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