EXECUTIVE SESSION

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United States Senate,

Committee on Finance,

Washington, D. C.

The Committee met, pursuant to notice, at 10:30 a.m. in room 2221, Dirksen Senate Office Building, Hon. Russell B. Long (Chairman of the Committee) presiding.

Present: Senators Long, Talmadge, Ribicoff, Bentsen, Matsunaga, Baucus, Bradley, Dole, Danforth, and Durenberger.

The Chairman: All right, Mr. Constantine. Tell us about the catastrophic health insurance proposal.

Mr. Constantine: Mr. Chairman, at the last meeting of the Committee, a number of issues were raised by Senators with respect to details of the catastrophic health insurance plan and we are now working on those with the administration and with the health insurers.

We hope to have most of those answers by tomorrow. If it is satisfactory with the Committee, we would prefer to defer further consideration of the catastrophic portion of the Committee's work until tomorrow and move with the second part, that is low-income coverage issues. There are three papers and areas of concern.

As you know, the catastrophic low-income and Medicare changes and if we could, Mr. Chairman, we would on the low-income, which is Document C in the folder, Dr. Mongan perhaps could present the administration's suggestions to describe what they are proposing and then Ms. Burke might describe the Dole-Danforth-Domenici low-income approach. The staff has developed an alternative approach that the Committee may want to consider in the low-income area.

Dr. Mongan: Mr. Chairman, thank you for the opportunity.

Let me take a few minutes, if I could, to describe what the administration is proposing in this area.

I think it might be helpful to set the low-income discussion into perspective, so if I could make just one introductory comment, to paraphrase what I have heard many of the members say around the table as we have been into the catastrophic discussion, it is not really by accident or because of the desire to do something extra for the poor that we get right into the middle of this low-income discussion, but when you are dealing with the catastrophic program, with deductibles like $3,500, to provide the same kind of protection from the low-income population, it demands some special provisions.

The Committee already took up one of those special provisions for the employed low-income population last week. What I would like to do here is talk a little bit about some

of the major gaps we see in the current Medicaid program and which we very strongly feel should be filled in as a part of this program.

So I will review our proposal to fill these gaps and then break out the elements of it.

With respect to the gaps that concern us in Medicaid, a number of people make the statement that we have the Medicaid program to cover the poor. The difficult is that the Medicaid program only covers a part of the low-income population.

The first, and what we think is the major gap in the Medicaid program, is that there are whole groups of the low-income who are not covered by Medicaid. Those are the noncategorically-linked people, the working poor, and two-parent families get no Medicaid coverage at all, one of the problems that your bill had dealt with in past years.

Also, single people and childless couples get no Medicaid coverage at all regardless of their income level, so that is one gap that we identified, the lack of the entire low-income population and the coverage only of the categorical groups.

Secondly, there is really no national floor of eligibility. Each state can set its own eligibility level, so that the result is that some states have very, very low eligibility levels whereas others have more adequate levels.

But again, as in the catastrophic area where the committee has set out a floor, no one will have to pay more

than $3,500 wherever they live.

We do not have that kind of floor in the Medicaid program.

The third very serious problem is that there is no spend down in half the states. That is a kind of special catastrophic provision for the low-income population.

What that means, where you do have a spend down that people who are slightly above the eligibility line -- for example, if the eligibility is $4,000 and their income is $4,100, after they incur $100 of medical expenses they can get into the program.

In states where that has been done, that kind of coverage is not available.

So what we have done is tried to address those three gaps: the lack of coverage of whole groups; the lack of a floor; and the lack of a spend down.

We feel that in putting together the administration bill, the President already has made a number of very tough decisions. This is not as generous a package as we would have liked to put together, but he was faced with the same fiscal realities that face you, and had to make a series of fairly difficult choices.

The first of this, none of our coverage is proposed to begin before fiscal year 1983, so that the first year of expenditure would be 1983.

Then, with respect to each of these defects, the President had to make some limited choices, which I will describe.

First, I talked about the fact that the program is not available to all people. There is this categorical link. We would break that link and under the administration approach, all low-income people, whether they were in working poor families, intact families, single or childless couples, they would all be covered.

We do that to only 55 percent of the poverty line. It would be very expensive to call all people up to the poverty line.

We break the categorical link and bring all people in, only up to 55 percent of poverty.

The Long-Ribicoff bill had broken that categorical link also and brought people in to a higher level, about 70 percent of the poverty line.

The second thing that we would do, we would put in a national floor, the same 55 percent of poverty. There are about 16 state Medicaid programs that have eligibility levels below 55 percent of poverty and we would raise them all to that same 55 percent of poverty level.

The third thing we would do, we would introduce a spin-down so that there would be a spin-down in all states, rather than half the states, as under present law, the

spin-down being that kind of special catastrophic protection for the low-income population, but if they are just above the eligibility line, they can spin-down into eligibility.

Again, we chose primarily for fiscal reasons, a very tough spin-down test. Every dollar that you have above this 55 percent of poverty must be spun down on medical expenses before you are eligibility.

So our package there is to break the categorical link and bring in all low-income people up to a national floor of 55 percent of poverty with a dollar-for-dollar.

If I could have one more minute, Mr. Chairman, what I would do is break down those separate elements for you. I have a piece of paper. I recognize that although I think there is a general limit on the committee that these very low-income people should be covered, at the same time we are talking about a larger number of dollars and we have tried responsibly to break down expenditures in our proposal to show you each of those pieces so that if you are unable or unwilling to support all of them, you will be able to see where the dollars go.

I have a piece of paper, which Mike Wilke has. Basically the total expenditures that we are recommending for the non-aged poor, starting in 1983, would be $9.3 billion. Of that $9.3 billion, $7.2 billion is for the expanded coverage that I have just talked about.

$2 billion of it is to improve the benefits for the population.

The Chairman: What year is this?

Dr. Mongan: 1983, Mr. Chairman.

The Chairman: All right.

Mr. Constantine: Are those 1983 dollars?

Dr. Mongan: The dollars are 1980 dollars. The coverage would begin in 1983.

What we have on this sheet of paper is a breakdown of the $7.2 billion of coverage expansion that we are recommending. It breaks down into those five items.

Item number one, that costs about $.8 billion would establish the national floor in all states of the 55 percent of poverty.

Item number two would extend coverage to all families -- in other words, bringing in intact families also. That is $500 million.

Item number three, expanded coverage for singles and childless couples, $3.2 billion.

Item number four, the spin-down for families, $.9 billion.

Item number five, the spin-down for single individuals and childless couples, that is $1.8 billion.

Again, the total is $7.2 billion for the expansion and coverage to give a floor beneath which everyone in the country

would have their expenses covered.

The Chairman: From my point of view, these things that we are talkingabout doing in 1983 are things that are somewhat meaningless. What I think people are concerned about is what are you going to do for me when I am still here?

A lot of these people are sick, they are very ill. You are not going to help them between now and 1983. Presumably, they will be dead and gone.

What can you suggest to us, Mr. Constantine, what we might do to have an earlier effective date?

Mr. Constantine: Mr. Chairman, the staff alternative could have an effective date of whatever time you chose. I should point out on all of these numbers, they are in 1980 dollars, so if you picked a 1983 date, under the admnistration proposal, you would probably have to increase them by 20 percent.

Also, we have not seen, as yet, any five-year cost estimates, just one year, and we question -- we really are concerned about the validity of the statistics on Medicaid. The latest year for which we have full data is 1977. It is a very awkward thing.

The staff alternative was an approach designed to give the committee the option of picking a number and setting up, in effect, an authorizing block matching grant to states. That is, if you picked a number of $2 billion or $3 billion

under the staff alternative it would be allocated among the states as an authorization for matching in proportion to their Medicaid spending.

That is, if a state had 5 percent of total Medicaid expenditures in the prior year, it would be eligible for up to 5 percent of the $3 billion, or $4 billion -- whatever number the committee chose -- with a maximum -- we would suggest a maximum of 10 percent and a minimum, ordinarily, of not less than $10 million.

That is the way it is drafted.

The Chairman: What?

Mr. Constantine: $10 million for some states.

So a state that is simply an authorization for matching. Under that, a state could then choose from among its presently noncovered low-income population ---that is, the singles, childless couples, intact families, working poor -- and they can choose among those in terms of what benefits it felt it could provide, where the areas of greatest need were and could provide benefits to those people with deductibles, coinsurance or without, if the state chose.

We would suggest not more than half the money would be able to go for hospital care and the states could not use it as a substitute for the state mental hospital system costs, but it would essentially give the states the discretion to focus their funds where they believe the greatest needs were.

It would also give you a fixed cap -- in effect, whatever number the Committee chose, it would not be open-ended. It would an authorization of additional Federal matching to those states.

We also suggested in the staff alternative that in those states, I believe, about 20 jurisdictions which do not have medically indigent programs that they would not be authorized under this proposal to start covering the intact families as single or childless couples until they had a medically indigent program.

However, to ease that transition, if a state opted to establish a medically indigent program during the first two years, we recommended we authorize an increase in Federal matching amounting to one-half of the difference between the state's Medicaid matching rate and 100 percent.

For example, New Jersey does not have a medically indigent program. It's matching rate under Medicaid is 50 percent.

During the two years ---if it established a medically-indigent program, the matching rate in New Jersey would be 75 percent. In Louisiana, which I believe at about 70 percent, the matching rate would be 85 percent for the first two years, if they chose to do that.

The virtue of the approach, as we see it, is that it is not open-ended and that it gives the states the discretion to

focus their program wherever they believe the needs are among their presently ineligible low-income populations.

It is not a flat block grant. It is an authorization of additional matching. If you had a flat block grant to the states, you might very well wind up with second- or third-class care. The states may very well use these for the county hospital, county poor farm, or what you will.

It is an alternative for their committee's situation which, essentially, avoids any open-ended program provides a discretion to the states.

It is optional with the states, not mandatory, and it is solely an authorization. If the state chooses not to exercise the option or exercises it only in part, the unused authorization simply terminates. It is not reallocated.

We have a table, for example, showing what that distribution might look like, simulating a $3 billion authorizatin for the noncategorically low-income population ---that is, the non-aged, blind, disabled or broken families, giving those states the discretion.

Senator Ribicoff: Do I understand that you are proposing to eliminate uniformity in this category throughout the United States and every state will be treating its people differently?

Mr. Constantine: It is not a uniform approach, you are correct, Senator, but it is not eliminating uniformity. In

other words, it does not change the uniformity that now exists in Medicaid. It would not be uniform in terms of what states did for additional groups of the low-income population. That is correct.

Senator Ribicoff You are going to have uniformity for employment-related catastrophic health insurance, but you are going to have a prospective 50 different systems for the low-income groups.

Mr. Constantine: Which essentially is what exists today.

Senator Ribicoff: I know, but you do not have employment-related catastrophic for the country now, and you are going to make it uniform, what you are proposing, dividing the country into two classes of citizens.

The Chairman: What you are talking about, as I see it, is simply expanding on what you have right now, are you not?

Mr. Constantine: That is right.

The Chairman: How much money do we have in Medicaid right now?

Mr. Constantine: Counting the state share? About $21.5 billion. I believe that is what it is, of which the Federal share is about $12 billion. $22 billion with the Federal share almost $13 billion.

The Chairman: What you are saying, you would let each state in the union take a look at what they think their problems are and they could decide to what extent -- give them

their share of the money and let them decide to what extent they thought they ought to expand it.

Mr. Constantine: Yes, sir.

The Chairman: Long before the Federal government got into this thing, we thought we were doing very well by people in Louisiana with regard to medical care. We had some very impressive hospitals and we had good doctors working there and if people felt they needed help, they could come there and get it.

With the Federal activity, of course, we have had a lot more money and are providing a great deal more care. One reason that the state was reluctant to go into the unemployed father program is that this would commit them sight unseen to look after all these additional families. They did not think they had the money for that.

If you provide the additional money, they could decide that they would like to take all these families in.

Frankly, just speaking for Louisiana, I am not aware of low-income people who are able to get medical care the way it is now, as far as the poor are concerned.

You can find -- they do not confine themselves to a Federal standard, necessarily, but they provide a great deal of medical care. I have seen a lot of people who could well afford to pay for what the needed who preferred to take a little more time and go a greater distance in order to be

cared for in a state hospital rather than to pay something which they could pay, if they wanted to, but preferred not to, and to go to a private doctor or a private hopsital.

Senator Ribicoff: You see, the difference, Mr. Chairman, you are talking about a state -- your own -- which has had a tradition, thanks to your father, of taking care of the health needs of its people and you are way out in front of most states.

But you do not have a catastrophic health insurance program for the country. We are going to do something about that, and I thought the concept would be that we would try to treat everybody equally irrespective of their income in this country in health needs.

Now what we are proposing are two different systems in which we are going to take care of the upper income groups with catastrophic; then we are going to throw the people in the lower income groups on the mercy and the vagaries in the philosophy of 50 different states. I am assuming that we are doing a Federal program to take care, one way or the other, of the entire population.

And this is a departure of what I felt that we started to do here.

I do not know what Dr. Mongan's thinking is on this, or Ms. Davis.

Dr. Mongan: If I could just take a moment, Senator

Ribicoff. I think I have a reputation as somebody who tries to see merit in a broad range of ideas and I have looked at this one. It troubles me a good deal. We discussed it within the Department. I am authorized to say that the administration is very much opposed to this idea.

Let me tell you what our two concerns are with it.

What we are really talking about is setting aside, earmarking, a pot of additional matching money, to throw at the current state Medicaid programs, and we think, to spend $3 billion, $5 billion or $7 billion on those kind of programs without remedying some of these basic defects in coverage that I have talked about is really not the best expenditure of that sum of money and it gets exactly back to the point you are making, Senator.

What the Committee has already done in the catastrophic area is start setting out some national rules that apply to everybody in the country about how high the deductible can be. We think that ought to be matched by some national rules about how bad the situation can deteriorate for the low-income.

Senator Talmadge: If I may ask a question at that point, does your plan envision 100 percent Federal financing, or does it mandate 50 states to appropriate more money for a program that will be mandated from Washington?

Dr. Mongan: Our plan is 100 percent Federal financing of these new costs. The cost I have given you is the total cost,

and the Federal cost, under our plan.

The Chairman: You would require the states to continue to pay into this program, right?

Dr. Mongan: We would require the states to continue to pay for the kind of people they are already covering and the kinds of benefits they are already covering those people for.

Senator Bentsen: Let me understand this, too. Yours go -- what is it, 55 percent of the poverty level?

Dr. Mongan: Yes, sir.

Senator Bentsen: To that group, the states would continue to carry whatever they are doing now in the way of taking care of them, but you would bring them up to a national standard and the Federal government would pick up the difference, at least for awhile.

Does that finally phase out, where the state picks up the rest of it, or not?

Dr. Mongan: Senator, when you look at this break out of our proposals, the first one is a little bit different than the other four. The first one is to bring up states to the 55 percent for the kinds of people we already cover. The last four are people who are not covered under Medicaid in any state, singles and childless couples and the intact two-parent families.

Senator Bentsen: Are those stated as a series of things that can be done over a period of time?

Dr. Mongan: These things could be done over a period of time.

Senator Bentsen: Phased in?

Dr. Mongan: Yes, they could be phased in. The administration decision was to do it in '83. There is no structural reason why they could not be done earlier than that, or later than that.

Senator Bentsen: Your number one priority is to get all of those at 55 percent of the poverty level taken care of. That is number one?

Dr. Mongan: That is correct.

Then to bring in the poorest of the noncovered groups up to 55 percent of poverty and then to bring in the spin-down.

Senator Bentsen: Let me understand this. You have not clarified this point.

The Federal government picks up the additional amount to bring it up to the 55 percent level. Is there a future point where the state picks part of that up, or not?

Dr. Mongan: Let me say what we would do. The Federal government, for the first two years, would pick up 100 percent of the additional costs. In addition, under our proposal, we would have given an immediate injection of fiscal relief in the first two years, in the third year, to prevent two things from happening -- to prevent people trying to switch people back and forth from 100 percent Federal category to the

others, and to prevent the states from having no interest at all in what is happening to health care costs.

We would do two things. We would average out the matching rate after two years, if the state had some of its people covered at 50 percent and the others covered at 100 percent we would set a net rate, which means the state would pay the same amount of money, and then we would would index it up by the increase in GNP so that states that were doing better in controlling health care costs will have a relatively better break and states that were not doing so well would have to pay a little more, so we would even it up.

Senator Bentsen: Thank you, Mr. Chairman.

Senator Talmadge: May I ask Mr. Constantine a question?

Do you concur with Dr. Mongan's theory that we would not mandate states to spend additional money beyond what they are doing now?

Mr. Constantine: I have always taken Dr. Mongan's word for it. If the Committee approved that, we would certainly draft anything in such a way that the states would not pay additional money, but there is an inequity in there, of course, with respect to the states that are now above the 55 percent who have voluntarily gone substantially above 55 percent in terms of what they would receive.

We think, Senator, that there might even be an additional, a middle ground tier within the framework -- Dr.

Mongan can certainly comment on that. I suspect it would not please him, but within the framework of the staff suggestion, where the states have the discretion, given the distribution, that you could say that a state could not go beyond -- could not go into other groupings of presently uncovered, if it were below 55 percent.

That is before it could go on to covering single, childless couples, intact families, it must have a standard that meets 55 percent of the additional matching at the state's option.

Senator Talmadge: I remember several years ago when we first put the Medicaid program into effect, I think New York and California were covering Medicaid people at that time up to $20,000 or something of that nature. That would be equivalent of $40,000 at the present time, with the inflation being what it is.

As I recall it, we had to step in and put a cap on Medicaid expenditures in those states.

Would this plan still subsidize those states to spend at that exorbitant level?

Mr. Constantine: I cannot judge whether they are exorbitant, but they would certainly beneit under some of the other things, but not under the 55 percent. They are well above that.

Dr. Mongan: Ours is a very severe cap, 55 percent of

poverty.

Mr. Constantine: For those states, obviously they would get additional funds, when you extend to the presently noncovered low-income population -- that is, the childless couples and singles and so on.

The Chairman: Basically, what you have here is a proposal from the admnistration to carry this thing to the guaranteed income to doing absolutely nothing. So you say, all right, we will set a Federal standard, we will set a certain level. You do not get this now, because we do not have the money, so we will start with 55 percent of the povrty levle and, in due course, amend it to make it 100 percent of poverty level.

The same thing, I assume, would be with regard to the cash payment to Federalize the whole program. If you do not have the money to pay for it, you have got to wait until 1983 to get something out of this thing but, for my part, it seems to me that you would do better just to provide the state with more money.

The way you are doing now, to provide more money for them and say, All right, here is additional money. You provide such additional health costs as you want to, and you set your standards, otherwise you are in the position of mandating to the states what they are doing, and they would not get any money out of a single 1983 -- if you try to put a Federal

standard in here based on the budget situation, you are thinking that you have got a drop to contribute to it, to ask the states to give up their right of who they think they should help and who they should not help.

If you take the approach that Jay was speaking to, you are in a position to say, go ahead and do it the way you think you ought to do it. We will make more money available to you, and you can take care of more people.

I know the wisdom over at HEW has contempt for the ability out there to know anything about what they are doing, but my impression is that someone who is running a health program in any one of 50 states is a lot closer to the problem and comes a lot nearer knowing how you could best use the additional money you might make available than somebody up here in Washington.

In due course when we have got everybody around here, we can vote on this matter, which approach you want to take personally. I would favor simply providing more money to the states.

Senator Talmadge: This program of yours, as I recall, you are advocating or recommending an additional cost of about $3 billion.

Mr. Constantine: Senator, the virtue of the thing, the vices have been described, I guess, by Dr. Mongan. The virtue of it is you can put in whatever number the committee chooses or finds that it has. You can set it at a level of $2 billion,

$3 billion, $4 billion, $5 billion, depending on whatever amount the committee chooses. Then it is just the allocation is done proportionately among the states.

On the table that we distributed, Senator talmadge, there is an example assuming a $3 billion authorization of how the distribution might look, and under that because of the minimums and maximums, it comes out to about $2.5 billion using a $3.5 billion base in authorizations. The reason for it -- California and New York, New York spends about 20 percent of Medicaid money, so if you ordinarily have a $3 billion program, New York would be allocated to an additional $600 million for the low-income.

The staff suggested that there be a maximum -- in this case, $200 million. The Committee might want to make it $300 million. That is the reason it is below the $3 billion. Similarly, California will get substantially more than $300 million as well because California accounts for 12 percent of total Medicaid expenditures.

Senator Ribicoff: Is that the basic issue facing us, as we raised it at the beginning, if we are going to have some type of national health insurance program, should we have two programs, one for the middle class and another for the poor, that you will have national uniformity for the middle class, but you will have 50 different progrms depending on the whims of the 50 states as to what you do for the poor. Is this not

what this was down to?

Now, the basic philosophy you are facing and this committee is facing now, as I listen to Mr. Constantine's proposal, is that correct?

Are you not developing two different programs for this country?

Mr. Constantine: Senator, it is not quite correct. We have two different programs and the administration's proposal also continues two different programs. You have already done something for the low-income population, that is the working population, with your 25 percent, not more than 25 percent of income towards the deductible for people who are under $14,000 in income.

Both programs, both the administration program and what we are suggesting continue Medicaid. What they would be would be to expand Medicaid along different lines. It does not become a uniform program, Senator. The states still select benefits. You can still have ten hospital days in one state, unlimited hospitalization in another.

The Chairman: Could I just make this point? We are not giving the middle income people anything with this catastrophic bill. We are not giving them anything at all. They are paying these bills the way it is now.

There are simply a lot of them, 70 percent of them are already insured for major medical, as I understand it. All we

are talking about here is arranging to see that they are all prepaid, but there is no free lunch in this thing. This whole thing is going to be passed through in the cost of the product to these people.

As far as the low-income people are concerned, we are proposing here to give them a free lunch. We are proposing to say, all right, let's put more money into the programs that benefit the low-income people. As far as I am concerned, how much can you afford.

Those people right now benefit from a program where taxpayers are paying. These people are not paying their share. They should not pay their share. I would not want them to pay their share.

We are taxing those who are working to pay for those who are not working. But to say you are discriminating here, if you are discriminating, you are discriminating against those on the putting up end, not the taking down end.

As far as the middle income people are concerned, they are paying the full cost of it. There is not free lunch for them. They are paying their own medical bills right now.

Senator Ribicoff: Yes, but there is a difference, Mr. Chairman. You are talking about putting into place a health care program to take care of the health needs of the people. You are doing it on an incremental basis by starting with catastrophic as against a full national health program.

If you are starting with catastrophic, you should treat everybody in this country this same. You do have programs for people who have nothing to pay with.

Whatever the standards are, people should be treated the same when it comes to the basic health of this country.

What this committee is doing is advocating two different classes of citizens who are entitled to health care, instead of giving everybody who needs health care the same treatment.

I thought there was a great opportunity to pass a health bill this session, but if there is one way you are never going to pass a health bill this session is to do what Mr. Constantine suggests.

I cannot imagine the country going for it. I cannot imagine the Congress going for it.

If you want to get this right in the center of Presidential politics, you are going to get it. This is the easiest way to get it without accomplishing anything.

To me, I think that all of this is an exercise in futility, if we are going to divide the health of this country between the rich and the poor.

Senator Bentsen: Let me ask you, Mr. Chairman -- I guess Dr. Mongan -- let us say that if we were to adopt the administration's approach on this thing, do we have some details here as to its application? What do we do about -- I recall one of the earliest bills, the Long-Ribicoff bill, I

believe it had something in there in the way of a disincentive for using doctors in excess.

Every one of these programs I have studied -- I can recall also when I was in the business, you needed some kind of disincentive, even amongst the poor.

They had to participate in a way. They had a $2 visit to the doctor, if I remember your earlier bill, up to ten visits after that. If you had to go more than ten times, obviously it was serious.

Senator Ribicoff: Somewhere along this line you are going to have to talk about cost controls. We have not reached that. Somewhere in this whole health bill, we are going to have to do the whole thing of cost controls.

Senator Bentsen: We have a much greater principle involved here. Where can do we find those kinds of details so I can get some feel for the thinking of HEW before I decide I want to embrace it?

Dr. Mongan: Senators, we can give you a series of papers with greater detail on the program which we are proposing and was provided in the staff material here. The point you raise is well-taken, I think. The knife's edge with the very low-income population.

If you start putting large copayments on it, it becomes a deterrent to getting the service.

What we want to find is a level --

Senator Bentsen: It is a tough thing, trying to figure out where that is.

Dr. Mongan: That is correct. In that proposal, we do not have those copayments. I think we would be quite open to the kind of proposal that is in the Long-Ribicoff bill where we had essentially $3 on the first ten visits.

So for the kinds of things that people volitionally choose to do that there would be some disincentive, but the assumption that someone that goes more than ten times probably, in fact, needs the treatment. We would be open to that.

Senator Bentsen: I would like to see some of those, so I can get a feel for what you have in mind.

The Chairman: Senator Dole?

Senator Dole: Are there any other options to consider?

Mr. Constantine: There is a Dole-Danforth-Domenici provision.

Senator Dole: If neither of these will work, there might be another one that might. I wonder if Sheila might comment on that.

I think it could be extended to cover an area that is not covered now.

Ms. Burke: Senator, the original Dole-Danforth-Domenici proposal deals with the low-income population. The third piece you have referred to is the residual marketplace. It was geared towards individuals not covered by Medicare, Medicaid

and other insurance plans in that population. That is a swing population that has no insurance at all.

The principle is to provide these individuals with sufficient money to purchase private insurance rather than putting them back into one of the public sector programs. The link with Medicaid in Dole-Danforth-Domenici, the Medicaid programs in the states have to provide at least comparable benefits in the sense of catastrophic coverage for the current populations. It did not alter the Medicaid program as currently designed, but rather help individuals who were not covered in that program to purchase private insurance.

That principle of assisting in the purchase of insurance is one that has been suggested for the low-income by other individuals but the insurance industry has indicated some concerns as to whether or not they could handle that population under their normal insuring arrangements.

Senator Ribicoff: Let me ask you, this sounds very interesting. Why cannot the insurance industry handle it?

Ms. Burke: Senator Ribicoff, I would like to call on the insurance industry and let them speak themselves.

Senator Ribicoff: The principle being enunciated now could have within it a solution. If everybody is being treated the same, then my hunch is it would cost the Treasury a lot less.

May I know why the insurance industry feels

they cannot handle it?

Mr. Troy: Senator, John Troy. I am with Traveller's Insurance Company. We had a discussion this morning and I think there are arrangements where the insurance industry could handle this essentially involving the purchase by an individual of insurance either from an individual private insurance company or potentially from a pooling arrangement with the government subsidizing of some portion of the premium, depending on the level you wanted to pick -- for example, the 25 percent of the income cap level that was discussed last Wednesday. That would be an appropriate level where, according to a pre-arranged table of costs for that kind of coverage, the government would subsidize the portion of the premium that would go to cap the individual's outlay at 25 percent, for example, of his family income.

Senator Ribicoff: So, in other words, there is no restriction on the insurance company's treating everybody the same. It is a question of how it is paid and how the premiums are paid, but once a system is found of paying the premiums then you could treat somebody on welfare the same or you could treat somebody in the middle class. Right.

Mr. Troy: We are talking here about people that the government is not paying for the entire cost of the medical care. They are agreeable to subsidize the costs at some level.

Presumably these people if they had the funds available

would want to protect themselves at a level lower than 25 percent of family income, so the premium would be X and the government subsidy would be some portion of the premium.

Senator Ribicoff: I understand. But once you did that, you would be taking the states out of the health care business, right?

Mr. Troy: I think we could distiguish, Senator, between the Medicaid population. The simplest groups are to think about all the categorically related people or the people on SSI payments who are 100 percent Medicaid, where the states are presently administering those programs.

There have only been several experiments in insuring those programs. It is a potential for the insurance industry to cover those programs, but with the state's administration completely in force, it would not seem practical, although that has been discussed and is continuously discussed on a state by state basis.

What I was addressing now was the potential of the government subsidizing some portion of the premium cost for those people who are not presently covered under the Medicaid programs.

Senator Ribicoff: Well that is right. Of course, since the government is subsidizing this group in accordance with the Dole-Danforth approach, there is no reason why you cannot drop down to the group below that because they are being subsidized

now, one way or the other, and the proposition is to continue subsidizing them with a different formula.

So if you are going to subsidize them, can you not extend to this group the Dole approach?

Mr. Troy: You are talking now about the people who are now fully in Medicaid?

Senator Ribicoff: That is right.

Mr. Troy: The states currently have the authority to contract with insurance companies for insuring the Medicaid populations. That has been done in North Carolina, to some extent, and in California and Texas.

Senator Ribicoff: How is that working in those states?

Mr. Troy: I guess the North Carolina experiment did not go too well, Senator but the problem is -- the general problem would be for an individual insurance company to have the systems and gear up and make the capital outlay necessary to administer an entire Medicaid program. That is a major investment, and one that the companies would want to be pretty sure they had a continuous market for before it was made.

Senator Dole: What about some voucher system where they just buy their insurance through a voucher system, even though they are covered by Medicaid?

Mr. Troy: In other words, instead of the continuation of the present Medicaid system, should we say replacing it by the Federal-state monies buying individual insurance policies?

I am not sure that it would be practical, Senator, in view, as I say, of the existing framework of Medicaid administration.

Senator Ribicoff: What you are doing, what you are about to do, if you follow the Dole -- and what I see down the line is you might collapse the Medicaid program and have a uniform system and different categories paid differently.

My hunch is I do not know that the overall costs will not be any more than you will have either under the Constantine approach or under the Mongan approach.

It has simplicity, it has uniformity.

I think the tragedy would be, now you have an opportunity to do something in the health care field, that you do not do something that has uniformity and eliminate a big hunk of bureaucracy that I see down the line.

I commend Senator Dole for his suggestion. I would like to take the remaining steps, Senator Dole.

Senator Dole: I would hope the insurance industry would see this as an opportunity, not as the end of the road, because it still maintains the principle I was talking about the private sector involvement, on the theory that we may eventually receive more for the dollar spent.

I think we are already making progress with the industry. I understood, as early as 9:00, you did not think that you could handle any of it. Maybe by 2:00 you may be handling the

whole packgae.

It does seem to me if we are sort of at an impasse, whether we Federalize our block grant, maybe there is some way to work out that problem at least that we could look at this approach, maybe seriously now, since there is some indication that it could be accomplished, and maybe find another alternative that would satisfy everyone, or most everyone, on the Committee.

The Chairman: I do not think you are going to have any difficulty. You are talking about providing the same thing for the poor that you do for the rich. I do not think we should have any difficulty.

If you start off with what we had in the beginning where you are trying to provide everyone with health care to take care of all their medical expenses, pay the $3,500 of medical expenses or assume the burden of $3,500.

Now we then proceeded to amend that with Mr. Ribicoff's suggestion that for the people who are on the lower level, the lower part -- I want you to hear this now -- I want you to bring me up to speed and tell me whether I am right about this.

We have said now with regard to the people on the lower end of the scale we are still talking about working people, lower middle income or working poor, they are going to get the benefit, after they are paid 25 percent of their wages. Is that not right?

Mr. Constantine: Yes, sir, to the extent that their wages are under $14,000.

The Chairman: Tell us what that is again? That gives you $3,500?

Mr. Constantine: That is right, yes sir, to the deductible. For example, someone with an income of $10,000 right after $2,500, in effect, their deductible would be $2,500, not $3,500, with general revenues picking up the next $1,000, then the catastrophic kicking in after that.

The Chairman: All right.

How do we pick up the tab for that?

Mr. Constantine: Out of general revenues.

The Chairman: General revenues pays in to pick up the difference between $2,500 and $3,500?

Mr. Constantine: Yes sir.

The Chairman: Maybe you could work out something that would take care of people further down the line. If you follow that procedure, you get to the point if they had no income of their own or if they are living purely on government income, you reduce that down and they do not pay anything for any of it.

If you try to do that, you do not have the money to pay for it, do you?

Mr. Constantine: No, sir. That essentially would be 100 percent coverage, at that point.

Senator Ribicoff: But you have 100 percent coverage now under Medicaid before you are through, and what you are suggesting between you, you either are going to throw them on the slag heap and have the equivalent of a Cambodian refugee in this country or you are going to give them the same treatment. I am very curious between now and tomorrow morning to see what the overall cost would be to follow the Dole approach as against what you are now paying out under various Medicaid type programs.

Dr. Mongan: Senator, we will look at that. I must say we share the sme sense that Sheila Burke and Senator Dole had, that the insurers were having enough difficulty with this concept that they had felt that we should move in other directions and we will converse later on this afternoon and see.

Senator Ribicoff Let me say something. I think I know a little about the insurance industry and let's put some burdens on them to do what they have to do.

They have been talking about their ability to take care of catastrophic and they can handle it, and everybody now is giving them the job. If they are willing to take that job, they can do the whole thing. If they are as good as they say they are -- I can understand their hesitancy in doing it because it is always tough to work with the poor and handle their problems. However, I would say from the House systems

delivery, by having something uniform where everybody is going to be treated the same, that it will ease the problems, eliminate a lot of bureaucracy and red tape, and there is no reason why the insurance industry cannot handle it.

Apparently, if Senator Dole says between 9:00 and 11:00 they hav changed their mind, you are unaware. I do not have any inside information. I have just come in on this, but I am glad that somebody from a company stood up and said they could handle it, because I would be disappointed with the Connecticut companies if they said they could not handle it.

Dr. Mongan: If I could just flag briefly for the Committee's attention two other general type problems that we are going to have to see what they have done in terms of working them out. One of them was a fact, as you know, group insurance tends to be a much more efficient way of operating than individual insurance. If you look at the private experience, they did very well with a pay-out ratio above 90 percent with group insurance, but with individually-sold policies, it is not nearly so good -- down to the 50 percent range.

Senator Ribicoff: All right now. The whole country will be in a group.

Dr. Mongan: Unfortunately, because of the income testing, each person has to be dealt with as an individual, and it has to be dealt with in an individual case by case situation.

Senator Ribcioff: I know, but even with the income variables, the group is so large -- for all practical purposes, they are huge groups. You are not talking about ones and twos in every category. You are talking about millions.

Dr. Mongan: Again, the difficulty being that with the income testing, income changing back and forth et cetera, it makes a determination necessary on a case by case basis. I would point out that is true in the public programs as well as it would be true under this program. In fact, we use the private insurers in administrative roles in existing programs and under the program we are recommending, it is really the relative role in the private sector we are looking at here, and so we can look at that, we can look at that administrative problem.

I think the second thing that was a concern in earlier discussions over this point, to the extent it does take on earmarks of a Federal system, people get so much more money to go out and get insurance, then you start running into a real problem with what is commonly called cream skimming.

People will be very attractive to sell to and insurers will sell to them because their expenses will not be high and you keep a large amount of that where the poorest will tend to wind up back in some kind of private program of one sort, if there are no county hospitals or public programs left.

We have some concerns in that area and will be glad to

talk further with them this afternoon.

Senator Dole: What companies would do that? You could protect against that.

Mr. Troy: Senator, what we envision here is that there would be a table of values that would be the basis for the government's subsidizing that portion of the premium attributable to this guaranteed level and that the pools that we are talking about would serve as a guarantee availability market for insurance at this table of values level, which would be -- in fact, a negotiated level between the insurance industry and the government.

Individual companies would be out marketing individual policies to these people, but they would have to be marketing them at a premium rate that would be consistent with a subsidy level or presumably they would not sell them.

The Chairman: I do not believe we are going to find it desirable to try and have somebody going out and selling individual policies to welfare clients. I do not think that that is going to work.

I think that you may be able to work out something to where you say, all right, at a certain special level these poor people will come into this thing. They will be eligible and we will pay for it and decide at what level you want to make it.

Obviously you would have a lower threshold level for them than you are going to have for other people because they are

not able to meet the threshold level.

Senator Bentsen: I agree with you, Mr. Chairman. There is no way that you can go out and individually sell all the poor policies and expect that you are going to get full coverage. You just cannot do it.

The Chairman: You have to buy it as a group.

Senator Ribicoff: I do not think anybody is advocating that, since basically this group of people is being handled now through some welfare programs and state programs, the insurance companies would have to compete, as I see it, for whatever is in Louisiana, Texas, that they will insure this category of people for X amount of premium, that there would be a blanket policy that would cover these people with the premiums being paid out of the fund and revenues that you have.

You are absolutely right. You do not take ten or fifteen people and sell them individual policies. It would be outrageous. Between the insurance companies and HEW and the committee staff, this could be worked out, the methodology of selling these policies.

Mr. Constantine: Mr. Chairman, under present law, Senator Ribcioff, any state is free to purchase insurance under Medicaid for its population. Today, whatever uniform benefits, very few have done that. They find, for a variety of reasons, they have their own bureaucracies in some instances. In other cases, they feel they will lose control over their program,

that the insurers they have to select from do not have effective controls, that there is a terrible eligibility determination problem that Dr. Mongan hinted out, that we have an enormous number of people who come in off the rolls, Senator, making eligibility very difficult.

It is part of the problem in New York today, that there are months and months of lag in determining whether somebody is eligible or ineligible.

There is no certainty you have people coming on or off. I think the possibility of a uniform level of catastrophic in Medicaid is probably a lot more feasible than getting down into the basic coverage area, where the states, as Texas has in the past, purchased coverage from Blue Cross-Blue Shield or on an administrative basis.

A number of the states used the private insurers to administer the program with the state assuming the risk rather than paying the insurer profit or underwriting gain on it. They are concerned about the controls.

Some of the states have developed fairly sophisticated control programs which some insurers do not have, Senator.

I think I also ought to point out that the proposal that Dr. Mongan was proposing earlier was not the administration proposal. That was not the health care on the low-income population. This is a new appraoch that Dr. Mongan was describing.

The admnistration's health care, the bill that President Carter supported, was Federalizing Medicaid as I understand it for everything except long-term care.

Dr. Mongan: I should make it very clear. I am sorry, Jay. You may have misunderstood, or I was not clear enough.

I was describing the administration bill, the health care approach. I was talking about the eligibility features of that, who we would bring into coverage. After the decision is made as to how far, if any, you all want to expand eligibility, then there is a set of administrative decisions to look at.

That is the kind of issue that we are just discussing now. That ranges from anywhere to current Medicaid, a state-run Federally-matched program in which most of the states use the private insurers in some capacities as administrative agents, through our proposal that will call for a Federalized Medicaid program along the lines of what had been in the Long-Ribicoff approach, where we would have health care, a program that would combine Medicare and Medicaid and low-income coverage, and again, we would use the private insurers on a competitive basis to do the administrative work throughout the country so that you could expand current Medicaid, go to our approach, the Federalized Medicaid or health care.

Now we are talking about yet a third administrative model, which is to use the private insurers instead of as the administrative agents only, in some kind of a voucher or

underwriting capacity.

Senator Ribicoff: The thing that least is important, whether it is the administration plan, the Long plan, the Ribicoff, the Dole or the Constantine, because we are devising a plan around this table, during these days and that is exactly what we are doing in this discussion. We are trying to come up with something that would be meaningful and I think the tragedy would be now that you have the opportunity, we only have a piecemeal program that you are going to have to start all over again each and every year, so we are trying to work out a program that has meaning and that will work.

There have been a lot of good ideas and we are synthesizing them around here today.

Senator Dole: I wonder if they could synthesize in between now and tomorrow morning. Then we could meet again.

The Chairman: Do you have something else? I think we will need to have some discussions about this matter between now and tomorrow. Do you have some?

Mr. Constantine: If I could suggest something, Senator, by way of self-defense, I think we will be prepared tomorrow morning to go back to clean up a lot of the catastrophic decisions that were left to work on.

What happens the employee whose employer does not pay the premiums? The decisions that the Committee left over.

Then if we could go back to the low-income on Thursday,

that would give us a little more time.

Senator Ribicoff: I am just wondering if we could do the low-income tomorrow. I will not be here Thursday.

Mr. Constantine: Certainly. We would be glad to do whatever the committee wants.

It was just that the insurers were ready. We are meeting with them today on the catastrophic, coming back with the questions. We are meeting with the administration this afternoon to go over the remaining questions and issues with respect to the catastrophic segment.

But we would be glad to put that aside and shift gears over to the low-income if that is what you want to do.

Senator Ribicoff: Is that not more complicated than the other?

Mr. Constantine: It is now, yes, sir.

Senator Ribicoff: It is almost the key to whether you really have a program this year or not between now and tomorrow morning with the insurance companies and the staff and HEW to do that.

The others, I think, is just a kind of reorganization.

Mr. Constantine: If the committee wants to proceed, Mr. Chairman, if that is what the committee wants, we will work on the low-income and be prepared to go bck to it tomorrow.

The Chairman: Let me ask you this. This thing that we agreed to that Senator Ribicoff and Senator Moynihan sponsored,

to whast extend does that partake of the nature of the spin-down proposal that Senator Ribicoff and I sponsored at one time?

Dr. Mongan: If I could try to explain that, Mr. Chairman, basically you could visualize the approach that you approved the other day as a four for one spin-down instead of a one-for-one spin-down.

The Chairman: Wait a minute. Put that in terms that somebody can understand.

Dr. Mongan: All right. Let me use an example.

It is a more generous appraoch in that sense. There is one other concept that I have to bring in. You have to talk about some base level that you are either spending down to or this 25 percent of income is applying.

Let us assume you are going to protect some level of income, $2,000, $4,000. Let me use, for example, $4,000.

A one-for-one spindown to $4,000 would mean that if somebody had $5,000 when his medical bills reach $1,000 he would then come down to full coverage, a four-for-one spin-down.

The Chairman. If you had a $4,000 level of income and you had $5,000 of income, then when he spent $1,000, he is eligible, right?

Dr. Mongan: That is correct.

The Chairman: Senator Ribicoff and I sponsored that.

Dr. Mongan: That is right.

The Chairman: We are together on that one point.

Where does the four-for-one get into it?

Dr. Mongan: The four-for-one gets into the kind of thing the committee approved the other day, the 25 percent of income. That basically would mean you did not discuss the level of what the Floor is, but let's assume the same Floor for the moment, the $4,000.

The Chairman: Right.

Dr. Mongan: That would mean if your income was $5,000 you would pay 25 percent of the $5,000, which is $1,250. I picked a bad example, because the spin-down would be more generous in that instance.

Let me take a $6,000 person. At 25 percent of income, if you are talking 25 percent of income above the $4,000 --

The Chairman: Let me see if I know what you are talking about. You are saying if you are assuming that at $4,000 income you are going to take care of him, right?

Dr. Mongan: Yes.

The Chairman: All right.

Then you are saying he has $6000 of income.

Dr. Mongan: Yes.

The Chairman: All right.

Dr. Mongan: On a dollar for dollar spin-down, as I described it, he has to spend $2,000 to get in the program.

Under 25 percent of income, whether you are protecting the basis, it is 25 percent of all income, he has to have $1,500 of expenses before he gets anything under the program.

If it is 25 percent of income above some protected base, the $4,000, then it would be much more generous. He would only have to have $500 of expenses before he got protected under the program.

Depending on how you do it, you have to talk about both the base you are protecting then about the spin-down or the percent of income.

Should I go through that once more?

The Chairman: I think I see what you are talking about.

I assume you take the 25 percent figure because that was in the Ribicoff and Moynihan proposal?

Dr. Mongan: Yes, that is right.

The Chairman: You are saying if he spends 25 percent of his income that he is eligible?

Dr. Mongan: Again, you have this issue of a base. If you have no base at all --

The Chairman: I understand.

Dr. MOngan: -- then it is $1,500 that he would have to spend to be eligible.

The Chairman: For the low-income people you could put a base beneath and say, spend a certain part. In other words, you could start out by saying we will protect the $4,000. We

are not expecting him to spend any of that $4,000 for medical care.

So if the man has $6,000 income and spent $500, then he would be eligible?

Dr. Mongan: That would be the most generous combination.

The Chairman: On the other hand, let's see if I understand you. If you cannot afford that much, you could say well, you protect $2,000 of it and say all right, that being the case if he spent $1,000 he is eligible?

Dr. Mongan: You have your choice of getting less generous by reducing the base or by increasing the 25 percent rate.

The Chairman: Right.

Senator Bentsen: When we are talking about $3,500 catastrophic, the fellow would be up to what? $14,000 on the 25 percent?

Dr. Mongan: That is correct.

Senator Ribicoff: We are going to have to tackle that at some future time.

I think it is important for the Committee to know whether you are going to protect $4,000 or 25 percent, at what stage do you take from a person -- do you throw that person onto welfare, or other programs that may even be more costly tha the general revenues and the public?

These are the questions. Once you go into it with this group you have other problems that you face up to where you

come out.

Dr. Mongan: This discussion, in a way, has come full circle. We are back, in a way, to what we started on. Now we are describing as a base you are protecting and we are saying that this is a base and that it should be 55 percent of poverty. Then you can either have the spin-down or some kind of percent above that base.

Senator Ribicoff: I think you have to present the Committee with alternatives in cost and you know, the bottom line, so that they can choose. Right now, we are talking in generalities because we do not know what happens.

Dr. Mongan: If I could give you a sense of direction, the bottom line using the 55 percent above poverty base and using a dollar for dollar spin-down, the bottom line for that coverage is the $7.2 billion that I talked about.

That amount of money will go up if you start talking about 25 percent of income instead of dollar for dollar spin-down. It can go down by either lowering the base ---we can get less generous than the dollar for dollar spin-down.

Senator Ribicoff: What we ought to have from you before we make these decisions -- all you are throwing out are these numbers and the figures. We do not all have computer minds. To try to extrapolate them is very difficult.

If you know we are going to be presented with these alternatives and choices, either on the blackboard or a piece

of paper, we would like to see what happens with these figures you are throwing at us.

Dr. Mongan: Yes, sir.

The Chairman: I would hope that you would help us work out something that would appeal to everybody on the Committee. If not, we will have to work it out the best we can, and choose sides

Maybe you have something here we can decide on this morning. I would like to get as many decisions as we can made, even though sometimes we are taking the easy ones first.

Do you have something that we might decide at this point?

Mr. Constantine: I hope there is an easy one in here.

The Medicare D, item D in the folder, on Medicare --

Senator Dole: I am just advised that Senator Packwood would like to be present for the Medicare presentation. He cannot be here this morning.

The Chairman: I love every Senator, and I love Senator Packwood. I wish that the Senators would love us enough and have enough consideration for those of us who show up at these meetings that if they cannot come that they would quit sending word, please do not do anything, plesae do not even talk about matters. Please do not even think until I get there.

How about at least telling us a little bit about what you have in mind so we can at least know --

Senator Dole: He did not object to that.

The Chairman: I would appreciate it if you would let me think a little bit, if we cannot do anything else.

What else do you have here?

Mr. Constantine: What we have got in the paper, Mr. Chairman, are the various proposals for improving Medicare coverage. Some of them are parts of the administration proposal, the Long-Ribicoff, the Long bill, Dole, Danforth, Domenici and so on. They are all here.

By way of preference, I think we also would like to point out that the hospital insurance trust fund, Part A Medicare, has an actuarial deficit of 1.04 percent, which in 1979 dollars, according to the actuaries, we are short $10 billion a year in '79 dollars in Medicare financing for each of the next 25 years.

That is just by way of background.

The Chairman: That is where the Roth amendment comes in, does it not?

Mr. Stern: Senator Roth's amendment simply deals with the increase in Social Security taxes that is scheduled to take place in 1981.

What Mr. Constantine is referring to is the actuarial situation in the hospital insurance trust fund over the next 25 years, but it still is in a serious deficit period over the longer run.

The Chairman: Right.

One of the possibiilties that we are talking about in making the Social Security program sound again would to be to move Medicare out of Social Security. Is that not right?

Mr. Constantine: Yes, sir, with general revenue financing.

The Chairman: That is right.

Mr. Constantine: Yes, sir.

The Chairman: All right.

Mr. Constantine: The proposals range, I guess, in cost from as high as $1.8 billion, is that correct? In the administration bill. I do not know where the administration is, right now.

In the aggregate of the approaches for Medicare for the aged 65 or over, I think your total cost was $1.8 billion.

Dr. Mongan: No, it is higher than that, Jay. There are two separate costs for the elderly population -- at least we have broken it into two separate costs.

One is -- again, back in the discussion we were just in, what you do for the poor and near-poor elderly. That is just parallel to what we were talking about, elderly below whatever base level you set and the spin-down. Then there is a cost to do the kinds of catastrophic benefits, if you will, for the elderly. Our costs there are 2.2.

Mr. Constantine: Mr. Chairman, in this regard recognizing, and with a great deal of hesitation, but

recognizing -- and these proposals, by the way, are staff alternatives -- it is not that we are necessarily charging ahead and advocating it. It is giving the framework of the committee concerns. It is another option for you to think about. I want to make that clear, Senator.

Given the problems in the trust fund, we would also suggest to the committee for its consideration only, not weighted by advocacy and consistent with the catastrophic, with the concern that you wanted something that could be implemented quickly, that one thing to consider might be to say that you preserve the present benefit structure in Medicare Part A, Part B, but put a ceiling on the amount of deductibles and coinsurance that any beneficiary would have to pay in a given year.

For example, if you decided that with respect to the hospital deductibles, medical deductibles and coinsurance and copayments for additional hospital days and skilled nursing days, that an older person would never have to pay more than $1,000.

After they have paid $1,000 in deductibles and coinsurance, copayments the programs would then pay 100 percent of the reasonable cost in the case of institutional care and 100 percent of the reasonable charges.

The cost of that would range initially for the first full year somewhere between $500 million to $700 million. That

would not open-end any more hospital days beyond the 90 days per episode and the 60 lifetime hospital days.

The actuaries tell me that only .3 of 1 percent of hospital discharges under Medicare exceed 90 days in the individual. Most people, also as lifetime days, it really depends, Mr. Chairman, as to how far you feel you want to go, how much money the Committee believes is available and you know, in the context of the balance of the package and in the context of the actuarial situation in the trust funds.

But basically by way of example of the simple option, which we are not advocating, is an individual goes into the hospital for, say, a three-weeks stay, a Medicare beneficiary.

During that time, under the new Part A deductible, he pays the first $180. He will pay the first $180 for his physician. He pays $60 and 20 percent of the reasonable charges.

By the time he gets out, it is conceivable that he would have incurred about $400 in copayments and deductibles.

He then goes to a skilled nursing facility for 60 days for a period of convalesence.

Senator Bentsen: Under what kind of bill? $400?

Mr. Constantine: After three weeks in the hospital, a $10,000 bill, he then goes to a skilled nursing facility for two months under Medicare.

After the first 20 days, he is obligated to pay one-fourth of each day, one-fourth, $22.50 a day, under the new deductible

effective January 1, in each of the next 80 days.

So, essentially, he would have reached, if my arithmetic is correct, about the 25th day, counting what he had to copay in the hospitals and his deductibles, he would have reached the $1,000 limit.

After that, for his continued stay in the skilled nursing facility, Medicare would pay the full skilled nursing payment. He would not be obligated to $22.50 and for subsequent physician's charges. Medicare would pay 100 percent of the reasonable charge.

It is a single standard. it would be a single amount. It has the virtue, at least, of being understandable. It is simply an option that we would suggest for consideration.

The cost, counting the kidney program, is estimated at $700 million, $700 million to $750 million.

Senator Dole: Where is that?

Mr. Constantine: It is not here, Senator. We are getting a little gun shy.

The Chairman: How much is this kidney program costing us?

Mr. Constantine: About $1 billion.

The Chairman: It seems to me in the kidney area, at least there is one area where we made a breakthrough and it has been criticized that the cost greatly exceeded the estimate but I think that as one who participated in putting that in the statute, that that was right. The kidney program.

Is that geared to the Medicaid program?

Mr. Constantine: No, Senator.

The Chairman: Medicare.

Mr. Constantine: What you did under that you said, in 1972 under the Long amendment --

The Chairman: Disabled?

Mr. Constantine: You deemed them disabled after three months for purposes of Social Security so the benefits are Medicare.

The Chairman: It comes under Medicare?

Mr. Constantine: Yes, sir.

The Chairman: After three months of kidney illness we deem that person to be disabled and we take care of them. Perhaps we could work on some basis -- where did Senator Ribicoff go? Tell him what I said -- perhaps we could work on a basis of broadening that concept and saying all right, the largest single element of catastrophic illness seems to be cancer, does it not?

What is the largest single group you have in the catastrophic situation, is it not cancer patient?

Dr. Mongan: Cancer and stroke are among the biggest, yes.

The Chairman: Cancer and stroke patients, and I guess the heart patients, they form the category.

Dr. Mongan: Cardiovascular -- broadly stroke, yes.

The Chairman: Just thinking in terms of people, at a

certain point a person qualifies for the kidney program.

You say after three months he qualifies?

Dr. Mongan: Yes.

The Chairman: For the kidney program. I wanted Senator Ribicoff to hear this.

It seems to me that we could well say after three months a person qualifies for the kidney program and I would think that if we wanted to apply that same concept to cancer and to stroke and perhaps to heart -- I do not know that we would have much argument about it.

Senator Bentsen: Mr. Chairman, it looks to me like Jay has come up with a rather simple approach, as I understand him, something that is already in being with all the coinsurance features and he has just put a cap or a maximum on how much that participant is finally called on to pay and he chose the figure of $1,000.

But all of this is in being.

It seems to me he has the answer, as far as the catastrophic coverage under Medicare.

The Chairman: Go over it again. Tell us that again?

Senator Bentsen: You were thinking about your approach.

The Chairman: Sometimes I make the mistake of thinking on my own when somebody is talking. That way you do not hear what the guy is saying the way you ought to.

Go ahead?

Mr. Constantine: Mr. Chairman, trying to finish on a semi-high note, we are suggesting simply taking Medicare and saying that the responsibility of the beneficiary of Medicare, beneficiary for copayments and deductibles on a combined basis under Part A, the hospital plan, and under Part B, the supplementary medical insurance plan, would not exceed $1,000 in any year.

That means that you count towards that the $180 hospital deductible which is required to be paid, effective January 1, the $45 towards the hospital care that is required to be paid from the 61st day through the 90th day, the $90 a day that he would have to pay on each of the 60 lifetime reserve days, the $60 Part B deductible, which they must pay plus 20 percent of the physician's charges and I think I left out the $22.50 a day that they pay for the last 80 days of the skilled nursing facility.

If all of that added up, it would benefit quite a few people. The people obviously who would benefit most rapidly ---and they add about $200 million to the cost -- are the end-stage, the kidney patients. They would account for $700 million, they would account for $200 million of that, but you would help a great number of people.

It probably would reduce the Medigap for many people. Many people who would self-insurance for that $1,000 maybe would buy supplementary coverage as they have now. Nearly half

the elderly now have coverage complementing and supplementing Medicare.

Senator Bentsen: It seems to me that we have fought hard over these points over the years, and we have tried to take care of abuses and we have tried to correct inequities so that it is all in the system.

But you are not saying -- earlier you said to me that the $200 coinsurance might relate to $10,000 worth of cost. If you are getting up to $1,000 finally, a maximum for the coinsurance cost to the patient, then supposedly you are up to $25,000 or more, perhaps.

Mr. Constantine: Yes, sir.

Senator Bentsen: Perhaps.

You finally put a maximum that that family, or that patient, has to pay of $1,000; from then on they are covered, period, without the coinsurance feature.

Obviously you have to take care of -- that person is terribly ill. It is not a question of malingering or abuse of the hospital.

I think he has a reasonable approach.

The Chairman: Yes, sir?

Dr. Mongan: Senator, if I might speak for just a moment and reinforce Jay's closing on a high note, that the good news is in this area, that our position is very close in broad outline to what Jay has talked about.

On the one hand, ours is less generous; on the other hand, it may be more generous.

Let me briefly take you through that.

Jay is talking basically about a cap of $1,000 on the out-of-pocket. In our bill, we have a cap of $1,250 so Jay has been more generous than what is in our proposal.

The kicker here is that there is one type of -- correct me on this, Jay -- that would not be covered under Jay's, that he has not removed the limit on the number of hospital days. We also proposed removing the limit on the number of hospital days.

The net effect of that is it adds cost to our appraoch. What you are left with if you do not do that is somebody has this $1,000 gap, but then it can be more.

Senator Bentsen: You have to remove the limit, it seems to me.

Mr. Constantine: Senator, the reason -- Medicare hospital days are very generous. Let me explain why.

We have some proposals on that, lifting the number of hospital days.

We generally would cover the first 90 days per spell of illness, then 60 lifetime reserve days that you can use at any time.

As I indicated, the Medicaid data show only .3 of 1 percent of hospital discharges exceed 90 days. Obviously, if

you are one of those .3 of 1 percent, you have a very substantial cost. The dilemma was we asked the actuaries what it would cost to lift those hospital days, many of which are custodial days and not acute care days.

And it really added extensively to the cost of the program.

Bob?

Dr. Mongan: $700 million.

Mr. Constnatine: That is $700 million.

Senator Bentsen: What do you do with those people?

Mr. Constantine: Many of them shift over. There are not that many of them but they shift to Medicaid at that point. Many of them are in custodial hopsitals, psychiatric hospitals, that we have a limit on in Medicare. I believe we have 190 days lifetime on psychiatric hospital care.

Senator, you can certainly add that in there.

As I say, it would double the cost.

The Chairman: One time I got involved in the health care matter, saying we ought to do a lot more. Some of you might have been around here at that time.

I was saying we ought to do a lot more.

Frank Carlson was on the Committee at that point and I was pointing out what a pitiful situation it is when people have to go to these state asylums for the mentally sick. Really, up to that point, I do not believe they have been improved at all

that much since that time, but it has been improved. They are doing a lot better.

But up to that point, that was something that people just did not want to talk about. They did not want to think about, and when you take a look to see what it would take to provide decent treatment for medically sick people you are talking about a ton of money.

And I want to do a great deal more about it than what was being done. And I think we have done substantially more since that time.

That is still an area, if you are going to give those people the same treatment that you are giving everybody else under this bill, it is going to cost you just a great deal of money.

I guess I am willing to spend as much as anyone on the Committee is willing to spend in this area. Gentlemen, it is not cheap.

Senator Talmadge: At what point is someone going to determine whether further hospital treatment is useless?

It seems to me when you go to a hospital after a certain period of days, depending on an illness, you make a determination that he is going to recover or he is not. At that point, it seems to me some sort of long-term nursing care would be preferable to remaining in the hospital.

Are there any records or statistics on that, Jay?

Mr. Constantine: We do have data, Senator. I do not have it handy, showing the number of people transferred to skilled nursing facilities or intermediate care facilities not covered under Medicare, but transferred from that.

I guess we are trying in the government programs consistent with the development of controls and criteria to determine who would be suitable for home health programs, who would be suitable for the kind of thing that Senator Dole is sponsoring ---the hospice concept.

Senator Talmadge: If you stay two more days in hospitals on the East Coast than you do on the West Coast, if my memory serves me correctly, is that correct?

Mr. Constantine: It is longer than that, yes, sir.

The Chairman: Senator Dole?

Senator Dole: I do not know whether you had an opportunity, Jay, to look at the Danforth-Dole proposal in this area. I think we are fairly much on target as far as deductible. I think we do provide that your adjusted annual reflect the changes in the medical care component of the consumer price index.

We also added to ours -- I am not sure how much that additoinal cost would be once that beneficiary has met the deductible. The payment would be made for certain drugs that are needed in the long term, not all drugs, but specific drugs.

Is that included in your suggestion?

Mr. Constantine: No, sir.

We described it as essentially the present Medicare benefit structure, not changing that. Among other thing, that is one, if you are to put something into effect next July 1 or October 1 you could do that. All you are doing is putting a cap on, not changing anything.

If you added additional benefits, it would require that the Department gear up.

One approach, Senator, could be, if that is what the Committee wanted to do -- I do not believe I have the cost on that -- is that after you have reached your $1,000 that the kinds of drugs that were covered for chronic illnesses in Senator Long's and Senator Ribicoff's -- the Committee approved the amendment in 1972 -- that it could be covered as an additional benefit at that point, if the Committee wanted to do that, you could put in the limitation, for example, on copayments and deductibles as of October 1, 1980 and say a year later, in October of '81 that you could then also have the coverage for long-term illness to give the department a chance in an early fashion to establish a program of coverage for long-term prescribed drugs for the chronically ill.

Senator Dole: Is there any estimate on cost if you did that?

Dr. Mongan: We do not have an estimate on that particular piece, as I recall.

Senator Ribcioff: Across-the-board in '72.

Mr.Constantine: About $700 million at that point. What you were doing -- that was not subject to, at that point, meeting the $1,000.

In other words, this would be for those people whose expenditures are severe. It would be considerably less than that.

My guess is we are talking probably on the order of $100 million or less, at that point.

Dr. Mongan: I would have to check. We do not have it.

Mr. Constantine: For people who have incurred $1,000 in medicare copayments and coinsurance up to that point in addition to their regular medicare benefits, certain prescribed drugs for chronic illnesses would also be covered as a Medicare benefit.

The Chairman: Let me get one more point here while we are working on these things.

What would it cost to do what we are suggesting about the limitation on these deductibles, Jay?

Mr. Constantine: $700 million, Senator.

The Chairman: 700 or 750?

Mr. Constantine: $750 million.

The Chairman: $750 million a year. I would think the Committee would like to do that. That is going to cost money. $750 million a year extra, once we trigger it into effect.

How does the administration feel about going along with that? Can you find the money to start in 1980?

Dr. Mongan: Mr. Chairman, the official administration position is that there would be no expenditures to 1983 but we would certainly be willing to talk to the committee about some type of reasonable phasing schedule.

The Chairman: It seems to me that some of these great philosophical differences between Senators might begin to dissipate when we think in terms of how much money we have to spend.

As far as this Senator is concerned, I am very much concerned about what we are going to be able to do in the immediate future. I expect to be a candidate next year. Bob Dole is planning to be a candidate. Herman Talmadge is planning to be a candidate, just to mention three.

We would like to talk about what you are going to get, not down the road somewhere, but what have we done for you folks lately.

If you are not going to get it until 1983, that sort of gets to be a philosophical thing we are talking about.

Senator Dole: We could postpone our elections.

Senator Ribcioff: I think what the committee needs is a guy like me who is not a candidate who can think for the country and not about the next election.

Senator Bentsen: Mr. Chairman, I would propose we follow

that approach with a $1,000 cap and phase it in in 1981.

The Chairman: That sounds good.

We had agreed we were not going to vote. Senator Packwood did not want us to vote on this matter.

Senator Dole: I do not know if this is his concern. I think we could go ahead and vote on it and if he does not like it, we can vote again.

The Chairman: All right.

Mr. Constantine: If I may understand, what you are doing is a $1,000 limitation effective October 1, fiscal '81 and a prescribed drugs coverage would become effective on October 1, 1981.

Mr. Stern: I believe under the Budget Act, you would have a problem. You might have to make it effective September, 1980.

Senator Bentsen: Fine. I amend it.

Mr. Stern: We can come back and list any budget problems after you make your base decision.

The Chairman: All in favor, say aye.

(A chorus of ayes)

Senator Dole: Would there be some annual adjustment?

Senator Bentsen: On the $1,000.

Senator Dole: On the $5,000, inflation? The Medicare component is going to go up and up.

Senator Bentsen: On the cap.

The Chairman: Would it be adjusted -- we will worry about that later on. Let's say for the first year it would be $1,000.

All in favor say aye?

(A chorus of ayes)

The Chairman: Oppose, no?

(No response)

The Chairman: The ayes have it.

Senator Dole: We are going to add these drugs?

Mr. Constantine: One year later.

Senator Dole: One year later, limited to the life-threatening illnesses or chronic illnesses.

Dr. Mongan: Are we talking about removing the limit on the days, also, or are we not doing that?

Senator Bentsen: We have not done that.

Senator Dole: We are going to do that next.

The Chairman: We have not talked about that.

Senator Bentsen: Let's talk about that later. I am worried about the numbers.

I want to see if Dr. Mongan's numbers come out the same as Jay's.

The Chairman: If we are talking about drugs, I would like to consider this thing that Senator Ribicoff and I offered before that was agreed to in this committe. Is there any difference between that?

Senator Dole: This would be a lot less becaue you have a threshold of $1,000.

Mr. Constantine: Yes, sir.

The cost of the circumstances have changed. In 1972, the estimated cost was about $700 million for the Long-Ribicoff drugs amendment for chronically ill. That was the basic benefit and today it is probably on the order of close to $2 billion, $3.7 billion.

This is the Senate proposal. It would probably be on the order of a couple of billion.

The Dole amendment is not in terms of a basic benefit, but simply when someone has reached the $1,000 threshold, has incurred expenses, and copayments and deductibles of $1,000. You also are assuming they are in a chronic condition state and an additional Medicaid benefit covering these kinds of long-term life-threatening drugs and so on would also be covered as a new benefit. It is much less costly because you are not providing it to everyone.

The Chairman: Could you give us an estimate of the cost?

Mr. Constantine: Our guesstimate is $100 million. We will come back. That may be high, Bob tells me.

The Chairman: I would like to be a cosponsor on that. It is not as generous as Abe Ribicoff and I were going to be.

Senator Ribicoff: It is in the direction that we are going on everything. It is a good idea.

The Chairman: All right.

All in favor, say aye.

(A chorus of ayes)

The Chairman: Opposed, no?

(No response)

The Chairman: The ayes have it.

Thank you, gentlemen. Those are two good amendments that we have agreed to today.

(Whereupon, at 12:10 p.m. the Committee recessed, to reconvene on Wednesday, November 7, 1979.)

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