector General and 25 to the various state insurance departments for follow-up action. HCFA reviewed and closed the other 30 complaints for lack of evidence. In fiscal year 1985, HCFA received another 17 complaints. HCFA closed 13 of the complaints because of a lack of evidence; the other 4 were referred to state insurance departments.

The October 1986 GAO report on Medigap insurance provided the most recent detail concerning state insurance department investigations of market abuses.

Chart Attached.

TABLE 1

PROPORTIONS OF SAMPLE REPORTING SPECIFIC AGENT SALES ABUSES THE LAST TIME THEY SAW AN AGENT FOR POLICIES NOT PURCHASED OR NOT CURRENTLY OWNED, BY STATE, 1982
(Standard Errors in Parentheses)

Sales Abuse	California N=61	Florida N=69	Mississippi N=79	New Jersey N=17	Washington N=70	Wisco N=7
Agent claimed to be from government	2.4% (1.7)	7.0% (3.4)	4.9% (2.4)	0% (0)	3.1% (1.7)	2. (1
Agent claimed policy approved by government	5.7 (2.4)	11.2 (4.0)	17.6 (4.5)	0 (0)	11.6 (3.5)	(2.
Excessive pressure to buy	37.0 (7.7)	42.4 (6.9)	39.0 (6.1)	10.9 (7.5)	30.0 (7.3)	42. (6.
Agent claimed premium available for limited time	16.5 (5.7)	17.5 (5.0)	20.1 (5.3)	4.9 (4.9)	21.4 (7.7)	5. (2.
Agent tried to frighten respondent	23.9 (6.7)	29.1 (6.0)	27.6 (5.8)	13.0 (8.8)	23.0 (7.3)	15. (5.
Agent pressured respondent to drop a policy	4.5 (3.0)	20.3 (6.1)	13.4 (5.6)	5.9 (5.8)	13.3 (4.2)	11. (4.
Agent pressured respondent to buy more than one policy	18.7 (5.7)	11.5 (5.1)	12.8 (5.2)	0 (0)	5.0 (2.5)	(1
Agent claimed policy would pay for everything Medicare didn't cover	30.5 (6.3)	42.6 (8.2)	37.2 (5.5)	12.1 (8.3)	44.4 (7.5)	25. (6.

SOURCE: Derived from McCall, et al. Medigap - Study Comparative Effectiveness of Various State Regulations. Final Report (Consumer Survey). Menlo Park, CA: SRI International, 1983, p. 12.

NOTE: Percentages are weighted according to study sample design. Therefore, the percentages reflect proportions of States' Medicare beneficiary populations.

TABLE 2

PROPORTIONS OF POLICIES PURCHASED BY SAMPLE MEMBERS FOR WHICH SPECIFIC AGENT SALES ABUSES WERE REPORTED, BY STATE, 1982
(Standard Errors in Parentheses)

	California N=100	Florida N=140	Mississippi N=259	New Jersey N=15	Washington N=94	Wis[illegible] N=[illegible]
s Abuse						
nt claimed to be om government	0.5% (0.5)	0% (0)	1.4% (0.8)	0% (0)	0% (0)	3.4% (1.8)
nt claimed policy pproved by government	3.3 (2.2)	6.7 (3.1)	9.9 (2.2)	0 (0)	9.4 (3.4)	14.1 (3.7)
essive pressure buy	6.6 (3.1)	2.0 (1.1)	5.8 (1.5)	0 (0)	3.8 (1.8)	12.2 (4.0)
nt claimed premium vailable for limited ime	5.2 (2.8)	0.9 (0.9)	4.4 (1.4)	0 (0)	1.7 (1.2)	3.9 (1.4)
nt tried to frighten espondent	5.3 (3.0)	2.5 (1.3)	5.3 (1.6)	0 (0)	1.2 (0.9)	7.6 (3.0)
nt pressured espondent to drop a	3.4 (1.8)	3.5 (1.7)	2.4 (1.1)	0 (0)	5.4 (2.1)	4.4 (2.4)
nt pressured espondent to buy more han one policy	4.4 (2.8)	2.0 (1.2)	5.2 (1.9)	4.8 (4.9)	0.8 (0.9)	7.5 (3.4)
nt claimed policy ould pay for everything edicare didn't cover	21.5 (4.8)	14.8 (3.9)	19.5 (3.1)	21.7 (11.4)	25.0 (4.8)	[illegible] [illegible]

URCE: Derived from McCall, et al. Medigap - Study Comparative Effectiveness of Various State Regulations. Final Report (Consumer Survey). Menlo Park, CA: SRI International, 1983, p. 131.

TE: Percentages are weighted according to study sample design. Therefore, the percentages reflect proportions of States' Medicare beneficiary populations.

(4)

TABLE 3

PROPORTIONS OF POLICIES PURCHASED BY SAMPLE MEMBERS FOR WHICH POLICIES SPECIFIC MAIL SALES ABUSES WERE REPORTED, BY STATE, 1982
(Standard Errors in Parentheses)

	California N=71	Florida N=81	Mississippi N=108	New Jersey N=51	Washington N=50	Wisconsin N=53
Sales Abuse						
Appeared policy was approved by government	25.1% (7.2)	25.6% (6.1)	26.0% (5.1)	34.8% (7.3)	46.0% (10.7)	33.6% (9.5)
Appeared premium available for limited time	10.0 (3.9)	6.7 (3.8)	11.9 (5.4)	14.0 (6.2)	21.0 (8.5)	8.9 (4.0)
Tried to frighten	4.4 (2.2)	12.9 (5.1)	20.1 (6.1)	3.2 (2.4)	8.1 (6.0)	1.0 (1.0)
Appeared would pay for everything Medicare didn't cover	9.0 (3.6)	21.3 (5.5)	21.9 (4.9)	28.7 (7.4)	31.0 (8.3)	18.4 (5.5)

SOURCE: Derived from McCall, et al. Medigap - Study Comparative Effectiveness of Various State Regulations. Final Report (Consumer Survey). Menlo Park, CA: SRI International, 1983, p. 133.

NOTE: Percentages are weighted according to study sample design. Therefore, the percentages reflect proportions of States' Medicare beneficiary populations.

TABLE 4

PROPORTIONS OF SAMPLE REPORTING SPECIFIC MAIL SALES ABUSES FOR POLICIES NOT PURCHASED OR NOT CURRENTLY OWNED, BY STATE, 1982
(Standard Errors in Parentheses)

	California N=61	Florida N=69	Mississippi N=79	New Jersey N=17	Washington N=70	Wisconsin N=61
Sales Abuse						
Appeared policy was approved by government	11.5% (2.7)	27.1% (4.5)	39.5% (4.9)	15.6% (2.9)	25.1% (4.7)	18.7% (3.1)
Appeared premium available for limited time	28.2 (3.9)	37.0 (4.9)	46.9 (4.7)	27.3 (3.3)	38.6 (4.7)	22.3 (3.4)
Tried to frighten	40.6 (3.7)	41.9 (6.1)	44.1 (4.4)	29.9 (3.8)	46.9 (3.6)	20.9 (3.0)
Appeared would pay for everything Medicare didn't cover	32.6 (4.3)	42.2 (5.6)	58.8 (4.4)	38.5 (4.0)	47.7 (4.9)	21.5 (3.4)

SOURCE: Derived from McCall, et al. Medigap - Study Comparative Effectiveness of Various State Regulations. Final Report (Consumer Survey). Menlo Park, CA: SRI International, 1983, p. 129.

NOTE: Percentages are weighted according to study sample design. Therefore, the percentages reflect proportions of States' Medicare beneficiary populations.

Question 2

How do you respond to the recent General Accounting Office report finding that loss ratios in commercial Medigap policies average only 60 percent (despite the fact that most States require much higher loss ratios)? Isn't this finding an indictment of the adequacy of State enforcement of their insurance regulations?

Response

First, there are only a few States (CN,MA,MI,MA,NJ,NY) which require a loss ratio greater than 60 percent for individual or direct mail policies (the minimum loss ratio standard required by P.L. 96-265, "the Baucus Amendment" is 60 percent). These six States require 65 percent. The loss ratio standards stipulated in P.L. 96-265 are based on the National Association of Insurance Commissioners (NAIC) guidelines for individual insurance. In addition, P.L. 96-265 requires certain group policies (employer groups are exempt) to have a 75 percent loss ratio. (No States require higher loss ratios for group policies) Second, until the introduction of new reporting forms in 1985, States did not have the ability to easily monitor actual loss ratio experience and compare it with what was anticipated. Some States (e.g., NY,NJ) did, however, conduct special reviews of loss ratio experience.

An NAIC committee prepared a revised standard Medigap reporting form for calendar year 1985 and later. NAIC recommends its reporting forms but does not have the authority to require their use; nevertheless, the NAIC forms usually become the industry-wide standard. These reports are due from the insurance companies by June 30 of the year following the year the data cover. The new Medigap form calls for loss ratio data to be reported for the "last completed calendar year" and "last three calendar years." The new form also requires loss ratio data for "Experience in Reporting State" and "United States Totals." These new forms, with historical data, will enable the States to more easily monitor loss ratio experience.

Question 3

Many state laws require that purchasers of Medigap policies receive information depicting gaps in Medicare coverage and how particular Medigap policies fill these gaps. Is the public receiving the required information and are these laws serving their intended purposes? If so, please supply any and all supporting documentation. If not, how might these educational efforts be improved so that everyone can obtain needed coverage at the most reasonable price?

Response

Forty-eight States and the District of Columbia have the requirement, per P.L. 96-265, that a consumer buyer's guide be delivered at the time of application for a Medicare supplement

polic· and that acknowledgement of receipt of delivery of the guide be delivered to the insurer. Direct response insurers are required to deliver the buyer's guide upon request, but no later than at the time the policy is delivered. Most of the States use the NAIC/HCFA Guide to Health Insurance for People with Medicare, but many States have developed their own guides as well. Only New York and Rhode Island do not require delivery of a buyer's guide; however, a guide is available upon request in New York. The acknowledgements signed by the beneficiary of receipt of delivery of the guide should be proof that the beneficiary is receiving the required information. In addition to delivery of a buyer's guide, almost all States require delivery of an outline of coverage, per P.L. 96-265, that describes what a particular Medicare supplement policy will cover relative to the medicare program.

There are other State services to assist the beneficiaries in making Medigap insurance decisions, such as:

- shopper's guides that compare prices and coverages of specific company policies,
- education programs available for presentation at senior citizen meetings,
- networks of counselors to help the elderly with insurance decisions, and
- telephone hotlines.

In examining whether these laws are serving their intended purpose, analysis of the 1982 SRI consumer survey found that the distribution of consumer buyer's guides was found to be effective in increasing the beneficiaries' knowledge of the Medicare program. Guides were also found to be effective in reducing reported abuses from insurance solicitations received in the mail. Analysis also revealed that counseling services which offered advice to Medicare beneficiaries on Medicare and the purchase of health insurance policies were effective in raising beneficiaries' knowledge of the policies they purchase.

Since a general consumer buyer's guide is available in almost every State, no further action is needed. More States could be encouraged, however, to develop counseling services for Medicare beneficiaries since these programs are not widespread.

Question 4

What has the Department of Health and Human Services done in the past, and what will it do in the future to adequately inform Medicare beneficiaries what Medicare covers and what it does not cover?

Response

To date, the primary source of beneficiary information has been Your Medicare Handbook. This 70 page booklet is, in effect, the

beneficiary's "insurance policy." In addition to a comprehensive description of coverage and reimbursement under both parts of Medicare (hospital insurance and medical insurance), the handbook contains descriptions of beneficiary appeal rights, services not covered by Medicare, and how and where to file medical insurance claims. It is automatically mailed to all new beneficiaries and it is available through local Social Security offices and Medicare intermediaries and carriers.

Other specialized publications and pamphlets produced for Medicare beneficiaries in the past, include:

How to fill out a Medicare Claim Form
Medicare and Prepayment Plans (HMOs & CMPs)
Your Right to Appeal Your Medical Insurance Payment
Your Right to Appeal Hospital Insurance Claims
Medicare and Employer Health Plans
Hospice Benefits Under Medicare
Guide to Health Insurance For People With Medicare

Brief messages about important Medicare program changes are transmitted to the entire Medicare population via Social Security check stuffers (Social Security recipients on direct deposit receive the same messages through a separate mailing).

Articles on Medicare topics of special interest are distributed to the editors of the major beneficiary organizations (AARP, Gray Panthers, etc.) through Medicare/Medicaid Notes.

Non-print media messages about Medicare include "The Medicare Magazine," a videotape series available to senior organizations through HCFA and SSA; plus public service radio and TV spots.

In addition to continuing and updating all of the aforementioned beneficiary information activities, the Health Care Financing Administration is in the process of developing three new beneficiary publications. Your Hospital Stay Under Medicare's Prospective Payment System, an explanation of PPS, DRGs and PROs, is now in production and will be available to the public through Social Security offices and Medicare contractors. Your Medicare Appeal Rights, a comprehensive description of the Medicare beneficiary's appeal rights in a single booklet, will go into production soon. HCFA is also developing a revised Medicare Handbook.

An Important Message From Medicare, while not a new HCFA informational issuance, is now mandated by the Omnibus Reconciliation Act of 1986, and HCFA is presently incorporating substantive language changes necessitated by that legislation. An Important Message... provides all Medicare hospital patients with an explanation of their right to appeal adverse hospital coverage decisions and gives the name, address, and phone number of their Peer Review Organization.

Finally, HCFA is presently working with other components of the Department and is soliciting advice from outside groups in the formulation of a public information strategy for that new program.

Question 5

The Department's recommendation to expand the Medicare program implies that the Department has concluded that it would not be prudent to rely on the private Medigap insurance industry to provide adequate coverage for catastrophic costs associated with acute illness of the elderly. Please detail the reasons why you chose not to emphasize private insurance initiatives in this area.

Response

The major reasons are:

- economies of scale resulting in lower adverse selection and lower premiums: The recent GAO report on Medigap showed that many private commercial insurers have loss ratios in the range of 60 percent. These loss ratios are what would be expected according to NAIC loss ratio guidelines because Medigap is predominantly an individual (rather than a group market) with higher marketing and administrative costs and higher potential for adverse selection with a fairly small number of enrollees involved per company. On the other hand, Medicare administrative costs have been traditionally low in the 2-3 percent range and would have a base of 30 million beneficiaries which would lessen adverse selection problems. Premiums can probably be kept lower than in the private sector.

- ease of understanding: the beneficiaries should find this easier to understand than the current combination of Medicare and private insurance because this benefit design will be similar to many that exist in employer group health insurance programs, with which many will be familiar - that is, coverage of backend costs and a catastrophic cap after a certain deductible. Several studies have confirmed beneficiary confusion regarding Medicare and supplemental insurance benefits (McCall, Rice and Sangl, 1986; Lambert, 1980; LaTour, Friedman and Hughes, 1983; Cafferata, 1984). With increased ease of understanding, there should also be less potential for marketing abuse and pressure by private insurance companies.

- accessibility to catastrophic coverage: every beneficiary electing Part B benefits will be covered for acute catastrophic costs; no one would be denied coverage. In the private market, companies, through their underwriting practices, would be able to deny coverage to beneficiaries in poor health, such as the disabled. It should be noted,

however, that not all companies perform underwriting in the Medigap market.

- maintain a Medigap role: The President's proposal recognizes the continued vital role Medigap insurance plays in protecting against out-of-pocket catastrophic expenses.

Question 6

The Baucus provisions appear not to cover dread disease policies and hospital indemnity policies. Has the Department considered reviewing and, more importantly, actually reviewed these policies? If so, how many policies are sold annually, what do they cover, and what are the average range of premiums charged for these policies? Please provide any and all supporting documentation.

Response

The Baucus provisions definitely do not apply to dread disease and hospital indemnity policies; most states require that they be labeled that they are not Medicare supplement policies. In fact, the Baucus provisions also exempt employer group and HMOs which may have Medicare supplement benefits.

The 1982 survey conducted by SRI International for HCFA did collect information on these types of policies. It is estimated that, depending on the state, 10 to 30 percent of beneficiaries may have these type of policies. Attached is the range of premiums found in the six survey states. These numbers should be used with caution since the data are old and some of the sample sizes are small. It is still true, however, that these policies are generally less expensive than Medicare supplements. The study did not review the policy benefit designs in detail. The Federal Trade Commission, the National Credit Union Administration, the National Association of Insurance Commissioners and some state insurance departments (e.g., Wisconsin and Massachusetts) have also conducted studies of these types of policies.

Chart Attachment

Table IV-5

MEAN ANNUAL PREMIUMS* OF THE HEALTH INSURANCE POLICIES COLLECTED, BY STATE AND CONTENT OF COVERAGE
(Standard Errors in Parentheses)

	California N=55	Florida N=102	Mississippi N=159	New Jersey N=115	Washington N=121	Wisconsin N=125
Content of Coverage						
Medicare supplement	$451 (53)	$327 (21)	$297 (21)	$234 (6)	$329 (19)	$473 (33)
Hospital indemnity	145 (12)	147 (23)	192 (15)	157 (19)	229 (44)	146 (17)
Specific disease	129* (0)	92* (3)	61 (7)	**	93* (29)	69* (5)
Nursing home	217* (69)	93* (14)	136* (2)	**	206* (22)	458* (0)
HMO	691* (75)	554* (209)	**	**	589 * 55)	360* (131)
Major medical	757* (257)	993* (237)	868* (212)	483* (20)	1,030* (52)	464 (43)
Other	1,961* (0)	73* (15)	283* (58)	**	**	165* (7)

*The premium reported here does not take account of number of people covered by the policy.

*Fewer than 10 observations are in this cell.

**There are no observations in this cell.

SOURCE: McCall, et al. Medigap - Study Comparative Effectiveness of Various State Regulations. Final Report (Consumer Survey). Menlo Park, CA: SRI International, 1983.

Question 7

Please provide an estimate of (and provide data on how you arrive at your figure) how long it would take for your Individual Medical Account (IMA) and other tax incentive proposals to be in place before we would witness a significant number of elderly with a sufficient amount of resources/coverage to finance long-term care for a year. For two years? For five years?

Response

The goal of the Administration in the long-term care arena is two-fold: first, of course, to increase the percentage of long-term care expenses that is paid by private financing mechanisms e.g. insurance and, second, to diminish the catastrophic effect that nursing home admissions currently have on many persons' assets. The way to achieve both of these goals is to encourage sharing the risk (cost) of nursing home expenses through insurance, and/or promote savings specifically dedicated to cover long-term care expenses. The President has directed the Department of Treasury to study these options. We expect to assist Treasury in this analysis.

Although it would be many years before persons who are at the ages of significant risk for nursing home admission would be helped by this approach, the number of persons helped could be large. In 1984, over 15 million (15.4 percent) of tax returns indicated IRA contributions, about two-thirds of which were for the maximum IRA amount. If even one-half of current maximum IRA participants were to enroll in an IMA/with insurance plan, a beneficial increase in the number of families able to afford private financing of nursing home costs without catastrophic financial effects could be realized in coming decades.

Question 8

While IMAs and other tax incentive proposals to help finance long-term care could eventually help many citizens meet the catastrophic costs of long-term care, there are many people who need financial assistance immediately. In addition, solutions involving tax incentives provide only limited help to those with middle and lower incomes who do not have the extra money to invest. What are your recommendations for those people who are already facing catastrophic costs for long-term care? How can the middle class and the poor finance their long-term financing needs. Please provide any and all supporting documentation.

Response

At present, persons and families who already face catastrophic costs for long-term care must rely on the existing system. While the existing system has shortcomings, it nevertheless is extensive. Resources currently available to families include personal savings, assets (including home equity) and income;

Federal, State and local programs that provide services through the Older Americans Act, the Social Services Block Grants, the Veterans Administration and locally-developed community service programs; and, when other resources are exhausted, the Federal/State Medicaid program. As you know, Federal, State and local governments are already significant partners in sharing the costs of long-term care--paying almost half of all costs through Medicaid and other financial assistance programs.

The President, has directed that study be done on the feasibility of a broad range of private financing strategies which can assist persons in paying for long-term care, attract broad participation and help limit out-of-pocket expenditures.

Question 9

How do you answer critics of your tax incentive proposals who say that significantly fewer numbers of people would take advantage of IMAs than those who took advantage of IRAs because, although everyone knows they will retire, few people are willing to believe that they eventually may require nursing home care?

Response

One of our high priority recommendations, which I am gratified to note was incorporated into the President's catastrophic proposal, was that a private/public sector initiative be mounted to educate the public about the costs of long-term care and the lack of coverage for those costs under Medicare and supplemental insurance plans. We firmly believe that once the public appreciates the risks and costs, the private market will be stimulated to provide protection.

IMA accounts were only one of several options proposed by the President. We believe that what is needed is a multi-faceted approach, in which no one strategy is expected to do the whole job.

Question 10

The Administration's present strategy for financing long-term care relies heavily upon the private insurance industry as a solution to the catastrophic costs of protracted nursing home stays and home health care. Does the Administration support public long-term care insurance, or its equivalent, for the many elderly who would be barred from the private long-term care marketplace because of the inability to pay for premiums, or due to pre-existing disabilities and chronic care needs?

Response

The Department's analysis of catastrophic long-term care expenses for the elderly focused exclusively on how governments (Federal, State and local) and the private sector could work together to

develop private financing mechanisms for long-term care services. Public mechanisms, beyond programs such as Medicaid (which now covers 50% of nursing home expenses) that already exist, were neither considered, nor are appropriate candidates for new Federal spending. As noted previously, it is the private protective mechanisms, of the type that families rely on for other types of health care, that are absent in the long-term care arena.

Question 11

Because the number of nursing home beds continues to lag behind the number of people who need nursing home care, many nursing homes preferentially accept those patients who can pay the most for their nursing home care. What approaches would prevent this access problem for Medicaid beneficiaries from becoming worse as private nursing home insurance becomes more common? Will this problem be addressed by the Department's Task Force on Long Term Health Care Policies? Please provide any and all supporting documentation.

Response.

The overall demand for nursing home beds can be expected to rise as a result of increasing number of old people at risk of institutionalization. The availability of private long-term care insurance is not expected, however, to increase the percentage of private-pay nursing home patients significantly. The major effect of private long-term care insurance will be to reduce out-of-pocket expenses for private payers.

The supply of nursing home beds is regulated in many states through certificate-of-need programs. If States discover that the supply of beds is inadequate, they can approve development of new beds.

Discrimination against Medicaid patients while not a widespread problem has always been a concern. The Department has recently written to nursing home operators across the country to make sure that they are aware of two Federal requirements relating to admission and discharge:

- Federal regulations prohibit the displacement of a resident once admitted to a facility participating in the Medicaid program on the basis of a change in source of payment for the resident.

- Federal law prohibits a facility from requiring a Medicaid eligible individual or those responsible for that individual to supplement Medicaid coverage for basic care and services. This includes requiring

continuation of a "private pay" contract once the individual becomes Medicaid eligible; and/or asking for contributions, donations, or gifts as a condition of admission or continued stay.

This letter, written by Thomas G. Morford, Director of the Health Standards and Quality Bureau of HCFA and dated January 5, 1987, concluded with the statement that "These actions are in direct conflict with Federal law." A second letter, giving similar warnings relating to facilities which have received Hill-Burton funds, was also issued by the Department's division of Civil Rights.

Finally, the Task Force on Long-Term Health Care Policies does not expect to address this issue. However, the Department has already established a task force which has been examining these issues under the Chairmanship of the Under Secretary.

Question 12

Although the Medicaid program offers some relief by providing coverage for long-term care, it only takes effect after a catastrophe has struck, and the recipient has spent virtually all his life-savings. How can we finance long-term care for the poor and middle class in a manner that will not significantly expand Federal expenditures, or force a person into poverty? Please provide any and all supporting documentation.

Response

The Department's study of private financing mechanisms for the elderly indicates that the potential for expanding private financing mechanisms is significant and should be carefully nurtured. Your question addresses the critical challenge we are facing -- can the cost of protection be brought within the means of a broad segment of the older population without increasing Federal expenditures? Again, there are no easy answers.

The Administration believes private long-term care insurance and combinations of insurance and other mechanisms show the greatest promise for achieving this end. In particular, development of insurance options and insurance options combined with alternate delivery approaches offer the opportunity to mass market insurance and to reduce concerns over adverse selection.

While employment-based long-term care insurance coverage has not been available, if developed, it also offers an opportunity to create large risk pools that permit lower premiums than those for individual policies. Group policies also offer companies means of avoiding the risk of adverse selection (i.e., that only those who know they will use long-term care services buy the policy) and of reducing marketing costs substantially, both factors which affect the cost (and therefore, the affordability) of policies.

The President has now directed the Treasury Department to study the following:

- encouraging personal savings for long-term care through a tax-favored individual medical account (IMA) combined with insurance, and amending individual retirement account (IRA) provisions to permit tax-advantaged withdrawal of funds for long-term care expenses;

- development of the private long-term care insurance market through legislation providing tax incentives for purchase of such care by individuals or employers; and

- the feasibility of an alternative program of health care savings accounts used to buy basic post retirement health insurance.

Question 13

What progress has the Department made in responding to the Blue Cross/Blue Shield Association's offer to collaborate in the development of a long term care policy for Federal employees? Please provide any and all supporting documentation.

Response

Secretary Bowen is appreciative of Dr. Tresnowski's, the President of Blue Cross/Blue Shield, offer to help in the development of a long-term care insurance proposal for Federal employees. Throughout the Department's Study of catastrophic illness expenses, Blue Cross/Blue Shield and other insurance companies provided valuable assistance. In fact, Mr. Tresnowski was an invited member of the Public Private Advisory Committee on Catastrophic illness.

Responsibility for the development of a long-term care insurance proposal for Federal employees has been assumed by the Office of Personnel Management. We will alert OPM to Blue Cross/Blue Shield's interest in further collaboration.

Question 14

The Senate and House Aging Committees have heard testimony from witnesses describing the extensive problems with the Medigap insurance industry. With such evidence of consumer fraud in the private insurance market, is it appropriate to use it as a model for private sector solutions to long-term care financing?

Response

The Medigap insurance industry is not being proposed as a model for long-term care insurance. In fact, one of the problems with developing a market for long-term care insurance is the misconception that Medicare, and therefore Medigap insurance,

covers long-term care. They do not. The emergence of long-term care insurance has helped focus attention on this fact, particularly by those who hope to sell this new form of protection.

The Medigap market does indicate that substantial numbers of older persons have the resources to purchase insurance protection and will do so when adequately informed of a serious financial risk. This fact points up the importance of the President's mandate in this area, to work with the private sector to educate the public about the risks, costs, and financing options available for long-term care.

The National Association of Insurance Commissioners is now studying appropriate ways for States to regulate long-term care insurance. It recently published a model statute that States may wish to enact, and model regulations to implement this statute are under development. The models, which address consumer fraud as well as other key considerations for long-term care policies, should help consumers, regulators, and insurers avoid problems as the market develops. In addition, the Department's Task Force on Long-term Health Care Policies (mandated by the Consolidated Omnibus Budget Reconciliation Act) will address potential problems of fraud and marketing abuse in relation to private long-term care insurance policies. The report of this task force is due in October 1987.

Question 15

Please summarize for us both Department accomplishments and plans regarding educating the public about the risk of needing long-term care services and informing them about the limits of existing public programs for long-term care. Please provide any and all supporting documentation.

Response

The President's original request on February 4, 1986, that the Department undertake a study and develop recommendations on catastrophic illness, generated considerable public interest in the long-term care financing problem. As the Department's work progressed, and particularly after the Department's report to the President was issued, this interest escalated and generated an extraordinary amount of news and television coverage. This attention has helped move the problem to the forefront of public awareness and is an accomplishment in and of itself. However, we would like to do much more.

The Department is strongly committed to developing a sustained and effective private/public sector approach to public education in the long-term area. We want to do this carefully and have a number of options under development. While we feel that we must work to inform the public, the Department wishes to be sure that the message sent is clear and offers real help to persons seeking

substantive information on the risks, costs and options available for financing long-term care.

We are in the process of developing a public education strategy under the Office of the Assistant Secretary for Public Affairs. This strategy will emphasize working with consumer-based organizations to enhance the understandability, completeness, and dissemination of the materials. The American Association of Retired Persons, The Health Insurance Association of America, and the American Health Care Association have all volunteered to assist with our campaign. We are in the process of assuming the broadest possible participation of interested parties before we finalize our plans. However, we are hoping to coordinate our efforts.

Question 16

The catastrophic proposals in your report are heavily oriented to reimbursement for hospital and other institutional services. To what extent should home and community-based services play a role in caring for our elderly and protecting them against inappropriate institutionalization? How could coverage for these services be incorporated into your report's recommendations?

Response

Our catastrophic health insurance proposal is aimed at eliminating the coverage gaps in the Medicare program that leave the elderly with acute care needs vulnerable to catastrophic out-of-pocket expenses that result from an acute catastrophic illness.

Our strategy for addressing the long-term care problem is guided by four considerations. First, Americans should be encouraged to make adequate plans for their own care in old age. Second, the financing of long-term care should not inhibit maximum choice regarding the types and level of care. Third, the elderly prefer and should be able to receive the least restrictive care possible. Thus, approaches should be emphasized that allow people to remain in their own homes, or in facilities that meet multiple personal and medical needs, such as church homes and Continuing Care Retirement Communities. Fourth, the public sector is already paying half the costs of formal long-term care through Medicaid.

Our specific recommendations for long-term care include improving the knowledge and understanding of Americans regarding the risk of needing long-term care and the options for financing, and encouraging the development of private long-term care insurance.

Question 17

To rectify the current home health reimbursement problems of inconsistent and unreasonable interpretations of the intermittency and homebound requirements, what are your legislative and regulatory recommendations that would help ensure consistency in Medicare intermediary coverage decisions? Please provide any and all supporting documentation. Would you support an expansion of Medicare coverage for home health services?

Response

The basic "intermittent" and "homebound" policies are derived from statutory requirements; the interpretation of which has been consistent throughout the life of the program. Problems in application of the policies have been attributed to the need for more intermediary specialization in home health claims review. To solve these problems, the Health Care Financing Administration --

- o conducted training for intermediary home health claims review staff,
- o developed and implemented uniform plans of care and other information forms designed to produce standardized claims data for use in the review process (second iteration soon to be released),
- o identified, as directed by Congress, 10 regional home health intermediaries and begun the transition of agencies to these intermediaries, and
- o fostered closer interaction between intermediary claims review staff and HCFA policy and operations staff to insure common understandings.

The transition to the regional intermediaries is currently in process. We believe that, when it has been completed, processing problems will have been largely resolved. During the next year, we also plan to--

- o increase our training efforts,
- o improve our claims review and experiment with concurrent review and approval of claims to provide greater certainty in the provider community, and
- o make other improvements in administration to assure that claims and appeals are processed in a timely and appropriate manner.

Our initial evaluation of the manner in which the regional intermediaries are working to assure that they have a common understanding of our policies leads us to believe that these

administrative improvements will eliminate the inconsistencies about which criticism has been raised.

We do not believe that statutory or regulatory changes are necessary to achieve these administrative improvements. There is a separate set of issues relating to the basic public policy question of whether or not Federal financing of home care should be changed or increased. We are considering these issues in the overall context of the Administration's budgetary plans and goals.

Question 18

What can be done to improve the availability of home and community-based long-term care services under the Medicaid program?

Response

A number of home and community-based services are available through waivers under the Medicaid program to individuals who would otherwise require institutionalization. Services include case management, homemaker, home health aide, personal care, adult day health, habilitation and respite care. States may also request permission to provide other services which are cost-effective and necessary to prevent institutionalization. States have responded enthusiastically to the availability of these waivers. Personal care services are also an optional service under Medicaid.

We believe that the restriction that these services are only available to individuals who are at risk of institutionalization should remain to assure that services are provided to those with the greatest need. We are conducting a multi-year evaluation of the effectiveness of the home and community-based waiver program. An interim report from the contractor was recently received by HCFA's Office of Research and Demonstrations. Two additional interim reports are to follow before the final report.

Question 19

How do you answer the criticism that, although your proposal for an actuarially sound additional premium might start off as a self-financing program, political pressures will eventually pressure the Congress and the Administration to tap general revenues for its operation?

Response

Obviously to avoid either future increases in the use of general revenues or a further erosion of Medicare trust funds it is important that the catastrophic program be maintained on a pay as you go basis where those who receive the added protection pay for

its costs. The Administration's proposal calls for a separate calculation of the catastrophic benefit's cost and for the maintenance of a separate trust fund. The cost of the catastrophic benefit will be calculated separately for the elderly and disabled, with a weighted composite premium being developed from these two separate calculations. Having such a close handle on costs should help in resisting political pressures to hold down any premium increases which might be necessary.

Additionally, it should be noted that the Administration's proposal calls for a separate calculation of the catastrophic benefit's cost and for the maintenance of a separate trust fund. The cost of the catastrophic benefit will be calculated separately for the elderly and disabled, with a weighted composite premium being developed from these two separate calculations. Having such a close handle on costs should help in resisting political pressures to hold down any premium increases which might be necessary.

Question 20

From your consultations with groups outside the government, how much consensus exists regarding a $2,000 out-of-pocket threshold for Medicare deductibles and coinsurance? How many people in families with heads of households over 65 would exceed a $1,000 threshold figure and how much would the premium have to be to keep such a program actuarially sound?

Response

The $2,000 annual limit on beneficiary liability was an HHS decision that considered a number of factors including historical data on beneficiary liabilities under both parts of Medicare, the economic status of today's elderly, recognition of other medical expenses the elderly incur that would not be included in the proposal, and the cost of providing differing levels of catastrophic protection. Obviously lower limits would result in substantial increases in the cost of the protection while higher limits lessen that cost and since our objective was to insure this was a proposal that was cost neutral, (i.e., paid for by those who benefited by the protection it afforded) the cost to the beneficiary was an important consideration.

After considering these factors the $2,000 limit was in our judgment a reasonable level at which to set the limit. While for some lower income beneficiaries $2,000 in expenses may well prove to be a burden it would be unlikely to produce a "financial catastrophe". For the substantial majority of beneficiaries a $2,000 cap would be an amount within their personal financial means.

If a $1,000 annual limit on liabilities were established and assuming all other provisions of the proposal remained the same,

an estimated 4.5 million beneficiaries would exceed the cap. The annual premium required to finance program costs in calendar year 1987 would be $152.00 or approximately $12.65 per month.

Question 21

Is it feasible to study the net financial effects of your main proposal to reform the Medicare programs with a new acute illness catastrophic protection option on the Medicaid and other publicly-funded programs? If so, did the study groups which worked on the catastrophic illness report do any such studies? If not, does the Department plan any such financial effect estimates?

Response

The study group on Medicare coverage of acute care catastrophic illness costs considered the financial impact of the proposed Medicare reform on Medicaid. However, because of limitations on time and resources, the group was unable to conduct any detailed data collection. The study group did conclude that because of the association between poverty and higher health services use, State Medicaid officials would probably find buying into a new Medicare catastrophic coverage program on behalf of dual Medicare/Medicaid eligibles attractive because the costs of the buy-in would likely be less than the costs of direct Medicaid coverage.

Question 22

Since so many elderly tell us they can barely keep up with current Medicare premiums and deductibles, how many beneficiaries do you estimate would not take advantage of the catastrophic option because they couldn't afford the $59 annual premium?

Response

We believe that the premium required to finance the Administration's catastrophic proposal is a very modest one that should not be a financial burden to the substantial majority of beneficiaries. By adding this sum to the Part B premium and spreading the cost among 31 million beneficiaries, we can assure a low cost per person for the benefit. Further, many of the lower income beneficiaries are also entitled to Medicaid, and for the majority of such individuals the States pay the monthly Part B (SMI) premium.

Question 23

At a time when non-Medicare-covered prescription drug costs alone annually total over $7.3 billion, would you acknowledge that drug expenses represent catastrophic expenditures for older Americans, in fact all Americans, of limited means? Do you have any recommendations and/or proposals which would reduce these very

burdensome out-of-pocket health costs? Please provide any and all supporting documentation.

Response

Prescription drugs can represent a significant medical expense for the elderly, principally those who have illnesses that require the continuing use of expensive maintenance medications. Though for many elderly prescription drugs are a financial burden, such expenses, by themselves, are unlikely to reduce financial catastrophe. However, when added to other out-of-pocket costs of hospital and medical services, expenses of a much larger magnitude, drug expenses can clearly exacerbate the potential for a financial catastrophe. Our proposal to limit out-of-pocket liability for these higher hospital and medical expenses will substantially lessen the burden of drug expenses. We believe that coverage of prescription drugs is an item that private Medigap insurers should consider incorporating into their plans.