GINGRICH ON MEDICARE

HON. J. DENNIS HASTERT

OF ILLINOIS

IN THE HOUSE OF REPRESENTATIVES

Tuesday, September 10, 1996

Mr. HASTERT. Mr. Speaker, I commend the following article to your attention. It ran on July 25, 1996, on page A–18 of the Washington Times. I think that the American people will benefit from the truth about the Medicare debate which is printed in this respected newspaper.

[From the Washington Times, July 25, 1996]

GINGRICH ON MEDICARE

Besides the customary $40 million in political action committee (PAC) contributions organized labor gives to Democratic candidates for Congress each election cycle, it pours millions of additional dollars of unregulated ''soft money'' into the Democratic Party and untold millions more in ''in-kind'' (telephone work, election-day duties, etc.) contributions.

For the 1995–96 election cycle, the AFL–CIO will supplement these normal contributions to the Democratic Party, all of which come directly from compulsory union dues, with a special assessment that will extract another $35 million from the paychecks of union workers irrespective of their political allegiance.

The bulk of these new funds has been used to finance ''issue advocacy'' ads for radio and television, so far mostly about Medicare. In the latest version, which splashes the label ''Newt Gingrich on Medicare'' across the television screen, the ad selectively and completely out of context quotes from an October speech by the Republican Speaker: ''Now, we don't get rid of it in round one because we don't think that that's politically smart and we don't think that's the right way to go through a transition. But we believe it's going to wither on the vine,'' Clearly, any viewer would infer—erroneously, as is easily demonstrated—that the antecedent of ''it'' is Medicare. In fact, the antecedent is the Health Care Financing Administration (HCFA), the bureaucratic behemoth administering Medicare, which presidential candidate Bill Clinton promised to ''scrap'' in his 1992 campaign manifesto, ''Putting People First.''

The ad further asserts that Republicans sought to ''cut Medicare and give new tax breaks to the wealthy.'' So inaccurate is the ad—the CNN ad-watch team has called it ''dishonest''—that the viewer would never know that, under the GOP seven-year balanced-budget plan vetoed by President Clinton, Medicare expenditures per beneficiary would have increased by 50 percent, rising from less than $4,800 in 1995 to nearly $7,100 in 2002. Aware of this indisputable fact, the typical viewer might have a difficult time understanding how Republicans sought to have Medicare ''wither on the vine.'' Concerning the ''tax breaks to the wealthy,'' in fact, more than 60 percent of the 7-year $245 billion tax cut would have financed a $500 per child (under 18) tax credit for families with adjusted gross incomes no higher than $110,000. Considering that production and non-supervisory employees were working on average more hours per week and earning a higher inflation-adjusted wage in January 1993, when Mr. Clinton was inaugurated, than they worked and earned in May 1996, union members might view the $500 per child tax credit vetoed by President Clinton differently than their labor bosses, who clearly have their own agenda in mind.

To conclusively demonstrate the AFL–CIO's campaign of intentional distortion and lies, it is worth repeating exactly what Mr. Gingrich said about the HCFA last October. ''We tell Boris Yeltsin, 'Get rid of centralized command bureaucracies. Go to the marketplace.' OK, what do you think the Health Care Financing Administration is? It's a centralized command bureaucracy. It's everything we're telling Boris Yeltsin to get rid of. Now, we don't get rid of it in round one, because we don't think that that's politically smart and we don't think that's the right way to go through a transition. But we believe it's going to wither on the vine.''

In the context of the entire quote and considering Medicare spending per beneficiary was scheduled to increase under the GOP budget plan by $2,300 per year by 2002, who could possibly believe that Mr. Gingrich was referring to Medicare when speaking of ''wither[ing] on the vine''? Only liars. The sooner union workers learn the truth about Medicare and tax cuts their bosses seem so afraid to share with them, the sooner they can choose leaders who pursue an agenda more compatible with their needs.

NATIONAL MENTAL HEALTH IMPROVEMENT ACT OF 1996

HON. FORTNEY PETE STARK

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, September 10, 1996

Mr. STARK. Mr. Speaker, today, I am introducing the National Mental Health Improvement Act of 1996. This bill will provide parity in insurance coverage of mental illness and improve mental health services available to Medicare beneficiaries. It represents an urgently needed change in coverage to end discrimination against those with mental illness and to reflect the contemporary methods of providing mental health care and preventing unnecessary hospitalizations.

The bill prohibits health plans from imposing treatment limitations or financial requirements on coverage of mental illness if similar limitations or requirements are not imposed on coverage of services for other conditions. The bill also expands Medicare part A and part B mental health and substance abuse benefits to include a wider array of settings in which services may be delivered. It eliminates the current bias in the law toward delivering services in general hospitals. It permits services to be delivered in a variety of residential and community-based settings. Through use of residential and community-based services, costly inpatient hospitalization can be avoided. Services can be delivered in the setting most appropriate to the individual's needs.

In 1991, as a nation we spent approximately $58 billion for the treatment of mental illness and another $17 billion for substance abuse disorders. Medicare expenditures in these areas for 1993 were estimated at $3.6 billion of 2.7 percent of Medicare's total spending. Over 80 percent of that cost was for inpatient hospitalization.

In addition to these direct medical costs there are also enormous social costs resulting from these disorders. It has been estimated that severe mental illness and substance abuse disorders cost $78 billion per year in lost productivity, lost earnings due to illness or premature death, and costs for criminal justice, welfare, and family care giving.

Two to three percent of the population experience severe mental illness or substance abuse disorders. This population is very diverse. When given the appropriate treatment, some people's mental health problems never recur. Others have chronic problems that can persist for decades. And mental illness and substance abuse disorders include many different diagnoses, levels of disability, and duration of disability.

This bill addresses two fundamental problems in both public, as well as private, health care coverage of mental illness today. First, despite the prevalence and cost of untreated mental illness, many health insurance plans do not cover the expense of mental illness treatment as they do other illnesses. Insurance companies set different, lower limits on the scope and duration of care for mental illness as compared to other illnesses. This means that people suffering from depression get less care and less coverage than those suffering a heart attack. Yet, both illnesses are real.

Access problems to mental health benefits are mainly the result of these restrictions. About half of all health care plans limit coverage for hospitalization cost from 30 to 60 days. Outpatient benefits are restricted by the number of visits or dollar limits in 70 percent of the plans. Plan participants with mental health disorders are subject to arbitrary limits that are unrelated to treatment needs. Patients rarely have the choice of alternative plans with greater coverage since more than 80 percent of all plans limit inpatient care and more than 98 percent of plans limit outpatient care.

Access to equitable mental health treatment is essential. And it can be done at a reasonable price. By enacting this bill, we can reduce public sector spending by $16.6 billion, while only slightly increasing insurance premiums—just 4 percent or around $2.50 per person a month. The out-of-pocket expenses for individuals receiving care would be lowered by about $3.2 billion. Two dollars and fifty cents is a small price to pay for ending health care discrimination.

Second, diagnosis and treatment of mental illness and substance abuse have changed dramatically since the Medicare benefit was designed. No longer are treatment options limited to large public psychiatric hospitals. The great majority of people can be treated on an outpatient basis, recover quickly and return to productive lives. Even those who once would have been banished to the back wards of large institutions can now live successfully in the community. But today's Medicare benefits do not reflect this change in mental health care.

This bill would permit Medicare to pay for a number of intensive community-based services. In addition to outpatient psychotherapy and partial hospitalization that are already covered, beneficiaries would also have access to psychiatric rehabilitation, ambulatory detoxification, in-home services, day treatment for substance abuse and day treatment for children under age 19. In these programs, people can remain in their own homes while receiving services. These programs provide the structure and assistance that people need to function on a daily basis and return to productive lives.

They do so at a cost that is much less than inpatient hospitalization. For example, the National Institute of Mental Health in 1993 estimated that the cost of inpatient treatment for schizophrenia can run as high as $700 per

day, including medication. The average daily cost of partial hospitalization in a community mental health center is only about $90 per day. When community-based services are provided, inpatient hospitalizations will be less frequent and stays will be shorter. In many cases hospitalizations will be prevented altogether.

This bill will also make case management available for those with severe mental illness or substance abuse disorders. People with severe disorders often need help managing many aspects of their lives. Case management assists people with severe disorders by making referrals to appropriate providers and monitoring the services received to make sure they are coordinated and meeting the beneficiaries' needs. Case managers can also help beneficiaries in areas such as obtaining a job, housing, or legal assistance. When services are coordinated through a case manager, the chances of successful treatment are improved.

For those who cannot be treated while living in their own homes, this bill will make several residential treatment alternatives available. These alternatives include residential detoxification centers, crisis residential programs, therapeutic family or group treatment homes and residential centers for substance abuse. Clinicians will no longer be limited to sending their patients to inpatient hospitals. Treatment can be provided in the specialized setting best suited to addressing the person's specific problem.

Right now in psychiatric hospitals, benefits may be paid for 190 days in a person's lifetime. This limit was originally established primarily in order to contain Federal costs. In fact, CBO estimates that under modern treatment methods only about 1.6 percent of Medicare enrollees hospitalized for mental disorders or substance abuse used more than 190 days of service over a 5-year period.

Under the provisions of this bill, beneficiaries who need inpatient hospitalization can be admitted to the type of hospital that can best provide treatment for his or her needs. Inpatient hospitalization would be covered for up to 60 days per year. The average length of hospital stay for mental illness in 1992 for an adult was 16 days and for an adolescent was 24 days. The 60-day limit, therefore, would adequately cover inpatient hospitalization for the vast majority of Medicare beneficiaries, while still providing some modest cost containment. Restructuring the benefit in this manner will level the playing field for psychiatric and general hospitals.

The bill I am introducing today is an important step toward providing comprehensive coverage for mental health. Leveling the health care coverage playing field to include mental illness and timely treatment in appropriate settings will lessen health care costs in the long run. These provisions will also lessen the social costs of crime, welfare, and lost productivity to society. This bill will assure that the mental health needs of all Americans are no longer ignored. I urge my colleagues to join me in support of this bill.

A summary of the bill follows:

IN GENERAL

The bill revises the current tax code to deter health plans from imposing treatment limitations or financial requirements on coverage of mental illness if similar limitations or requirements are not imposed on coverage of services for other conditions. The bill also revises the current mental health benefits available under Medicare to deemphasize inpatient hospitalization and to include an array of intensive residential and intensive community-based services.

TITLE I PROVISIONS

The bill prohibits health plans for imposing treatment limitations or financial requirements on coverage of mental illness if similar limitations or requirements are not imposed on coverage of services for other conditions.

The bill amends the Tax Code to impose a tax equal to 25 percent of the health plan's premiums if health plans do not comply. The tax applies only to those plans who are willfully negligent.

TITLE II PROVISIONS

The bill permits benefits to be paid for 60 days per year for inpatient hospital services furnished primarily for the diagnosis or treatment of mental illness or substance abuse. The benefit is the same in both psychiatric and general hospitals.

The following intensive residential services are covered for up to 120 days per year: Residential detoxification centers; crisis residential or mental illness treatment programs; therapeutic family or group treatment home; and residential centers for substance abuse.

Additional days to complete treatment in an intensive residential setting may be used from inpatient hospital days, as long as 15 days are retained for inpatient hospitalization. The cost of providing the additional days of service, however, could not exceed the actuarial value of days of inpatient services.

A facility must be legally authorized under State law to provide intensive residential services or be accredited by an accreditation organization approved by the Secretary in consultation with the State.

A facility must meet other requirements the Secretary may impose to assure quality of services.

Services must be furnished in accordance with standards established by the Secretary for management of the services.

Inpatient hospitalization and intensive residential services would be subject to the same deductibles and copayment as inpatient hospital services for physical disorders.

PART B PROVISIONS

Outpatient psychotherapy for children and the initial 5 outpatient visits for treatment of mental illness or substance abuse of an individual over age 18 have a 20-percent copayment. Subsequent therapy for adults would remain subject to the 50-percent copayment.

The following intensive community-based services are available for 90 days per year with a 20-percent copayment—except as noted below: Partial hospitalization; psychiatric rehabilitation; day treatment for substance abuse; day treatment under age 19; in-home services; case management; and ambulatory detoxification.

Case management would be available with no copayment and for unlimited duration for ''an adult with serious mental illness, a child with a serious emotional disturbance, or an adult or child with a serious substance abuse disorder—as determined in accordance with criteria established by the Secretary.''

Day treatment for children under age 19 would be available for up to 180 days per year.

Additional days of service to complete treatment can be used from intensive residential days. The cost of providing the additional days of service, however, could not exceed the actuarial value of days of intensive residential services.

A nonphysician mental health or substance abuse professional is permitted to supervise the individualized plan of treatment to the extent permitted under State law. A physician remains responsible for the establishment and periodic review of the plan of treatment.

Any program furnishing these services—whether facility-based or freestanding—must be legally authorized under State law or accredited by an accreditation organization approved by the Secretary in consultation with the State. They must meet standards established by the Secretary for the management of such services.

ONE-YEAR ANNIVERSARY OF ABDUCTION OF HUMAN RIGHTS ACTIVIST

HON. DAN BURTON

OF INDIANA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, September 10, 1996

Mr. BURTON of Indiana, Mr. Speaker, September 6 marks the 1-year anniversary of the Indian Government's abduction of human rights advocate Jaswant Singh Khalra. As I have said in previous statements on the floor about this tragic case, Mr. Khalra was kidnaped after he exposed the widespread use of cremations by Indian authorities in Punjab to dispose of victims of extrajudicial killings.

Recently, India's Central Bureau of Investigation was forced to admit in court that at least 1,000 such cremations had occurred in Punjab. The actual number is certainly many times higher than that. The United States State Department reported that between 1991–93, the Indian Government paid over 41,000 cash bounties to police in Punjab for the killings of Sikhs.

Before Mr. Khalra was abducted, he stated publicly, and with a great deal of courage, that the number of cremations of innocent Sikhs was probably as high as 25,000. He was picked up by authorities a short time after that statement and has not been seen since. That was 1 year ago.

In the video, ''Disappearances in Punjab,'' a policewoman testifies that she saw prisoners in custody whose legs had been broken. These prisoners were reported to have been killed later in staged ''encounters.''

Mr. Speaker, it is time for the Indian Government to release Jaswant Singh Khalra and own up to the crimes committed in Punjab. With the Indian Government's atrocious human rights record, it is no wonder that there is such a strong movement among the Sikh people for an independent nation of Khalistan.

Mr. Speaker, I hope that the pro-India lobby, and my friends in Congress who have opposed legislation to punish India for it brutal treatment of the Sikhs, the Kashmiris, and other minorities, will pay attention to what is happening over there, and will also call for the immediate release of Mr. Khalra.