

EXTENSIONS OF REMARKS

DRUG COVERAGE MEANS EXTRA COST

HON. DOUG BEREUTER

OF NEBRASKA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, June 15, 1999

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

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

DRUG COVERAGE MEANS EXTRA COST

PRESIDENT HAS A PLAN FOR INCLUDING PRESCRIPTIONS UNDER MEDICARE PROGRAM

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

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

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

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

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

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

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

Better coverage will cost more; and those costs ought to be paid largely through real-

istic premiums for those who wish and can afford the extras.

INTRODUCTION OF THE MEDICARE EARLY ACCESS ACT

HON. FORTNEY PETE STARK

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, June 15, 1999

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

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

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

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

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

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

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

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

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

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

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

MEDICARE EARLY ACCESS ACT OF 1999 SUMMARY

TITLE: HELP FOR PEOPLE AGED 62 TO 65

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

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

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

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

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

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