

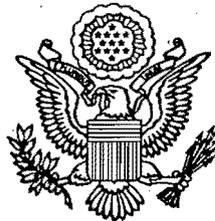
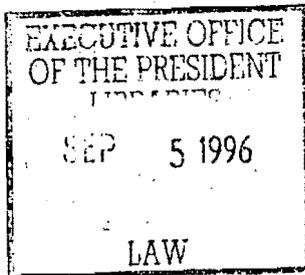
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NOT VOTING—2

Hatfield	Murkowski
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The amendment (No. 5191), as modified, was agreed to.

Mr. HELMS. Mr. President, I move to reconsider the vote by which the amendment was agreed to.

Mr. BOND. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

Mr. BRADLEY addressed the Chair.

The PRESIDING OFFICER. The Senator from New Jersey is recognized.

AMENDMENT NO. 5192

(Purpose: To require that health plans provide coverage for a minimum hospital stay for a mother and child following the birth of the child, and for other purposes)

Mr. BRADLEY. Mr. President, I send to the desk an amendment and ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from New Jersey [Mr. BRADLEY], for himself, Mrs. KASSEBAUM, Mr. FRIST, and others, proposes an amendment numbered 5192.

Mr. BRADLEY. Mr. President, I ask unanimous consent that further reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

(The text of the amendment is printed in today's RECORD under "Amendments Submitted.")

Mr. BRADLEY. Mr. President, this is an amendment that deals with the Newborns Act. It is an attempt to require at least 48 hours for a childbirth.

Mr. FRIST addressed the Chair.

The PRESIDING OFFICER. The Senator from Tennessee.

AMENDMENT NO. 5193 TO AMENDMENT NO. 5192

(Purpose: To require that health plans provide coverage for a minimum hospital stay for a mother and child following the birth of the child, and for other purposes)

Mr. FRIST. Mr. President, a number of my colleagues have expressed concern regarding a provision in the amendment just sent to the desk which appears to have a conflict in it. I wish to offer a second-degree amendment at this time to clarify the intent of the legislation. Specifically, language was added to the section on postdelivery

care to clarify that it is the attending provider, in consultation with the mother, that determines the appropriate location for followup services in combination with an earlier discharge which is less than 48 hours. It is confusing as initially written because the amendment appears to give the mother the option of demanding home care regardless of the attending provider's assessment of their individual needs.

This decision is most appropriately made in cooperation with the provider and the mother. Therefore my second-degree amendment strikes the language which appears to conflict with this intent.

The PRESIDING OFFICER. Does the Senator intend to offer this amendment at this point?

Mr. FRIST. Yes, I do.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from Tennessee [Mr. FRIST], for himself and Mr. BRADLEY, proposes an amendment numbered 5193 to amendment No. 5192.

Mr. FRIST. Mr. President, I ask unanimous consent that further reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

(The text of the amendment is printed in today's RECORD under "Amendments Submitted.")

Mr. FRIST. Let me just briefly close by saying one other thing that this second-degree amendment does. The amendment guards against monetary incentives directed at discharging mothers and babies before the attending provider feels it is appropriate. Specifically, my second-degree amendment provides language sought by health plans to provide that nothing in this bill interferes with rate negotiators between a plan and a provider.

Mr. BRADLEY addressed the Chair.

The PRESIDING OFFICER. The Senator from New Jersey.

Mr. BRADLEY. Mr. President, I welcome the second-degree amendment by the distinguished Senator from Tennessee. I do think he clarifies my own intent in the original amendment. I believe that it is important. It adds to the purpose of the original amendment.

Mr. President, the amendment I have offered and that has been second-degree by the distinguished Senator from Tennessee I think is a very important amendment. His is offered on behalf of himself and me. I offered mine on behalf of myself and him, as well as the distinguished chairman of the committee, Senator KASSEBAUM, the ranking member Senator KENNEDY, Senator DEWINE, Senator MURRAY.

Mr. President, I ask unanimous consent that all 52 cosponsors of this amendment be listed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

COSPONSORS

The following Senators have cosponsored the Newborns' and Mothers' Health Protection Act as of September 5, 1996.

Bill Bradley.
Nancy Kassebaum.
Bill Frist.
Jay Rockefeller.
Barbara Boxer.
Barbara Mikulski.
Paul Sarbanes.
Patty Murray.
Mike DeWine.
Harry Reid.
Claiborne Pell.
Edward Kennedy.
Paul Simon.
Paul Wellstone.
Carol Moseley-Braun.
Richard Bryan.
Wendell Ford.
Frank Lautenberg.
Daniel Inouye.
Ben Nighthorse Campbell.
Robert Kerrey.
Mitch McConnell.
Carl Levin.
Jesse Helms.
Charles Grassley.
Pete Domenici.
John Kerry.
Olympia Snowe.
Alan Simpson.
Patrick Leahy.
John Glenn.
Charles Robb.
Ted Stevens.
Diane Feinstein.
Joe Biden.
Rod Grams.
Alfonse D'Amato.
Ernest Hollings.
Kay Bailey-Hutchison.
Herb Kohl.
Bob Graham.
John Warner.
Pat Moynihan.
Chris Dodd.
John Breaux.
Larry Pressler.
Arlen Specter.
Bill Cohen.
James Inhofe.
Max Baucus.
Byron Dorgan.
Ron Wyden.

Mr. BRADLEY. Of these cosponsors, 19 are Republican. So this is a bipartisan amendment and a bipartisan bill. What the bill does is very simple. It says that insurers are required to allow 48 hours, up to 48 hours, for a woman in the hospital after giving birth and requires insurers to allow up to 96 hours if that birth is a Caesarean section.

If the mother and her doctor choose to leave the hospital in less than 24 hours, less than 48 hours, she is permitted to do so. There is nothing in this bill that says that she cannot leave earlier. Followup care will be provided if she leaves earlier.

Mr. President, why is this amendment needed? Why are we offering this amendment? The answer is because all of us, I am sure, have received reports of women in our respective States being required to leave a hospital prior to 48 hours, in some cases prior to 24 hours. In California, for example, in 1994, for 1 in 6 babies that were born, the mother had to leave the hospital in less than 24 hours. That is for 90,000 births.

The problem here is that some illnesses do not develop until the second day. If the mother were in the hospital, they would be able to detect it and deal with it. A good example is jaundice, which does not really develop until the second day. Heart defects are another. What happens is that the mother is pushed out of the hospital. She goes home after 12, 14 hours, 16 hours, 26 hours. In the second day jaundice is detected, or worse, a heart defect, and the mother is rushed back to the hospital at a much greater cost.

In New Hampshire, for example, there was the study that showed that women who leave the hospital in less than 48 hours have a 50-percent increased risk of readmission to the hospital, a 70-percent increase in risk to be readmitted at the emergency room. So in the long run, by saying that someone has to leave in 24 hours, you are really saying it is going to cost more, it is going to cost more because the readmission and the treating of the more serious illness could have been avoided had she been in the hospital when it was first detected.

So, Mr. President, the need here is very clear. It is kind of common sense. I mean, my distinguished cosponsor on this bill, Senator FRIST, refers to a safe haven of time, 48 hours. That is why it is needed. Who supports this amendment and this bill? It is supported by the American Medical Association, The American Academy of Pediatrics supports this. The College of Obstetricians and Gynecologists supports this.

In fact, the Academy of Pediatrics, their recommended guideline is 48 hours. Gynecologists and obstetricians, 48 hours is the guideline they set. That is how we arrived at this number. Why 48 hours? Because the doctors in question recommended that. The obstetricians and gynecologists stated that, if we keep the 24-hour limit, "it could be the equivalent of a large uncontrolled, uninformed experiment on women and babies."

We all want to reduce health care costs. We can do so without jeopardizing the health of mothers and their newborns. Again, who makes the decision? That is really the question here. We believe that the person who makes the decision should be the doctor and the mother, that the decision should not be made by an accountant in a distant office seeking cost savings and forcing women out of hospitals within 12 to 14 hours after they have given birth to their child.

This is the basic question: Who makes the decision? We have stories all across the land of doctors who have been put under great financial pressure to discharge in 24 hours or less or they will be dropped from health plans.

So, Mr. President, this is needed because there is a clear health problem with women who are discharged too early. The 48-hour and 96-hour for Caesarean section limits were set pursuant to the guidelines of the American Academy of Pediatrics and the Amer-

ican College of Obstetricians and Gynecologists.

A number of States have already acted on this. Twenty-eight States have passed laws requiring a 48-hour limit. Why, then, do we need a national law, people ask. You need a national law obviously for the other States that have not passed it, but even if all of them passed it, you would still have many in a State that would be unaffected by the State law.

For example, we need a Federal law to get at the so-called ERISA plans, the self-insured plans, the plans of large companies like Boeing, IBM, 3M, Dupont, and others. They would not be affected by a State law because they are self-insuring ERISA, controlled by Federal law.

There is also another problem, at least in my State of New Jersey. There is a State law that says you have 48 hours, but the law says the State has no authority to regulate insurance companies that are headquartered in a different State, Mr. President. So there are large numbers of people who are not covered then, of course, in States like Kansas, Missouri, New Jersey, Pennsylvania, New York. You might have a 48-hour law in a particular State, but you might have a hospital in another State, and when you gave birth to the child in a hospital in another State, you would not be covered by the 48 hours and you would be pushed out of the hospital in 24 hours.

That, not coincidentally, would have been the case in my own family when our daughter was born. The birth was delivered across the line in New York—24 hours, you are out.

We need this national law in order to make sure women have 48 hours to stay in a hospital. There are some places, for example, in Kansas, 40 percent of the companies—only 40 percent—would be subject to regulation under just a State law. In some States, 75 percent of the women are uncovered because State laws do not and cannot reach them as they are now written.

Now, Mr. President, this is an issue that came to my attention because I had several letters from women who had been subjected to this rigid 24-hour-and-you're-out policy. Drive-through deliveries is what they are called. There was an article about it, after this came to my attention, in Good Housekeeping magazine, and someone, the author of the article, put a little box in the article that said if you care about this issue, write to Senator BRADLEY.

Mr. President, I have received, since that article appeared about a year and a half ago, more mail than I have received on any one issue, with the exception of interest and dividend withholding, in my entire 18 years. I received over 85,000 pieces of mail from women and families of women in this country who have been pushed out of the hospital in less than 24 hours. Now, I do not intend to read a long list of these letters—85,000 is a long time. We

want to move this amendment as quickly as possible. Let me share two with you.

The McCloskeys, who live outside Philadelphia, write:

Our daughter Shannon was discharged from the hospital approximately 27 hours after birth. After only 8 hours at home, she went into seizures and we had to rush her back to the emergency room. She was diagnosed with streptococcus. The timing of our arrival at the hospital was critical, and we feared for her life. The doctor told us that if we had arrived at the hospital 15 minutes later, she would have been dead.

Linda Dunn of Knoxville, TN, writes:

We almost lost my grandson, Brantley, because of an early hospital release. Brantley was one month premature and was born via a Caesarean section. In spite of this, he was released with his mother only 36 hours after the birth. Within 20 minutes of arriving home, Brantley choked, quit breathing, and was rushed to Children's Hospital in Knoxville, where he was placed in neonatal intensive care and noted as having "a serious, life-threatening episode." The frightening part of the scenario was that if I had not been trained in infant resuscitation at my prior job, the baby would simply be dead.

Mr. President, if the baby were in the hospital, the baby would not have been even risking death. In the first 48 hours when some baby started to turn sort of a greenish color and jaundiced, it would be recognized and dealt with immediately. You are a first-time mother and you have a child, you are forced out of the hospital, you do not know quite what to do and you arrive home with the baby. In the first 24 hours you have a life-threatening health problem; you do not have anybody to turn to. Mr. President, that is why we need this bill.

I might also say that there were people who say you will not get any support from the insurance industry or HMO's, that they are the bad guys here. Mr. President, that is not necessarily so. We have letters of endorsement for this bill from one of the largest HMO's in the country, Kaiser Permanente. We have an endorsement from the HIP plan of New York-New Jersey.

Mr. President, this bill has 52 cosponsors, 33 who are Democrat, 19 who are Republican. This passed out of the Labor and Human Resources Committee 14 to 2. In the House, the leader on this legislation is a Republican, GERALD SOLOMON, with GEORGE MILLER as his No. 1 helper in this effort. They have over 150 cosponsors.

It is time to do this amendment. It is time to do it now. I hope we will pass it on this bill and that we will send it to conference and hopefully the conference will hold this amendment, say to those hundreds of thousands of women out there who are going to give birth in the next 6 months that you are not going to be rushed out of the hospital. You will have a little time to take care of the health problem of your child if it should develop. You will have

a little time to gather yourself after an exhausting delivery. You will have a little time to get you and your baby off to a right start, a healthy start, because the U.S. Senate saw fit on this bill at this time to say that 48 hours is not too much to require an insurance company to give you after giving birth.

The PRESIDING OFFICER (Mr. THOMPSON). The Senator from Delaware.

Mr. BIDEN. I want to thank Senator BRADLEY. This issue was called to my attention by someone reading Good Housekeeping who asked me why everybody was writing to BRADLEY. I contacted Senator BRADLEY and wanted to know more about what he was talking about because I was hearing about this and found it hard to believe. You hear so many rumors today, so many people are upset about HMO's—much of it legitimate, some of it not legitimate—that you hear these horror stories.

Quite frankly, when I first heard this back in my home State, I really did not believe that some HMO's and insurance companies were actually doing this. I did not think it was a joke, but I thought it was a clear misunderstanding on the part of the people who were saying this was happening—24 hours and you are out.

This is, quite frankly, very scary. The potential danger is real. Think back, those of you women and men on this floor when you were young parents, to the first child you had and think back to when you brought that child home. I know this is a distant memory for some of us, myself included, but remember how it was. You brought that baby home, and when your wife turned and handed the baby to you, your first concern was maybe, "Is it going to break?" Or, "I don't know what I am going to do here, I'm not sure." Then your wife, no matter how instinctively good a mother she is, used to go, in the first couple days the baby was home, and literally lean over the crib to make sure the baby was breathing. How many of you actually leaned over the crib and stuck your ear down to see if you could literally hear the baby breathing? The reason I point that out is the baby was healthy. Your children were, 99 percent of the time, healthy and nothing was wrong. But the point is, you didn't know. There are so many young mothers. The tragedy is that there are teenagers giving birth to children. The tragedy is that there are thousands of unwed mothers out there. What do they do when they go home—you may say that maybe they shouldn't be in that position, but they are—without anybody even having an opportunity to instruct them on how to deal with the baby, what to look for? These are very basic little things, just basic things.

So I contacted the Delaware Medical Association and other doctors in Delaware. I wanted to know what their view on this was before I cosponsored Senator BRADLEY's bill. I was pleasantly surprised when the leading pediatri-

cians and ob/gyn's showed up at a meeting I held and they unanimously supported the Bradley proposal. It was unanimous. Usually, you get some kind of heat when the Government is going to indicate that something must be done or when the Government is going to dictate something. In this case, it would dictate that an insurance company can't throw you out in 48 hours or 24 hours if the doctor says no. But here you had all these doctors, who are no fans of Government intervention, every one of them saying this is important. I will not take the time now to recount what they said because we want to move along. But, they gave me specific story after story, incident after incident, in just that one long breakfast meeting, of specific cases they had personally handled. This was 21 or 22 pediatricians and obstetricians. It amazed me. The intensity of their political views and the variation of their views was wide.

So the only real mystery to me is, why in the devil is it taking us so long to pass this? That is the real mystery. The mystery to me is no longer if it is needed; the mystery is no longer that enough Members of Congress want it; the mystery to me is, who is stopping it? Why? Who is stopping this? Why isn't it done already?

Now, you know the fact of the matter is that this is not the usual vehicle to pass this. I understand my friend from New Jersey concluded that he is getting all kinds of promises that we can bring this up and will have a chance to vote on it. I have not had a chance to speak to him about this point, but I assume the reason he is attaching it here is that his patience is running a little thin. He wants to make sure that before we go out of session we get a chance to act on something that clearly a majority of people want. So the biggest mystery to me is not why it is needed, not why it is important, not why do doctors support it, not why do mothers support it, but why hasn't it been done?

Now, I know that speed was not what my colleague was known for on the court—I am only joking, Senator. I want to make it clear that he could go to his left and right and he could do everything on the court. He is a Hall of Famer. But the fact of the matter is, the reason it is not being done is not for the lack of my friend's pushing it. Although I imagine we are going to hear that this is not the vehicle—the HUD appropriations bill—to put this on, we are running out of runway and running out of time. A lot of women and a lot of children are at risk. Some would say, oh, what difference does it make to wait another month? In another month we are out of here, which means waiting until next year, and waiting until next year means the end of the next year. So the health and safety of hundreds of thousands of women and children are at risk here. It is a really basic proposition.

Let me conclude by reiterating one point. A lot of my colleagues and indi-

viduals have asked me about this. And because they have not focused on it, I suspect, they did not understand one of the first points the Senator made when he took the floor, and that is, why don't they do it at the State level? Why not get this done at the State level? The Senator explained ERISA. The bottom line of this is that, in Delaware, only about 15 percent of the people with health insurance would be affected by a State law that my State is passing. My State is passing a law saying leave it to the doctor to decide. Notwithstanding that, those State legislators have come to me and said, we need a national law, because even with the State acting, and acting promptly, only 15 percent—15 percent—of the people with health insurance would be positively affected by the State law. To put it another way, the other 85 percent are out. They are out, without Federal legislation.

I see Congressman SOLOMON on the floor. I thank him for his leadership. I thank Senator BRADLEY on this side for calling my attention to this and making me realize that this was not some exaggerated criticism of HMO's—which I honestly thought was the case when I first heard it in my State, that this was one of these horror stories that had been blown out of proportion. It is real, it is genuine, and the bottom line is that this will make a difference in the lives of mothers and their children. We should not wait any longer.

I thank the Chair.

Mr. FRIST addressed the Chair.

The PRESIDING OFFICER. The Senator from Tennessee is recognized.

Mr. FRIST. Mr. President, the bill before us, the Newborns' and Mothers' Health Protection Act of 1996, does one very simple thing. I refer to it as a "safe haven." It guarantees a safe haven for care of mothers and their newborn infants during the immediate postdelivery period. That period of time is 48 hours after delivery, that postdelivery period. I have been very aware of the potential for having Government get too involved, but it does this without excessive interference by the Government in the health care system.

As background, maternity care today—many people don't know this—is the most frequent reason for hospitalization today. Hospital stays of 24 hours or less have indeed become the norm in many parts of the country for those routine, uncomplicated vaginal deliveries. Sometimes hospitalizations are as short as 12 hours and even 6 hours. However, adopting this approach of a 6-hour discharge, or even a 12-hour discharge, to the general population, and not being able to predict every time which child will have a ventricular arterial contraction or a defect, it has not proven to be uniformly successful.

This bill ensures appropriate coverage. Let me make it clear. It does not mean 48 hours for everybody in the hospital. People can still be discharged

at 12 hours or 24 hours. What this bill says is that the insurance company does not decide when you are discharged, but it is you, the mother, in consultation with the physician. The physician and mother decide, the two of them, not an insurance company.

Why has all of this become an issue today in 1996 when it was not an issue 8 or 10 years ago? Over the last several years, we have seen how these progressively shortened hospital stays have, in some cases, hurt new mothers and their infants. These cases that will be referred to have been brought to the attention of physicians, have been brought to the attention of the American people, and have been brought to the attention of the U.S. Congress. Problems for both the mothers as well as the infants—either one of them—can simply occur with too early a discharge.

Today with the evolution of care in our rapidly changing health care system there are certain dynamics which can and do raise their heads that encourage too early discharge overruling the mother and overruling what the physician regards as being in the best interests of that child or that mother. The decision for discharge should remain with the health care provider in consultation with the mother.

Changes in maternity stay have occurred over the last 2 decades. We only need to look back at older brothers and sisters and see how long they were in the hospital, or how long we were kept in the hospital and compare it to today. Mothers used to stay in the hospital routinely for 5 days or more. At the same time—remember this is not that long ago—infants were frequently isolated from mothers and brought to them only at nursing time. And mothers were heavily sedated during birth. And fathers very, very rarely were present at the delivery of their infants and children.

Over time—again it has been over the last 30 years—this type of delivery environment was recognized as being abnormal and unacceptable to many people—to parents who asked for more, and who won more appropriate care for this most natural of all events; that is birth. But increasing emphasis was placed on returning home as soon as possible. Many people wanted to get back home.

This legislation does not discourage innovation, creativity, new environments in which this delivery can be carried out; this birthing can be carried out. Alternatives to hospital delivery have become available. We now have birthing centers under the supervision of other types of health care providers, not just physicians, but midwives. All of this experience which has occurred in the last 20 years has taught us much about what is necessary, what is not necessary, what is safe, and what is not safe for the delivery during a normal pregnancy. Midwives carefully screen their mothers for such deliveries, prepare the parents for this expe-

rience, and visit their patients shortly after discharge.

And in this framework of carefully-crafted policy mothers and their newborns are frequently ready—yes, ready—to return home as early as 6 hours after delivery. But then on the flip side insurers—again not all insurers—but insurers seeing these results have been attracted by the successful outcomes and by the opportunity to decrease costs and free up funds which can be utilized elsewhere in the system—all of that can be a laudable goal. But an overvigorous institution of a policy of early discharge without enough attention paid to potential consequences when this approach is inappropriately applied has resulted in the situation in which we find ourselves today.

Health care providers—that is physicians and midwives—frequently feel undue pressure to discharge a mother and her infant before they believe it is in the best interest of their patients. We just simply cannot let that happen. I concluded that in this limited situation in which there has been excess interference in the exercise of a physician's best interest of the patient, a physician's responsibility for his or her patient, Federal legislation is justified.

Very quickly, what does this bill do? Number one, as I said, it provides a safe haven of time during which those making the decision about discharge are those most directly involved—the mother—and the health care provider. Many times I will hear from my medical colleagues who will tell me that sometime in that 48- or 96-hour period a health care provider will receive a phone call, and say, "We need to encourage your patient to leave earlier." Then you may think it is in the best interest of that patient. That is simply unsatisfactory today.

No. 2, this bill guarantees that in those cases where the provider in consultation with the mother decides that a mother and her newborn can safely leave the hospital before 48 hours, that the insurer, if they say they are in the business of covering maternity benefits during that 48-hour period, will provide coverage for these timely postdelivery care situations.

That is very important because some people come, and say, "You are forcing people to stay in the hospital for 48 hours." We are not. The provider and the mother decide about discharge. If it is before 48 hours, timely care must be given by that insurance company.

No. 3, this bill guarantees that there will no longer be undue pressure in the form of a monetary incentive to either the mother or the health care provider to discharge in less than 48 hours.

This bill does not do several things. Again, to understand the bill fully, we need to look at those things.

First, this bill does not require a mother and her newborn to stay any fixed time in the hospital.

Second, this bill does not require that a mother go to a hospital to de-

liver her infant. It allows other types of environments. It allows innovation within our changing health care system.

Third, it does not preempt laws or regulations passed by any State that provide already as much or more protection for the mother and her infant than is provided in this bill.

Many mothers are ready for early discharge, and many health care systems have the appropriate safeguards in place for this to occur, but not all, and that is why we need this legislation. With time more will provide appropriate prenatal preparation and follow-up. However, now and in the future, it should always be the health care provider in consultation with the mother who will decide when the mother is ready to go home with her newborn child and to what environment.

The amendment before the Senate guarantees this period of time which I call a safe haven for this decisionmaking process to be carried out. It is the best and the only way to support the successful transition for mother with child to mother caring for child.

What will be appropriate for health care in the 21st century? There is no way for us to predict now and, thus, in this bill we have the flexibility to allow innovative solutions to the problems that may face us in the future. It is not a rigid bill.

Professional organizations such as the American College of Obstetrics and Gynecology and the American Academy of Pediatrics have endorsed the bill. Some managed care plans have endorsed the bill as well. The National Association for Home Care has endorsed the bill. The American Medical Association supports the bill and their comment is basically that this bill does not dictate medical practice nor lock medical care into statute. It restores the clinical autonomy of doctors and their patients to make the best decision about health care for women and their newborns. It provides flexibility for early discharge when both the mother and physician agree on an abbreviated stay.

It is also endorsed by the American Nurses Association, the Association of Women's Health, Obstetrics and Gynecologic Nurses, the March of Dimes Birth Defect Foundation, the Consortium for Citizens with Disabilities, the American Association for University Affiliated Programs, and a number of other organizations.

Mr. President, I opened by saying that I am not a fan of big Government intruding into our health care. But in very specific situations—situations where the care of patients is being restricted in many ways I think to the detriment of society—there is a point for Government to stand up. At the same time we must guard against a one-size-fits-all health care system, or to use the Federal Government to micromanage those difficult cost-benefit tradeoffs that every health care plan must make.

However, I do believe that there are times when it is appropriate for Government to provide guidance by setting national rules. This is one of those times. The challenge is to do so in a way that protects the individual but still allows the necessary flexibility for the system to respond appropriately and in a timely manner to a rapidly changing health care environment.

This bill does exactly that. Therefore, I urge all of my Senate colleagues to join me in supporting this important and timely piece of legislation.

Mr. DOMENICI addressed the Chair.

The PRESIDING OFFICER. The Senator from New Mexico.

Mr. DOMENICI. Mr. President, I only want to ask a question. I am not going to speak.

Parliamentary inquiry, Mr. President. After this amendment is disposed of, is there some pending business by order or what will be the pending business?

The PRESIDING OFFICER. After the Bradley and Frist amendment is disposed of, the bill will be open for further amendment.

Mr. DOMENICI. Is there a time agreement on the amendment that is pending?

The PRESIDING OFFICER. There is not.

Mr. DOMENICI. And do I understand then a Senator taking the floor and getting recognized with an amendment would be the pending business after the disposition of this amendment? Is that correct?

The PRESIDING OFFICER. The Senator is correct.

Mr. DOMENICI. I would like to state to the Senate that when this matter is disposed of, I do intend with the aid and assistance of my able friend, Senator WELLSTONE, to call up the compromise Domenici-Wellstone mental health coverage issue as an amendment if possible yet today before we finish.

I yield the floor.

Mr. WELLSTONE addressed the Chair.

The PRESIDING OFFICER. The Senator from Minnesota.

Mr. WELLSTONE. I ask unanimous consent that after this amendment is disposed of, the Domenici-Wellstone amendment be next in line.

The PRESIDING OFFICER. Is there objection?

Mr. DOMENICI. I reserve the right to object.

The PRESIDING OFFICER. Objection is heard.

Mr. WELLSTONE. Does the Senator know I asked unanimous consent that our amendment be brought up?

Mr. DOMENICI. Yes. I had to reserve the right to object in behalf of the leadership because the manager deserves an opportunity to pass judgment on whether that should be granted.

Mr. WELLSTONE. I see.

Mr. President, I will just take a moment. I certainly thank Senator BRADLEY and Senator FRIST and other Senators for their leadership, and I am

very proud to be a cosponsor of this amendment. I just want to make four points. The first one is the point the Senator from Delaware, [Mr. BIDEN] made.

I come from a State where very simple legislation has now been passed with overwhelming support. The problem is, as with so many of the self-insured plans, that people because of ERISA are just not covered at all. In Minnesota I think it is about only 40 percent of the people, actually a quite smaller percentage in Delaware. So we really have to do this at the Federal level to provide this protection for women, their husbands and their children.

My second point, an alarming one, is that too many health plans are refusing to provide the postpartum coverage both women and their physicians feel is necessary. Senator DOMENICI and I are going to talk about mental health. That is another example where too often in the plans you find discrimination or you sort of find a point where some of the limits set are arbitrary. That is exactly what is going on here. This is really an effort to deal with what some people call the drive-through deliveries.

I think this amendment is long overdue. It is not that often we can pass an amendment or a piece of legislation which so clearly connects to people's lives—women's lives, children's lives, husbands' lives, families' lives.

This is an extremely important amendment.

Again, point one is that we do need to do this at the Federal level to provide this coverage to people in the United States.

My second point is that we do have these drive-through deliveries.

Three, as referred to by my colleague from Tennessee, nobody is mandating that a mother stay in the hospital 48 hours. My daughter, Marcia, had a boy several months ago and in a day was more than ready to go home. But what I am worried about is the bottom line becomes the only line, and what you have is people discharged out of the hospital when they should not be and when they are in need of more assistance or when their babies are in need of more assistance. So I think it is extremely important on those grounds.

And the final point, which is different, is that I think this amendment and the fine work that was done in the House of Representatives speaks to a broader question. We are not going to get to it today, but I really do think that what is going on in the country is a major concentration of power in health care. The fact that there have not been a lot of changes taking place in the 104th Congress does not mean that there are not major changes taking place all around the country.

These are rough figures; I am just speaking from memory here, but something like the nine largest insurance plans control over 60 percent of the managed care plans in our country

today. I am not trying to make any conspiracy argument, but what I am trying to say is when you move toward this kind of concentration of power and you find situations when women and their babies are leaving the hospitals, really forced to leave the hospitals because they do not have the necessary coverage where they should be there that extra day, that points to a larger set of problems, and I think we need to legislatively figure out how to build more accountability into the system, how to make sure some of the care givers are involved in setting some of these standards, how to make sure that there is more consumer protection, how to make sure that while we move forward with cost cutting or cost containment, all of which we need to do, the bottom line is not the only line because when it comes to the health of a mother and her newborn or when it comes to the concerns of families, there is nothing more precious than good health.

That is what this amendment speaks to in a very dramatic and very direct way, and I am very pleased to be an original cosponsor.

I yield the floor.

Mr. DEWINE addressed the Chair.

The PRESIDING OFFICER. The Senator from Ohio.

Mr. DEWINE. Mr. President, I rise in strong support of this amendment. I believe it is a major step toward insuring health for newborn babies and for their mothers. For the last few decades, we have made great progress in medical care, pregnancy and childbirth. I have had the occasion, as my wife has, to see this firsthand. My wife, Fran, had our eight children over a pretty widely spaced period of time. We have had children in the 1960's and 1970's, the 1980's, and the 1990's. So we have seen a lot of changes.

The progress during this period of time has certainly been measurable. In 1968, for example, when our first child, Patrick, was born, there was relatively little in the way of prenatal education for the mother. Since then, with each new child, we have seen some truly remarkable improvements: Prenatal child birthing courses now for both parents, ultrasound, fetal monitoring during labor to detect problems, birthing rooms which have done a lot to make the whole process much easier and certainly much more humane. Fran and I have watched all of these innovations as they were introduced, refined and perfected, and we can both testify that as a result of these improvements today's mothers are better prepared to deal with their pregnancies in a healthy way and better prepared to give birth.

All that being said, we still have a long way to go if we want to make sure new mothers and their babies get the care they need. This amendment addresses one of the key areas in which we need to make substantial improvements. We can no longer ignore the fact that today's new mothers and

their babies are often being moved out of hospitals far faster than a real concern for their health would allow. This is being done without any real consideration for what else needs to be done to compensate for that quick movement out of the hospital, what kind of additional care the mother and child need if the hospital stays are shorter and shorter, and shorter. Often, as we have already heard in the Chamber today, the mother and the baby are moved out of hospitals just 24 hours after the child is born, in some cases even less than that.

If you talk to doctors, as I have, they will tell you that they are under a tremendous amount of pressure to keep the new mothers moving out the hospital door. The pressure is coming on the doctors, coming on the mothers. It is coming on the hospitals. I think it is wrong. I think it is unconscionable. This is a decision, as Dr. FRIST said just a moment ago, that should be made between the mother and the doctor. That is who should be involved in this decision. It is a decision that should be based on the best interests of the mother and the child. It should not, frankly, be a business decision.

When our son Patrick was born in 1968, my wife, Fran, stayed in the hospital with him for almost 5 days. That was standard operating procedure in Hamilton, OH, in 1968. When our last child, Anna, was born in 1992, Fran stayed in the hospital for 36 hours, about a day and a half.

This trend is not bad in and of itself. In some cases, a mother might want to leave the hospital sooner rather than later. For example, back in January 1987, my wife Fran had just given birth to our son Mark, when a blizzard threatened to hit. In fact, she gave birth between two blizzards—one had come, then we went to the hospital, then we were worrying about the second one coming. So for her the choice was clear: either leave the hospital after a day and a half, or risk being stuck there for up to a week. Fran chose to take Mark home. That is what she did. The blizzard came just a few hours after we got home.

But it is not, therefore, a question of mandating hospital stays. Government should not be in the business of doing this. All we are trying to do with this amendment is to make sure it is the mothers and their doctors who are making this important choice, a choice that affects the health of the mother and the child.

It is also important that we not look at the number of hours mothers spend in the hospital as if it were an isolated issue or an isolated problem. I think we need to pay greater attention to the overall issue of postnatal care. The way my wife Fran likes to put it, it is time to make the same kind of investment in improving postnatal care as we have invested in prenatal care in recent years.

Let me tell another story which I think illustrates this. Last year, our

daughter Jill gave birth to our second grandchild. At 10:55 p.m. on a Wednesday, the birth took place. At 2 a.m., Thursday morning, just about 3 hours later, Jill was being taught how to bathe the baby and other necessary information. At 7:30 that morning, they started marching Jill through three or four separate videos on child care. And by noon on Friday, she and the baby were out the hospital door. Jill, at least, was exhausted.

We all realize the doctors and nurses who take care of our young mothers and their babies are the best in the world. They are true professionals with the best combination of competence and compassion. But they have an incredibly long checklist—that is literally what it is today—a long checklist of things that they have to teach the new mother. Frankly, they do not have enough time to teach it in. Sometimes we forget the new mother needs some time to rest, too, especially after an exhausting labor, during which she may well have missed a night's sleep. Longer hospital stays very well may be an answer to these problems.

But, in addition to that, we have to look at the overall issue, the overall issue of postnatal care. Frankly, there ought to be more followup care for the mothers and their babies. As we heard in testimony in our committee, and as my daughter-in-law Karen just experienced when she had her baby, the enlightened insurance companies, the enlightened HMO's, are now building into the policy, building into the plan, this type of postnatal care, because the fact is that most doctors do not require a followup visit for a week or two. Frankly, as parents, sometimes it is hard to take a new baby out before then. We, therefore, need to consider the importance of followup in-home visits. This kind of followup care can make a huge difference, a huge difference in the welfare of the child.

We had an experience, I think, that would shed a little light on this as well. Our youngest child, Anna, was born 5 weeks early, but she appeared to be healthy and had no medical problems. My wife, Fran, and our daughter Anna, were sent home after 36 hours. But after a few days, Anna began to look slightly yellowish. Fran and I really were not worried. We knew it was common for breast-fed babies to become slightly jaundiced. Fran was watching her, and about the fifth day she took her to the doctor. It turned out Anna's bilirubin level was dangerously high. Even as experienced and educated parents—seven other children—we had not noticed the change and had not noticed how fast the change was occurring. If Fran had not taken her in when she did, there could have been medical complications. This whole incident was particularly scary for us. We felt we knew the danger signals, but we obviously missed them.

This is a case of a mother and father who had seven children, who had been through this before. If it was tough for

us, can you imagine how difficult it must be for a young mother, with no experience at all, to detect some of these medical problems? Therefore, we need to do more in this area. In fact, when we were considering this legislation in the Labor and Human Resources Committee, some of my colleagues and I added the provision requiring a study of post partum care. I think this study is very important and is, in fact, included in the pending amendment.

Let me conclude by saying that today we are making, I think, a very good beginning. It is a very good beginning to deal with a problem that I have seen firsthand, a problem I have discussed with doctors and a problem that I have discussed with other constituents.

So, I commend my colleague from New Jersey, my colleague from Tennessee, and the other cosponsors of this amendment for the work they have done, the work they have done to refine the amendment and the work they have done to bring it to the floor of the Senate today.

I yield the floor.

Mrs. BOXER addressed the Chair.

The PRESIDING OFFICER. The Senator from California.

Mrs. BOXER. Mr. President, I rise in strong support of the Bradley amendment. I want to say to my colleague before he leaves the floor, I am going to miss him from this Senate. This is a perfect example. This is a Senator who understands what makes a difference in the lives of real people and goes after these issues with great skill.

I am so delighted to rise as, I think, the first Senator here who has ever actually given birth to testify that this is a very important amendment. I believe it will save lives. I believe it will spare families a great deal of heartache.

I will explain that. First of all, it is just incomprehensible to me that there would be a one-size-fits-all prescription being put out by so many of the HMO's today, when, in fact, each particular case is different from the one before. Not all women have an easy time giving birth. Not all babies have an easy time being born. There are so many complications, there are so many differences, so many problems. Senator DEWINE spoke, I think, from the heart, about having the seventh child and still almost missing a serious problem. I am going to address that in my remarks, I say to my friend.

I think it is important to note that this amendment really gives the flexibility where it belongs, to the patient and to the doctor. I strongly believe that, in any medical procedure, any medical issue, that is where the decision belongs, in the hands of the patient and the hands of the doctor. Childbirth is one of the most incredible experiences a woman can have. It is probably the most exciting—more exciting than winning elections. And, I have to say, it is also very difficult. It is usually very painful. Even in the

best of circumstances, where everything just goes according to the book, if there is such a book, it is hard on the woman and it is hard on the baby—even a perfect birth.

In the old days when my mother gave birth to me—and that's the old days—she stayed in the hospital for a week or longer. When I had my children, I stayed in the hospital for several days. It was very important, because I gave birth to premature babies, and they were there in little incubators. In those days, they did not even let you hold the babies, but I so wanted to be close to them, and I was able to stay in the hospital several days while I got stronger, and I watched them happily grow stronger.

When my daughter gave birth just a year ago, or so, the hospital figured she could stay in for 24 hours. She asked her doctor if she could stay in for 2 days. She felt she needed that extra day. Fortunately, he intervened on her behalf and she got to stay in for 48 hours and was very grateful for that.

I do not think that should be a gift from an insurance company. I think it ought to be something that is absolutely a right of a patient. When we've gone from women staying in the hospital for a week or 10 days down to where they are being thrown out after 24 hours, believe me, women are not any longer today physically than they were then. It is the same thing. So it doesn't add up.

Particularly new mothers need that education, it seems to me. They need to know how to nurse their children. That may sound strange, but I want to say the benefit of my colleagues that raising a baby takes a little bit gets used to. You have to learn how to do it. That added day in the hospital is very important to become comfortable in your baby, to understand the signs to look for if there is trouble. That brings me to the issue that Senator DEWINE spoke about, the jaun-

The fact is that many babies do become jaundiced, and it is easy to treat with light, if you know what to look for. But many of these mothers, because it takes a while for the jaundice to develop, are out of that hospital in 24 hours and are not prepared, and terrible consequences can flow from that.

In the case of my own grandchild, I noticed something right before she was left. They told her to watch for jaundice, and it happened. They had to come over and bring the little light box into the home.

I just want to say to my colleague, that added chance, that extra day can make a great difference. I am very glad he put in the RECORD that the Permanent Committee supports this. They have a huge HMO in California. I could be more proud of them for that.

Again, I thank my colleague for bringing an issue to the floor of the Senate that is extremely important to the families of America. I am so proud

that I had a moment or five or six to speak to your amendment.

I yield the floor.

Mr. WYDEN addressed the Chair.

The PRESIDING OFFICER. The Senator from Oregon.

Mr. WYDEN. I thank the Chair.

Mr. President, I, too, rise to speak in support of the Bradley-Frist amendment. I am going to be very brief this afternoon, but I did want to take a minute or two and discuss a General Accounting Office report that I will have coming out next week. The General Accounting Office has summarized a number of findings in a report for me, which report will be available next week, and I would like to discuss those findings very briefly.

First, it seems to me that, if you pass this important legislation, our country increases the odds that the next generation gets off to a healthy start. That is what this legislation is all about: getting off to a healthy start.

As I mentioned, I asked the General Accounting Office a number of months ago to help the Congress identify the risks attributable to foreshortened hospital stays for mothers and their newborns, as well as to analyze health care plans on how well they provide postpartum care.

The General Accounting Office has given me a letter, Mr. President, that I will make a part of the RECORD this afternoon, but I would like to summarize very briefly just four of the findings in the General Accounting Office report that they will have next week.

The first is the General Accounting Office has pinpointed studies analyzing readmission statistics that indicate that babies staying less than 48 hours do, in fact, have a higher rate of rehospitalization for health problems.

The General Accounting Office concludes that not every early discharge is a danger to each and every child, but certainly there are studies that do indicate that readmission statistics demonstrate that babies staying less than 48 hours do, in fact, have a higher rate of rehospitalization.

Second, the General Accounting Office has found that a number of the discharge plans are simply that they are just a drive-by delivery with no at-home follow up to ensure that the mother and the child are doing well.

Third, the General Accounting Office has found that while a number of the States do have laws on the books that deal with this practice, not all of the insured individuals, and certainly some of the most vulnerable of America's families, are protected by these laws. So I think it is fair to conclude that there is a very significant variation with respect to consumer protection in terms of State laws, and I think that, too, makes a compelling argument for the Bradley-Frist legislation.

Fourth—and I close with this point, because I think it is the most significant one and, in and of itself, makes the case for the Bradley-Frist bipartisan legislation—the General Account-

ing Office has found that a significant number of plans offer doctors alternative financial incentives for early discharge and significant penalties for keeping young mothers and babies in the hospital longer than the plans would like. So what we have—and I point out that this will be the first Government study looking at this problem—is already significant evidence that two sets of disincentives to good health for young families exists on the basis of the GAO report: first, the question of plans offering financial incentives for early discharge and, second, the matter of heavy penalties that the GAO has found in a number of instances for keeping young mothers and babies in the hospital longer than the plans would like.

What it comes down to—and I sure hope we get a unanimous vote in a few minutes with respect to this legislation—is that this Congress has a chance to put some votes behind all of the family-friendly rhetoric.

I am very hopeful that the Bradley-Frist legislation will pass on a bipartisan basis. I think that the Senator from New Jersey has contributed so much, but what an important bill on which to finish a stellar career.

Mr. President, I ask unanimous consent to have printed in the RECORD the letter from the General Accounting Office to which I referred.

There being no objection, the letter was ordered to be printed in the RECORD, as follows:

GAO, HEALTH, EDUCATION, AND
HUMAN SERVICES DIVISION,
Washington, DC, September 4, 1996.

HON. RON WYDEN,
U.S. Senate.

DEAR SENATOR WYDEN: To contain costs, some health care plans have adopted guidelines to shorten hospital stays associated with maternity care—the most common condition requiring hospitalization. Some plans have limited hospital coverage for mothers and their newborns to a maximum of 24 hours after delivery. As a result, between 1980 and 1994, the percent of 1-day postpartum hospital stays rose from about 9 percent to about 40 percent of all births. Many in the medical community have voiced concerns that these shortened stays expose newborns to undue risks.

To better understand the issues involved, you asked us to (1) identify the risks that are attributable to short hospital stays for maternity care, (2) examine health plan actions to ensure quality postpartum care for short-stay mothers and newborns, and (3) determine state responses to concerns about patient protection. To do this study, we analyzed pertinent trend data and interviewed medical experts and representatives from hospital maternity programs, managed care organizations, home health agencies, medical specialty societies, and health care trade associations. In briefing your staff on our work, we noted that our report would be available by the end of next week. In the interim, you asked us to summarize the results of our work. Our key findings include the following:

Guidelines issued by the American Academy of Pediatrics suggest—notwithstanding the presence of complications—either minimum 2-day stays for vaginal deliveries and 4-day stays for caesarean sections or shorter stays if: (1) Medical stability criteria are

met, (2) the decision on length of stay is agreed to by physician and patient, and (3) provisions are made for timely, comprehensive followup care delivered by a maternity care professional.

Neither researchers nor medical experts agree about the direct effect of short stays on maternal and newborn health. Using hospital readmission rates as an indicator of adverse outcome, one recent study shows no association between the number of days a newborn spends in the hospital and the rate of readmission, while other studies show increased risk for newborns discharged within 48 hours of birth.

Some plans allow physicians flexibility to apply early discharge policies selectively. In addition, they have programs of maternity care services that include intensive prenatal assessment and education and comprehensive followup care provided within 72 hours of discharge by a trained professional at home or in a clinic. We found, however, that some plans with shortened postpartum stays do not provide adequate prenatal education or appropriate followup services. For example, some plans' followup care consists of a phone call rather than an actual home or office visit.

Early discharge policies have prompted more than half the states to enact laws that regulate the length of maternity stays but vary widely in degree of consumer protection and do not apply to all insured individuals. For example, states vary on whether the law specifies stay minimums, identifies discharge decision makers, or mandates number of home visits covered, among other things. The laws are also limited in jurisdictional scope in that they: (1) Do not apply to plans that are exempt from state regulation under the Employee's Retirement Income Security Act of 1974 (ERISA) or (2) may not apply to individuals living in one state but working and receiving insurance in another.

Federal legislation has been introduced to make maternity care more consistent nationally and available to all privately insured women. The Senate is considering S. 969, Newborns' and Mothers' Health Protection Act, which would mandate a minimum 48-hour hospital stay for normal vaginal deliveries and 96-hour stays for caesarean section deliveries unless the attending provider, in consultation with the mother, makes the decision to discharge early and coverage is provided for prescribed timely followup care. Timely care is defined as care provided in a manner that meets the health care needs of the mother and newborn, provides for appropriate monitoring of their conditions, and occurs within 24-72 hours immediately following discharge. These provisions are consistent with the findings contained in our forthcoming report.

We hope that this information meets your needs in considering proposed federal legislation on hospital length of stays for maternity care. Please call me on (202) 512-7119 if you or your staff have any questions regarding the issues discussed above.

Sincerely yours,

SARAH F. JAGGAR,
Health Service Quality and
Public Health Issues.

Mr. WYDEN. Mr. President, I yield the floor and will make for the Senators a copy of the General Accounting Office's findings a matter of the Record. I yield the floor.

Mr. HELMS addressed the Chair.

The PRESIDING OFFICER. The Senator from North Carolina.

Mr. HELMS. Mr. President, I thank the Chair for recognizing me.

I am so glad Senator BRADLEY came to me sometime back in October about

this legislation and asked if I could become a cosponsor, which I readily did. I have not been a mother myself, but I have been around mothers. I am the husband of one, the father of two, and potentially the grandfather of five.

In any case, this Newborns' and Mothers' Health Protection Act, as it is formally titled, will be beneficial to countless mothers and their newborn children, because it will restore health care decisions to those best suited to make them—the mothers and their doctors—while making certain that new mothers and their babies are allowed to remain in the hospital at least 48 hours following natural births and 96 hours after Caesareans.

As Senators have already pointed out several times, in some instances new mothers and their babies are forced to leave the hospital as early as 8 hours after delivery because insurance companies often refuse to pay the bills otherwise.

It simply is unconscionable to require a new mother and her doctor to make this decision based on arbitrary insurance deadlines. That is what the distinguished Senator from New Jersey had in mind. I compliment him on this amendment and I am honored to be a cosponsor.

I am not alone in my contention that mothers and their physicians are better able to determine what is needed to promote a mother's and child's health rather than some arbitrary insurance deadline.

As a matter of fact, a Dartmouth-Hitchcock Medical Center study concluded that babies released earlier than 48 hours after birth had a 50-percent greater chance of needing readmission to the hospital and a 70-percent increased risk of emergency room visits.

Mr. President, the too-early discharges so often lead to jaundice which afflicts approximately one-third of newborns, dehydration resulting from breast-feeding difficulties and infections. Although these conditions are of course treatable, each must be diagnosed quickly, within 3 to 5 days, lest they result in brain damage or worse.

Mr. President, in recent years hospitals around the Nation have reported an increasing number of babies being readmitted to hospitals with complications of dehydration and jaundice.

A Virginia infant suffered dehydration-induced brain damage, and severe dehydration of a Cincinnati baby led to the amputation of his leg. The truth is that these tragedies could have been prevented with longer hospital stays.

Back in the 1970's, postbirth hospital stays were about 4 or 5 days for routine normal births, and 1 to 2 weeks for Caesareans. According to the Centers for Disease Control, the median length of hospitalization between 1970 and 1992 for mothers having normal births declined by 46 percent, from 3.9 to 2.1 days, and by 49 percent for mothers having Caesareans, from 7.8 to 4 days.

There is broad agreement, I think, about the importance of reducing

health care costs and I agree with that. While I am convinced that this goal can best be accomplished through less not more, Federal regulations, I also insist that the well-being of mother and babies must not be compromised in the process. This amendment addresses a unique, isolated problem which can be addressed by a carefully crafted Federal rule. And that is exactly what Senator BRADLEY has done. And I compliment him for offering this amendment.

In short, Mr. President, the Newborns' and Mothers' Health Protection Act of 1996, will ensure that arbitrary insurance guidelines do not override the objective of healthy births.

I thank the Chair and yield the floor. The PRESIDING OFFICER (Mr. BROWN). Who seeks recognition?

Mr. BRADLEY addressed the Chair.

The PRESIDING OFFICER. The Senator from New Jersey is recognized.

Mr. BRADLEY. Mr. President, I suggest the absence of a quorum.

Mr. CHAFEE. I wonder if the Senator would withhold that.

Mr. BRADLEY. I withhold.

Mr. CHAFEE addressed the Chair.

The PRESIDING OFFICER. The Senator from Rhode Island.

Mr. CHAFEE. Mr. President, when I heard about this amendment of the Senator from New Jersey originally my first thought was, why is the Federal Government getting involved in deciding how long hospital stays are? It seemed to me that was a matter that quite properly should be handled by States. And indeed in my State we have handled it. We have a bill, the best as I understand it, that is very similar to the suggestion of the bill proposed by the Senator from New Jersey.

Indeed, I made notes of the Senator's remarks. He indicated that some 28 States have taken action. That does not mean they have gone the complete route—and the Senator can obviously explain that further—but I take it some 28 States have dealt with this matter of how long a hospital stay should be or could be.

So I will confess that my original reaction was unfavorable to the Senator's proposal. However, two things happened. For one thing, my daughter called me. She has four children and she has some views on this subject. And also the ERISA point that the Senator raised. And I would like to explore that if I might.

Finally, the so-called Frist amendment. I am not sure exactly what the Frist amendment does. But my first question would be, of the Senator from New Jersey, as I understand it—first, I want to say, I listened to his arguments. One of his arguments is that you need a national law because you might have the State wherein the individual resides on a town right on the border of another State where the hospital is that serves that town, and the other State does not have the legislation.

However, I thought the most telling argument he made was the so-called ERISA argument. That is, as I understand it, that because ERISA applies to those corporations that have interstate health care plans, that the ERISA law prevents the State government—and we dealt with this, of course, when we were dealing with the health care business in 1994—the ERISA prevents the State law from getting involved with the plans that are covered by the ERISA statute.

I had not thought of that. And so first, if the Senator would be good enough to explain a little bit on that. Is that point correct?

Mr. BRADLEY. Mr. President, I say to the distinguished Senator from Rhode Island, yes, the Senator is correct. For example, we have had on the floor today the Senator from Delaware speaking. One of the largest employers in his State is DuPont. And we had the Senator from Minnesota speaking. One of the larger employers in his State is 3M. Each has what is known as a self-insured ERISA plan. And under a State law, in Minnesota or Delaware, as each of the Senators has testified today on the floor, it could not reach those plans in requiring them to allow 48 hours for delivery. Only this Federal law would achieve that objective.

Mr. CHAFEE. So your point is, to follow it up, it only would be a Federal law that would deal with that situation. The State law could not affect it.

The second point that would be helpful—maybe I should address this to the Senator from Tennessee. I am not sure exactly what the Frist amendment is. What does it do?

Mr. BRADLEY. I think I can answer. Essentially, the differences between the first- and second-degree amendments are minimal. The only difference relates to a deletion of the sentence that essentially is inconsequential but was confusing, and the second-degree amendment adds a sentence that gives some flexibility to health plans.

Mr. CHAFEE. Now, is this the so-called Kaiser Permanente language? Is that in the first amendment?

Mr. BRADLEY. I say to the Senator that in the first amendment is language that does allow some flexibility, and I think it would be in the first amendment. I think Kaiser Permanente endorsed both the first- and the second-degree amendments.

Mr. CHAFEE. Now, the final question, the number of States that have dealt with this you say is 28 in total or in part?

Mr. BRADLEY. The answer to the question is yes, 28 States have passed laws that require insurers to provide 48 hours for a delivery, coverage for 48 hours for delivery.

As the Senator has pointed out, there are a few gaps there. One is the ERISA problem; the other is the problem of the hospital that is across a State line in a State that is uncovered. Then there is the New Jersey problem. I guess some other State law might have

that problem, but in New Jersey the State passed a law that said that the State requirement of 48 hours would apply to only those insurance companies that were headquartered in New Jersey. So you could be headquartered in another State and you would not be covered. This could get at that issue as well.

Mr. CHAFEE. I thank the Senator for that description.

As I say, I am troubled by the U.S. Congress getting involved in an issue like this. I found the explanation, particularly the ERISA argument, to be a very telling argument.

The PRESIDING OFFICER. The Senator from Tennessee is recognized.

Mr. FRIST. Mr. President, just to sort of further clarify, the Kaiser Permanente language was basically a clarification of the way it was written. It was written in the bill that if you are discharged in fewer hours than 48 hours—this bill says you have a safe haven for 48 hours and followup care has to be somewhere—you have to have care for 48 hours. You cannot be dumped out of the hospital after 6 hours, and that is the end of it.

What Kaiser said is you need to make it clear that it is the health care provider who determines, in consultation with the mother, as to where that followup care is delivered. In other words, it is not just up to the mother as to where the followup care during the 48 hours was delivered. That was written into the bill.

My amendment was to clarify that further.

Mr. CHAFEE. Mr. President, I think that is an important point. I will give my qualifications in the area. I had six children. I suppose that would give me some knowledge about this subject.

As I understand it, if a mother should choose to leave in 24 hours—obviously, that is a big savings to the insurance company; say it cost \$1,000 a day in a hospital, and I do not think that is outrageous and that suggestion is pretty much on the mark, or something like that—it may well be that the mother would vastly prefer being home but have some help at home, and maybe that help would extend for 5 days. How do you handle that?

Mr. FRIST. The health care plan can put whatever they want in. It has to be a minimum of 48 hours coverage. That coverage can be in any facility that the mother and the physician decide—not the health insurance plan—that they decide, during that 48-hour period. After that 48 hours after vaginal delivery or 72 hours after a C-section, it can be dictated by the insurance company.

Mr. CHAFEE. So in other words, the mother could say, "I want to go home in 24 hours," but she would get the care, somebody at home would care, if she wanted, for the next 24 hours?

Mr. FRIST. That is right. It could be at home, a followup clinic, a birthing clinic. That is why it was important in this bill to give the flexibility. We do not know how babies will be delivered 4 years from now.

Initially, it was fairly rigid, 48 hours in the hospital. Now the bill is flexible enough to say for 48 hours you are covered, and it can be in the setting that you and your doctor decide, not some insurance company or not somebody sitting 500 miles away behind a telephone.

Mr. CHAFEE. Thank you.

Mr. BROWN. Mr. President, the Bradley amendment denies consumers the right to select the type of insurance coverage they wish to purchase. While I would hope all policies would include the type of maternity coverage he suggests, for the Federal Government to mandate it is a mistake. It establishes a precedent that consumers are no longer free to choose. I thus oppose the amendment.

Ms. MOSELEY-BRAUN. Mr. President, I want to take this opportunity to express my support for the Bradley amendment.

A few weeks ago Congress made an important step in the right direction of adding necessary reform to our health care system. By limiting exclusions for pre-existing conditions and by making health insurance coverage portable, we answered the concerns of millions of Americans that they will lose their access to health care. While I believe universal health coverage should be the ultimate goal, the Health Insurance Reform Act represented a practical, incremental, and caring attempt to deal with the real health care problems facing so many Americans, based on their everyday realities.

Similarly, the Bradley amendment makes an important step in the right direction. It is hard to conceptualize that the growing trend among health insurers is to force new mothers and their infants to leave the hospital 24 hours after an uncomplicated vaginal delivery and 72 hours after a cesarean section. In many cases, 24 hours is not sufficient time to recover physically from the birth, not to mention have time to learn essential child care information. You would think that this alone would be sufficient to warrant allowing new mothers to stay longer in the hospital. Having a mother who is strong and prepared to care for her new child will avoid unnecessary return visits to the hospitals due to insufficient care.

It is also important to note that many of the health problems newborns face such as dehydration and jaundice do not appear until after the first 24 hours of life. If undiagnosed, these easily treatable conditions can lead to brain damage, strokes, and in the worst case scenarios, death. There is no justification against monitoring babies that we know may be at risk for clearly preventable health conditions.

I do not believe that this bill is the panacea for health problems facing mothers and newborns in this Nation. The proportion of babies born at low birth-weight in the United States has been rising since 1984, and is now at its highest level since 1976. Nearly 300,000

babies, 7.2 percent of all those born in 1993, were born at low birth-weight. These infants were more vulnerable to infant death and serious health problems, such as developmental delays, cerebral palsy, and seizure disorders, as a result of their shaky start in life.

We need to focus more attention on making our children healthy on the front-end so that we never have to have a discussion about how long a new mother and baby should stay in a hospital. In 1993, almost 200,000 children were born to women who received either no prenatal care or prenatal care after the first trimester of their pregnancy. Good prenatal care can reduce rates of low-weight births and infant mortality, thus preventing disabilities and savings billions of dollars which are spent each year on caring for very sick newborns.

While the Bradley amendment is far from the total answer to the health problems of new mothers and their children, we should not underestimate the importance of what we will be achieving if this policy becomes law. Protecting the ability for mothers and infants to remain in the hospital up to 48 hours for vaginal deliveries and 96 hours for cesarean births has been endorsed by all four major medical groups which involved in maternal health and caring for newborns: the American Medical Association, the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, and the American Nurses' Association.

I want to conclude by congratulating Senators BRADLEY, KASSEBAUM, and FRUST for their leadership and for all the hard work they have put in to building momentum for this important amendment. I strongly urge the Senate to adopt the Bradley amendment. I urge all of my colleagues to think about how much this bill means to Americans all across this country, and how critically necessary it is to make this improvement in our health care system. This amendment is another good step in the right direction.

Mr. KENNEDY. Mr. President, I commend my colleagues, Senator BRADLEY and Senator KASSEBAUM, for their leadership in bringing this important legislation before the Senate for consideration. Current trends in health care financing have created a clear need for this legislation. Doctors are under increasing pressure from insurance companies to discharge mothers and newborns earlier and earlier.

Until a few years ago, the birth of a child was typically followed by a 4-day hospital stay for the mother and her newborn, so that mothers had time to recover from labor and delivery, and learn about the care of their infants. Health care providers had adequate time to watch the initial development of the newborns carefully, to assure that the babies were healthy. This initial period of expert observation is critical, since it means early diagnosis and immediate response and treatment when complications develop.

Now, however, the length of stay following a normal delivery is commonly only a day or two, and in many cases, even less.

To some extent, this change results from better medical management of childbirth, and greater responsiveness to women's desire for a less hospital-centered and more family centered experience of childbirth. But the dominant motivation behind these shortened stays, however, is the financial incentive to reduce the cost of childbirth, which is the most common cause of hospitalization in the United States. Profit, not sound medical judgement is driving the increasingly serious problem of drive-through deliveries.

The guidelines of the major medical societies provide for at least 2 days of hospitalization after a normal delivery, to give mothers adequate time to recover and learn to care for their infant in a restful atmosphere where professional help is immediately available.

Serious harm can result if a mother and her newborn are released too soon. Conditions such as jaundice and dehydration typically do not appear until after the first 24 hours of life. Recent research in Massachusetts shows that babies discharged less than 1 day after birth have a 25 times higher rate of not being screened for treatable congenital disorders, compared with babies who stay longer.

Many serious conditions are not easy to detect. Long-term disabilities—even death—may result. Congress should not acquiesce in irresponsible insurance industry practices that put profits ahead of families and the bottom-line ahead of babies. This legislation will guarantee that mothers and their doctors—not insurance companies—decide when to leave the hospital after childbirth.

This legislation was written in accord with the recommendations of the two leading medical societies with expertise in this area—the American College of Obstetricians and Gynecologists, and the American Academy of Pediatrics. They endorse this amendment. There is clear agreement among these experts that hospital stays should range from 48 hours for normal deliveries to 96 hours for cesarean sections.

By adopting this legislation, the Senate will not be requiring mothers and newborns to stay in the hospital unnecessarily. In many cases, mothers, in consultation with their doctors, will elect to go home early. But this amendment will guarantee that patient choice and medical judgment guide this decision—not insurance company orders.

I urge the Senate to support this important legislation. It has broad, bipartisan support. It is endorsed by the American Academy of Pediatrics, the American College of Obstetrics and Gynecologists, the American Medical Association, the American Nurses Association, the Association of Women's Health, Obstetric, and Neonatal Nurses, and the March of Dimes Birth

Defects Foundation. It is appropriate—indeed overdue—for the Federal Government to set these minimum standards for health and safety. Newborns should not be placed at risk for the sake of insurance industry profits.

Ms. MIKULSKI. Mr. President, I rise today in support of the newborns' and mothers' health protection amendment. I am proud to be a cosponsor of this legislation. This amendment is about family friendly health care. It puts the care of mothers and babies before the financial interests of insurance companies. It puts into practice what we have always preached—to honor the mother and to defend motherhood.

This amendment requires that insurance companies provide coverage for care for a minimum of 48 hours after a vaginal delivery and 96 hours after a caesarean section. It allows mothers and infants to be discharged earlier if there is appropriate follow-up care. This is consistent with the practice guidelines issued jointly by the American College of Obstetricians and Gynecologists [ACOG] and the American Academy of Pediatrics [AAP].

What I like about this amendment is that what we explicitly state as our values, we implicitly practice in public policy and public law. What we do with this legislation is ensure that mothers and their babies receive the care that they need, that is deemed appropriate by their physicians. On both sides of the political aisle, we talk about putting families first. This amendment does that. It puts value on motherhood.

This whole movement around providing care for 48 hours or 96 hours or whatever is medically appropriate came from mothers themselves. Then it was the movement of the extraordinary medical facilities that were willing to step forward and even defy the insurance companies. St. Agnes Hospital in my hometown of Baltimore insisted that they would provide this care if they had to do it out of a charitable endowment or if we all had to pitch in and do bake sales. St. Agnes took a stand—they were going to assure that mothers and their babies got what they needed when they needed it. That resulted in the Maryland general assembly acting—and now I am proud to say that Maryland has a law that really mirrors in many ways what we are doing in the Federal legislation.

So, I salute Senator BRADLEY for offering this amendment, but I also salute the mothers who organized, and the doctors and medical facilities who defied the insurance companies. I want to see managed care, but I don't want to see doctors managed. There is a fundamental distinction. We have to start getting our priorities straight and decide where we are going to be making our decisions. And in the case of newborns and their mothers—I believe decisions need to be made in the delivery room and not the boardroom.

I urge support for this amendment. Ms. SNOWE. Mr. President, as a cosponsor of the Newborns and Mothers

Health Protection Act, I am extremely pleased to rise in support of this amendment to the VA/HUD appropriations bill. My colleague from New Jersey, Senator BRADLEY, has worked steadfastly and diligently for well over a year to bring this important bill to the floor, and I commend him for his tireless efforts. I share his concern over the growing practice of what has come to be known as drive-thru deliveries, and I believe that this practice of discharging new mothers and their infants too soon after delivery is simply unacceptable.

This amendment requires health plans to provide coverage for a minimum hospital stay for a mother and her newborn infant following delivery, in accordance with established medical guidelines. These guidelines, developed in 1983 by the American College of Gynecologists and Obstetricians and the American Academy of Pediatrics, recommend that mothers remain in the hospital for 48 to 96 hours after giving birth, depending on the type of delivery. Shorter hospital stays are permitted if the physician, in consultation of the mother, determines that is the best course of action. For those mothers and newborns who leave the hospital after staying less than 48 or 96 hours, followup care within 72 hours of discharge must be provided in order to monitor both the mother and the infant during this vulnerable time.

Since 1970, the average hospital stay for newborns has been cut almost exactly in half. Today, many insurers provide for only a 24-hour stay for deliveries, while some medical plans call for discharging women within 8 to 12 hours of a birth. Usually, women are not informed of these policies until they are already in the hospital. Many doctors who decide, based on their best medical judgment, that their patients should stay beyond the short timeframe are overruled by insurance companies. Others are unduly pressured to release these women and their babies prematurely.

There are certain myths surrounding the impact of this bill, so I would like to clarify what this bill does not do. It does not mandate how long a mother and baby must stay in the hospital. It simply states that these patients may stay in the hospital up to the minimum period recommended by established medical guidelines. Insurers are permitted, and even encouraged, to develop alternatives to inpatient care, and to allow doctors, in consultation with their patients, to select the type of care which is most appropriate for a mother and her baby.

I believe that this bill is one of the most important pieces of legislation this Congress has and will consider in the 104th Congress. To date, stories abound about women whose infants have suffered physical harm and even death as the result of early discharge policies. No woman or family should have to endure such tragedy.

Often, doctors are not able to detect certain health problems in infants

within the first 12 or 24 hours after birth. For example, doctors may be unable to detect jaundice—a disorder which may lead to permanent brain damage—within the first day after birth. Other infants have been released before their doctors had time to test them for PKU—an easily treated metabolic disorder that causes mental retardation if not detected early enough.

In addition, early discharge deprives mothers of important opportunities to learn how best to care for their infants, including proper breast feeding techniques. Problems with breast feeding can cause infants to suffer severe medical complications—even death—from dehydration. Hospitals report that increasing numbers of women and their children are returning for care after discovering problems such as life-threatening infections that could have been caught if the mother and child had been able to stay in the hospital just a little bit longer. While the financial costs of hospital readmissions resulting from early discharge can be astronomical, the human costs can be truly tragic.

Twenty-eight States have passed maternity stay laws similar to this bill, including my home State of Maine. However, State legislation alone does not sufficiently protect the women of America and their newborns. For example, many women are not protected by State legislation because they work for employers with self-insured plans shielded by Federal ERISA preemption. In addition, women who live in one State and work in another may find themselves vulnerable without Federal legislation.

Don't we owe it to the women of America and to our very youngest citizens—those who are only a few days old—to ensure that they enjoy the full protections and benefits of one of the best health care systems in the world?

There is nothing more precious than the birth of a child. There is nothing more tragic than the death of an infant that could have been prevented. That is why we must leave it to doctors, not insurers, to decide how long women stay in the hospital following delivery in accordance with established medical guidelines. I urge my colleagues to join me in supporting this important amendment.

Mr. FAIRCLOTH. Mr. President, I would like to comment briefly on the amendment offered by Senator BRADLEY, the Newborns' and Mothers' Health Protection Act.

Supporters of this legislation contend that it is becoming a widely used cost-containment practice of health insurers to force the premature discharge of mothers and their newborns from the hospital following childbirth. In other words, insurance companies supposedly are improperly influencing doctors' medical decisions regarding the appropriate lengths of stay for mothers and newborns following childbirth. The remedy proposed in this amendment would require insurance

companies to cover at least 48 hours of inpatient care following an uncomplicated vaginal delivery and 96 hours following a cesarean delivery.

Mr. President, I certainly share the concerns which have been expressed in this debate regarding the health and safety of mothers and their newborn children. I am troubled, however, over the construction of this legislation. Not only would this amendment become the first Federal law to mandate health insurance benefits, it also comes dangerously close to being a statutory prescription for the practice of medicine.

I believe that no one is more qualified than a woman's doctor to judge how long that woman and her newborn child should stay in the hospital following childbirth. Just as I believe that an insurance company has no business second guessing this decision, I firmly believe that the Government also has no prerogative to interfere.

While I realize that this legislation does not require a woman and newborn to spend 48 hours in the hospital after childbirth, the construction of this amendment, and the specification of 48 and 96 hours of coverage, strongly implies that these figures are some sort of legally significant standard for the length of stay.

The sponsors of this legislation argue that legislation is necessary to ensure that mothers and newborns are assured an appropriate hospital stay following childbirth. Obviously, the appropriate length of stay will depend on each mother and child individually, and the attending doctor is the most qualified authority to make this decision. I am concerned that, according to this amendment's construction, the decision of the doctor is made an exception to the legislation's 48 and 96 hour standards, rather than the rule.

If it is necessary to pass legislation to assure the health and safety of mothers and newborns, then we should do it by protecting the authority of doctors to make medical decisions regarding their patients, free from interference from both insurance companies and the Government. We should not replace insurance company interference with Government interference.

Mr. BRYAN. Mr. President, I am pleased to be a cosponsor of the Newborns' and Mothers' Health Protection Act of 1996 introduced by Senators BILL BRADLEY, NANCY KASSEBAUM, and BILL FRIST.

This bipartisan legislation—with the support of 52 Senate cosponsors—will help ensure that newborns and their mothers will have the best possible beginning.

Unfortunately, a pattern has begun to develop throughout this country of pushing mothers and their newborns out of the hospital too quickly. Too often, some health insurance plans covering the costs of childbirth offer very limited benefits for post partum hospital stays.

Sometimes the coverage is limited to as little as 24 hours, which in many

cases is not long enough to ensure that a mother and her infant remain healthy after their hospital discharge. Sometimes doctors have found that insurers refuse to agree to longer hospital stays, even when the doctor argues the mother and newborn need to remain in the hospital longer.

It is the first couple of days following the birth of a child that are the most critical to ensure the long-term health of both the infant and mother. Many mothers have difficulty in learning how to properly breast feed, putting their infants at risk of inadequate nutrition in their first days of life. Likewise some mothers are just not physically capable of providing for a newborn's care needs within 24 hours of giving birth.

Medically, many health problems experienced by newborns do not show up until after the first 24 hours of life. These include jaundice and dehydration, and other conditions that only health professionals can detect. Early hospital discharges can mean these conditions go undetected until it is too late.

The length of a hospital stay is a question that should not be driven by the limitations of an insurance policy, but should be the joint medical decision of the mother and her physician.

Under this bill, if both the mother and her doctor agree that a shorter post partum stay is acceptable, the stay can be shortened. However, in these situations—and this is the key distinction—the decision will still be a medical one, rather than a financial one.

This bill will require all health care insurance plans, which offer maternity benefits, to cover post-partum stays of at least 48 hours after a vaginal birth, and at least 96 hours after a caesarean section. The bill's hospital stay requirements are consistent with post childbirth guidelines of the American College of Obstetricians and Gynecologists, and the American Academy of Pediatrics.

This bill will end these drive-through baby deliveries, which push mothers and their newborns out of the hospital before they are medically ready to go home. Such drive-through deliveries put the health of both mothers and their babies at risk. A mother and her newborn's homecoming should be a time of celebration, not a time of trepidation because neither was ready to leave the hospital.

In August, the Centers for Disease Control and Prevention released its study of New Jersey's maternity stay law. Following enactment of The State's law, the CDC found that new mothers who had problem free deliveries were the mothers who had stayed in the hospital approximately 10 to 12 hours longer than mothers had prior to the law. The CDC research appears to indicate that just a few hours longer in the hospital can result in major improvements in the health of both the mother and the newborn baby. The im-

portance of those few more hours cannot be underestimated.

Many managed care plans place the care of the mother and newborn infant at the forefront.

But many other managed care plans appear to have put the bottomline of profitability ahead of the real medical needs of newborns and their mothers. Those managed care plans should view this bill as a heads up. Cutting medical costs will not be allowed to undermine the quality of health care.

We all acknowledge the need for controlling health care costs, and support efforts to curtail unnecessary spending. But there also must be a reality check when cost cutting goes so far, that the quality of health care is endangered.

We want every newborn child to have the best chance for long-term health. I urge my colleagues to join in supporting this legislation to give mothers and newborns the assurance that their health needs will always be paramount.

Mrs. FEINSTEIN. Mr. President, I am pleased to support Senator BRADLEY's amendment to require health insurance plans to cover hospital maternity stays for 48 hours for routine deliveries and 96 hours for cesarean deliveries.

The issue here is whether the decision on how long a mother and her newborn stay in the hospital is based on the mother's health or the insurance company's bottom line.

I believe it is a medical decision that should be made by a doctor and a patient.

Before 1970 the median length of stay in this country for routine deliveries was 4 to 5 days. By 1992, the median stay dropped to 2.1 days.

In 1991—the latest year for which figures are available—nearly 40 percent of newborns in California were discharged in fewer than 24 hours.

And the problem seems to be even worse today.

Some insurers limit coverage of postpartum hospital care to 1 day or 12 hours.

One large California HMO has reduced coverage to 8 hours.

These are not generally doctors determining that it is in their patients' best interest to be discharged sooner. The reduction in hospital care is the result of insurance companies making that decision based on how much they want to pay—and the real cost is being borne by patients—mother and child—in greater health risks.

There are many medical reasons why a longer hospital stay may be necessary. Some medical conditions do not manifest in 10 or 24 hours after delivery, such as jaundice, heart murmurs, circulatory disfunctions and fevers.

Early discharges can also exacerbate medical problems:

Studies presented to the Senate Labor Committee have shown that early release of infants can result in the baby having jaundice, feeding problems, respiratory difficulties, metabolic disorders and infections.

In fact, a New Hampshire study of hospital readmission rates found that babies discharged at less than 2 days of age have a 70 percent increased risk of facing an emergency room visit.

Early discharge not only increases health risks, in many cases, it is so much more costly.

A Pasadena woman and her 6-week premature infant were discharged after only 23 hours of delivery. The baby was readmitted to the hospital for jaundice and dehydration 2 days later, costing an extra \$20,000—\$1,000 that had to be paid by the family.

Let me give some examples of the human impact of this problem:

A Los Angeles woman was released 15 hours after giving birth because of limited insurance coverage. Two days later, her baby was hospitalized for malnutrition—the infant had difficulty with lactation and breast feeding.

A San Francisco woman had to leave the hospital 23 hours after delivery against her doctor's advice, even though her baby was 5 weeks premature. The baby was in the emergency room less than 2 days later, and was readmitted to the hospital for dehydration and jaundice.

Another California mother was discharged less than 14 hours after deliver. The next morning she was shaking, feverish, and nauseous. She was diagnosed as having a staph infection and was readmitted to the hospital for 4 days.

Sometimes these stories have tragic endings.

Leigh Fallon, of Petaluma, CA entered the hospital on July 25, 1994. After 2 days of labor with extraordinary complications, she had an emergency caesarean section.

The mother had a high fever and great physical distress. Her baby boy developed jaundice, was being treated with antibiotics, and was diagnosed with a heart murmur.

Still, under pressure from their insurance company, Leah and the baby were discharged 72 hours after birth. The baby was rushed to the hospital a few days later and did not survive emergency heart surgery.

Perhaps nothing could have saved Leah's baby. But clearly, the decision to discharge such a fragile patient was made in the interest of saving money instead of saving a life.

Medical decisions should be made by medical professionals—not insurance companies. That is what they are trained to do.

Twenty-nine States have enacted legislation or regulations to curb what's called drive-through deliveries. In California, the legislature failed to come to agreement on legislation at the close of the current session. California voters, instead, will face two ballot measures which include regulations on the subject this November.

This is a national problem, and Congress must set a uniform standard in the interest of public health.

I urge my colleagues to join me in voting for the newborns and mothers bill.

Mr. BRADLEY. I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The bill clerk proceeded to call the roll.

Mrs. KASSEBAUM. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mrs. KASSEBAUM. Mr. President, as an original cosponsor of the legislation before us, I would like to say how pleased I am that we are ready now to vote on what I think is a very important and useful piece of legislation. I have been proud to work with Senator BRADLEY and Senator FRIST, and I appreciate the efforts of those who have offered some very constructive improvements in the language that have helped to clarify some concerns that existed.

I have visited maternity floors at a number of hospitals. I must tell you, I think this amendment will provide an increased sense of security, particularly to first-time mothers, who will now feel that they can remain in the hospital a bit longer if necessary. Some will ask, "Why not even longer?" Well, how do we know the correct length of stay in each situation? This should be decided on an individual basis. But we do know that even an additional 24 hours is going to make a difference. For some, it will make a big difference—where there is no family available to offer support when they come home and, particularly, as I mentioned, with first-time mothers, where there is uncertainty about what lies ahead. I say thank you to all who have spent a great deal of time and effort on this amendment. It is a very constructive and beneficial piece of legislation.

I yield the floor and suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. HELMS. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

CHANGE OF VOTE

Mr. HELMS. Mr. President, it was called to my attention that last evening there must have been some confusion. I take responsibility for it. I don't know what happened. I was incorrectly identified as voting against the motion involved in vote No. 267.

I ask unanimous consent that it be in order for me to have my vote recorded as voting in the affirmative in that instance instead of in the negative.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

The PRESIDING OFFICER. I thank the Chair.

I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. FRIST. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. FRIST. Mr. President, I ask unanimous consent that the vote on the Frist amendment No. 5193 occur at 5:35 p.m. today, and immediately following that vote, the Senate proceed to vote on or in relation to the Bradley first-degree amendment, as amended, if amended; further, that immediately following that vote, Senator DOMENICI be recognized to offer an amendment regarding mental health, which was previously listed as a Wellstone amendment, and that the preceding occur without any intervening action.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

Mr. FRIST. Mr. President, I ask for the yeas and nays on my amendment.

The PRESIDING OFFICER. Is there a sufficient second?

There is a sufficient second.

The yeas and nays were ordered.

Mr. BRADLEY addressed the Chair.

The PRESIDING OFFICER. The Senator from New Jersey is recognized.

Mr. BRADLEY. Mr. President, I strongly support the amendment of the distinguished Senator; the amendment to my amendment. I hope we adopt it unanimously by a large, overwhelming vote, and hopefully we will be able to move forward. It is an amendment that would confirm that insurers have to allow 48 hours for delivery of a child by a mother in the hospital, 96 hours for cesarean section. The Senator's changes are merited and important. It is a pleasure to work with him. I look forward to the 5:35 hour so that we can vote. Maybe we can move sooner.

I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. BRADLEY. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

The hour of 5:35 having arrived, the question is on agreeing to the amendment of the Senator from Tennessee. On this question, the yeas and nays have been ordered, and the clerk will call the roll.

The assistant legislative clerk called the roll.

Mr. NICKLES. I announce that the Senator from Oregon [Mr. HATFIELD] and the Senator from Alaska [Mr. MURKOWSKI] are necessarily absent.

I further announce that, if present and voting, the Senator from Oregon [Mr. HATFIELD] would vote "yea."

The result was announced—yeas 98, nays 0, as follows:

[Rollcall Vote No. 272 Leg.]

YEAS—98

Abraham	Feinstein	Lugar
Akaka	Ford	Mack
Ashcroft	Frahm	McCain
Baucus	Frist	McConnell
Bennett	Glenn	Mikulski
Biden	Gorton	Moseley-Braun
Bingaman	Graham	Moynihan
Bond	Gramm	Murray
Boxer	Grams	Nickles
Bradley	Grassley	Nunn
Breaux	Gregg	Pell
Brown	Harkin	Presler
Bryan	Hatch	Pryor
Bumpers	Heflin	Reid
Burns	Helms	Robb
Byrd	Hollings	Rockefeller
Campbell	Hutchison	Roth
Chafee	Inhofe	Santorum
Coats	Inouye	Barbates
Cochran	Jeffords	Shelby
Cohan	Johnston	Simon
Conrad	Kassebaum	Simpson
Coverdell	Kempthorne	Smith
Craig	Kennedy	Snowe
D'Amato	Kerrey	Specter
Daschle	Kerry	Stevens
DeWine	Kohl	Thomas
Dodd	Kyl	Thompson
Domenici	Lautenberg	Thurmond
Dorgan	Leahy	Warner
Exon	Levin	Wellstone
Patricio	Lieberman	Wyden
Feingold	Lott	

NOT VOTING—2

Hatfield Murkowski

The amendment (No. 5193) was agreed to.

AMENDMENT NO. 5192, AS AMENDED

The PRESIDING OFFICER. The vote now occurs on the Bradley amendment as amended. The question is on agreeing to the amendment.

The amendment (No. 5192), as amended, was agreed to.

Mr. BRADLEY. Mr. President, I move to reconsider the vote.

Mr. FORD. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

AMENDMENT NO. 5194

(Purpose: To provide health plan protections for individuals with a mental illness)

The PRESIDING OFFICER. Under the previous order, the Senator from New Mexico is recognized to offer an amendment.

The Senator from New Mexico.

Mr. DOMENICI. Mr. President, I just wanted to tell the Senators this is going to be the Domenici, Wellstone, et al., amendment that we have voted out here before on mental illness. I do not believe we are going to take more than 40 minutes on the entire amendment. We will ask for the yeas and nays. I would just like to make sure everybody understood that.

Shortly, I am going to send to the desk an amendment on behalf of myself, Senator WELLSTONE, and a number of Senators who have asked to be cosponsors, including Senator SIMPSON, CONRAD, KENNEDY, INOUE, REID, DODD, GRASSLEY, KASSEBAUM, BURNS, HARKIN, and MOYNIHAN, and I send the amendment with the cosponsors to the desk and ask for its immediate consideration. I ask Senator CHAFEE be added, and Senators HATFIELD and DORGAN also.

The PRESIDING OFFICER (Mr. BENNETT). The clerk will report.

The assistant legislative clerk read as follows:

The Senator from New Mexico (Mr. DOMENICI), for himself, Mr. WELLSTONE, Mr. SIMPSON, Mr. CONRAD, Mr. KENNEDY, Mr. INOUE, Mr. REID, Mr. DODD, Mr. GRASSLEY, Mrs. KASSEBAUM, Mr. BURNS, Mr. HARKIN, Mr. MOYNIHAN, Mr. CHAFEE, Mr. HATFIELD and Mr. DORGAN, proposes an amendment numbered 5194.

Mr. DOMENICI. Mr. President, I ask unanimous consent that the reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

At the appropriate place, insert the following new title:

TITLE —MENTAL HEALTH PARITY

SEC. 01. SHORT TITLE.

This title may be cited as the "Mental Health Parity Act of 1996".

SEC. 02. PLAN PROTECTIONS FOR INDIVIDUALS WITH A MENTAL ILLNESS.

(a) PERMISSIBLE COVERAGE LIMITS UNDER A GROUP HEALTH PLAN.—

(1) AGGREGATE LIFETIME LIMITS.—

(A) IN GENERAL.—With respect to a group health plan offered by a health insurance issuer, that applies an aggregate lifetime limit to plan payments for medical or surgical services covered under the plan, if such plan also provides a mental health benefit such plan shall—

(i) include plan payments made for mental health services under the plan in such aggregate lifetime limit; or

(ii) establish a separate aggregate lifetime limit applicable to plan payments for mental health services under which the dollar amount of such limit (with respect to mental health services) is equal to or greater than the dollar amount of the aggregate lifetime limit on plan payments for medical or surgical services.

(B) NO LIFETIME LIMIT.—With respect to a group health plan offered by a health insurance issuer, that does not apply an aggregate lifetime limit to plan payments for medical or surgical services covered under the plan, such plan may not apply an aggregate lifetime limit to plan payments for mental health services covered under the plan.

(2) ANNUAL LIMITS.—

(A) IN GENERAL.—With respect to a group health plan offered by a health insurance issuer, that applies an annual limit to plan payments for medical or surgical services covered under the plan, if such plan also provides a mental health benefit such plan shall—

(i) include plan payments made for mental health services under the plan in such annual limit; or

(ii) establish a separate annual limit applicable to plan payments for mental health services under which the dollar amount of such limit (with respect to mental health services) is equal to or greater than the dollar amount of the annual limit on plan payments for medical or surgical services.

(B) NO ANNUAL LIMIT.—With respect to a group health plan offered by a health insurance issuer, that does not apply an annual limit to plan payments for medical or surgical services covered under the plan, such plan may not apply an annual limit to plan payments for mental health services covered under the plan.

(b) RULE OF CONSTRUCTION.—

(1) IN GENERAL.—Nothing in this section shall be construed as prohibiting a group health plan offered by a health insurance issuer, from—

(A) utilizing other forms of cost containment not prohibited under subsection (a); or

(B) applying requirements that make distinctions between acute care and chronic care.

(2) NONAPPLICABILITY.—This section shall not apply to—

(A) substance abuse or chemical dependency benefits; or

(B) health benefits or health plans paid for under title XVIII or XIX of the Social Security Act.

(3) STATE LAW.—Nothing in this section shall be construed to preempt any State law that provides for greater parity with respect to mental health benefits than that required under this section.

(c) SMALL EMPLOYER EXEMPTION.—

(1) IN GENERAL.—This section shall not apply to plans maintained by employers that employ less than 26 employees.

(2) APPLICATION OF CERTAIN RULES IN DETERMINATION OF EMPLOYER SIZE.—For purposes of this subsection—

(A) APPLICATION OF AGGREGATION RULE FOR EMPLOYERS.—All persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as 1 employer.

(B) EMPLOYERS NOT IN EXISTENCE IN PRECEDING YEAR.—In the case of an employer which was not in existence throughout the preceding calendar year, the determination of whether such employer is a small employer shall be based on the average number of employees that it is reasonably expected such employer will employ on business days in the current calendar year.

(C) PREDECESSORS.—Any reference in this subsection to an employer shall include a reference to any predecessor of such employer.

SEC. 03. DEFINITIONS.

For purposes of this title:

(1) GROUP HEALTH PLAN.—

(A) IN GENERAL.—The term "group health plan" means an employee welfare benefit plan (as defined in section 3(1) of the Employee Retirement Income Security Act of 1974) to the extent that the plan provides medical care (as defined in paragraph (2)) and including items and services paid for as medical care) to employees or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement, or otherwise.

(B) MEDICAL CARE.—The term "medical care" means amounts paid for—

(i) the diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body,

(ii) amounts paid for transportation primarily for and essential to medical care referred to in clause (i), and

(iii) amounts paid for insurance covering medical care referred to in clauses (i) and (ii).

(2) HEALTH INSURANCE COVERAGE.—The term "health insurance coverage" means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer.

(3) HEALTH INSURANCE ISSUER.—The term "health insurance issuer" means an insurance company, insurance service, or insurance organization (including a health maintenance organization, as defined in paragraph (4)) which is licensed to engage in the business of insurance in a State and which is subject to State law which regulates insurance (within the meaning of section 514(b)(2) of the Employee Retirement Income Security Act of 1974), and includes a plan sponsor described in section 3(16)(B) of the Employee Retirement Income Security Act of 1974 in the case of a group health plan which is an employee welfare benefit plan (as defined in section 3(1) of such Act). Such term does not include a group health plan.

(4) HEALTH MAINTENANCE ORGANIZATION.—The term "health maintenance organization" means—

(A) a federally qualified health maintenance organization (as defined in section 1301(a) of the Public Health Service Act),

(B) an organization recognized under State law as a health maintenance organization, or

(C) a similar organization regulated under State law for solvency in the same manner and to the same extent as such a health maintenance organization.

(5) STATE.—The term "State" means each of the several States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

SEC. 04. SUNSET.
Sections 1 through 3 shall cease to be effective on September 30, 2001.

SEC. 05. Federal Employee Health Benefit Program. For the Federal Employee Health Benefit Program, sections 1 through 3 will take effect on October 1, 1997.

Mr. DOMENICI. Mr. President, first, I thank Senator WELLSTONE early on in the debate on this bill that is pending. He had the good sense to put the amendment in, and, thus, it became relevant under the unanimous-consent decree.

I thank him for his generosity in permitting me to call up his amendment, which is commonly known as the Domenici-Wellstone amendment. I am not going to take a lot of time. The U.S. Senate has heard me argue this issue a number of times.

I do believe in the 5 weeks that we have been gone—many of us at home—I think a lot of U.S. Senators and a lot of House Members have been approached in their respective States and districts with reference to the need to adopt this amendment and to make it part of the substantive law of this land.

I am counting on that, because I believe the U.S. Senate will adopt it by a rather overwhelming margin. But I do want to say to those who wonder whether or not we are just offering an amendment again that has passed and then did not see the full rising Sun and the beauty of daylight as a piece of legislation because the House had denied it in conference, that we clearly intend for the U.S. House to take a very serious look at this, even though it is in a conference and they have already passed the HUD and independent agencies bill.

I believe before this bill is finally conferred that there will be many House Members on both sides of the aisle who will indicate their support. How we will go about doing that within the technical rules of the U.S. House, I am not prepared yet to discuss, but a number of House Members, both Republican and Democrat, want to help us get this amendment before the President as part of this appropriations bill.

Having said that, let me make sure that Senators and that those out in the

audience, called America, whether it is families of severely mentally ill young people, or whether it is small businesses, or whether it is big businesses in the United States, this amendment is not the bill that passed that brought concern as to the cost to business. This is a very simple proposition.

This bill, let me make it clear, does not mandate mental health services or determine charges. It does not require parity for copayments and deductibles. It does not require parity for inpatient hospital stays or outpatient limits.

This amendment, as presented, does not cover substance abuse, and it does not cover chemical dependency. It excludes Medicare and Medicaid, to be handled separately in legislation with reference to those statutory benefits. It allows for managed care and mental health carve-outs, does not apply to individual health coverage, and exempts small businesses with 25 or fewer employees.

So I guess with that clearly understood, one might ask, what does it do? Essentially, this is a compromise to begin down the path of parity and non-discrimination for the mentally ill people in this country who have health insurance. It does just two very fundamental things.

The aggregate lifetime coverage on an insurance policy and the annual payment limits, Mr. President, must be the same for mental health coverage as for the physical health coverage.

In simple terms, if heretofore you bought an insurance policy and it covered mental health, with whatever conditions are attached—normally down here well into the policy it would say the aggregate lifetime coverage is \$50,000, and up here in the bolder print it might say the coverage for everybody in this policy, not otherwise provided for, is \$1 million. So if you get sick from cancer or a heart condition or tuberculosis or, God forbid, any of the serious illnesses, the lifetime coverage is \$1 million under that policy.

But if you get schizophrenia when you are 16 or 18, which is within the age, between 17 and 32 or so, you might get that dread mental disease, this policy that I was just alluding to that is out there now would say mental health is covered, mental illness, but it would say for that one, you only get \$50,000 worth of aggregate lifetime coverage.

This Domenici-Wellstone amendment says that will not be legal anymore, for it says if you choose to write that policy or if you choose to buy coverage as a big company and you buy a \$1 million aggregate coverage for your employees for their illnesses, then if you want to cover them for mental illness, you have to cover them lifetime for \$1 million also.

And if the annual payment limit, for those are common also—you may have a \$1 million aggregate for your lifetime, but it may only cover \$50,000 a year as the annual, or \$100,000—it says that figure, too, for the annual limits has to be the same for the coverage

provided for mentally ill people as for others with physical ailments covered in an insurance policy.

Frankly, Mr. President, I say to my fellow Senators, from where we started, I will confess to everyone, this compromise truly—truly—dramatically reduced our expectations and our hopes. But we understand. We have dramatically reduced the scope.

We understand that the first bill that cleared the Senate with 68 votes required the same exact coverage for the mentally ill as you provide for anyone else, for other illnesses. And we understand there was a concern about that in terms of how much it might cost. There was some concern expressed about what kind of treatment is treatment of the mentally ill. Is it just an ordinary visit to a psychiatrist because you have marital difficulties or because you have a very temporary kind of depression?

So what we decided to do was to scale back our desire and our hope for parity for this very important part of the American population and say let us get started by eliminating the hoax that exists in many cases where mentally ill people think they have coverage, but when you look at the fine print, the aggregate lifetime coverage is so small as compared to the coverage for other illnesses that, in many cases, it is a shock to those who have a family member who comes down with manic depression or severe depression or schizophrenia or one of the bipolar illnesses.

So we, to make it clear again, do not mandate the copayments. If you want to differentiate by having different copayments for mentally ill people and the coverage you provide, that is your privilege, that will be negotiated. That will be there in big companies as they work out how they are going to cover people. We do not mandate that parity to go down that far. We say just parity at the top, parity for the aggregate and parity for the aggregate annual.

We are starting down a path of at least beginning to understand that there are indeed millions of Americans who have members of their family with these dread diseases. Believe you me, the stereotype of old as to how these happen, where they come from, are all out the window. They did not come because a mother mistreated a child. They did not get schizophrenia because somebody neglected them for 10 years. These are very, very serious illnesses of the brain. Someday we will tie those down into very, very understandable physical treatments with medicines and other things which are already making dramatic, dramatic progress for this part of our population.

So we have a chance to just send a little ray of hope to the millions of American people, hundreds of thousands of families who have this kind of situation that heretofore your companies, if they are insuring you and your family through your employment, if they cover you for mental illness, then it will not be trivial coverage, it will

not be a scaled-down coverage so insignificant that it hardly, hardly deserves being called coverage, because if you get schizophrenia or one of your children do or they get manic depression or they become seriously depressed where it becomes chronic for any period of time, anybody in this room knows those \$50,000 lifetime limits do not cover it at all no more than they would cover for somebody who is desperately ill with cancer and needs 10 operations and chemotherapy and 6 months in the hospital. That \$50,000 would be gone in 5 months or 3 months.

So we get a little bit of what we call parity. And we move just a little bit further away from the rampant discrimination that besets coverage for the mentally ill men, women, teenagers, young people across this land.

I repeat, when you vote for this tonight, many of you will have heard—many of the men and women in the Senate on their trips home and certainly many House Members in their districts will have heard from the Alliance for the Mentally Ill, thousands and thousands of their members. I have already run into two Senators who met their membership at home. And some were joking. I say to Senator WELLSTONE, because they seem to say your name right but they seem to say my name wrong. So they say you have to support that "Dominichi"-Wellstone bill. But that is all right just so long as we all understand what it is.

So Mr. President, at this point I am going to yield to Senator WELLSTONE. But I am wondering if we could get a time agreement to satisfy—we have a second-degree amendment being offered here. Before I agree to a time agreement, I want to see it. So I yield the floor.

Mr. WELLSTONE addressed the Chair.

The PRESIDING OFFICER. The Senator from Minnesota.

Mr. WELLSTONE. Mr. President, I will be relatively brief because I know there are several other Senators who want to speak tonight. Senator KENNEDY has spent many of his years as a Senator fighting on behalf of parity and fairness for people struggling with mental illness, and others.

Mr. President, on April 18 of this year, 68 Senators voted for our amendment. This was really an amendment that said we ought to end the discrimination. There ought to be full parity for the treatment of mental illness in our country. I think what the Senate was saying—68 Senators, which is really a significant vote—was that for too long the stigma of mental illness has kept many in need from seeking help and for too long it has prevented policymakers from providing the help. We heard from a number of Senators who spoke in very personal terms about their own families and their own experiences—Senator CONRAD, Senator SIMPSON, and Senator DOMENICI.

Mr. President, their testimony was eloquent and powerful. But in addition

I want to point out tonight that there are also very sound policy reasons for supporting this amendment. I will not describe our amendment. Senator DOMENICI has already done so. But I do want colleagues to know that it is just an incremental step forward, but a significant one.

What we are saying is that when it comes to lifetime caps and annual caps, at least have parity there so that we do not have a situation where there is a million-dollar cap for someone who is struggling with cancer or heart disease and then you find out that if someone is struggling with mental illness all together it is a \$40,000 cap or an annual cap of only \$10,000.

This amendment would really help many families in our country who right now, given the present arrangement, which is an arrangement of discrimination and stigma, just face economic catastrophe. People just go bankrupt. People go under all too often.

So, Mr. President, this amendment is incremental. It is not full parity, but it would be an enormous step forward. As I said, it is not just the personal stories. Certainly I could talk about this tonight in very personal terms. We have done that already. But there are sound policy reasons. The MIT Sloan School of Management reported in 1995 that clinical depression costs American business \$28.8 billion in lost productivity and worker absenteeism.

In addition, there are too many people in prison who should not be. There are too many children who could be doing well in school who do not do well. There are too many families under tremendous strain that do not need to be under so much strain. I mean, in many ways we talk so much about the importance of supporting families.

If we could pass this amendment tonight with a huge vote, and then work hard and get the support in the House—and I think we will. Senator DOMENICI is right, so many families and so many people who have struggled with this have been active. One of the things that has changed through organizations like the National Alliance of the Mentally Ill and others is that people no longer will accept the idea that because they have to struggle with mental illness they are somehow women or men of less worth or less substance or less dignity. People are speaking up for themselves.

I think if we get a really strong vote tonight—and I think we will—I think you will see many of those families working hard with Members of the House and we will pass this. And we should, Mr. President. It would make an enormous difference.

I said to my colleague, Senator DOMENICI, and I have said to other friends as well, that the only thing that troubled me that evening—I will never forget; I was very proud to be a part of this—was that at the very end the expectations of all of the people that had

just risen, the hopes would just be dashed and people would end up just being devastated and discouraged and feel like it all was for naught.

We did not make it on the insurance reform bill, but this is not just a symbolic exercise tonight. We are hoping to get a huge vote from Republicans and Democrats alike. I think we have the support for this. Then we are hoping that in conference committee this stays in and this becomes the law of the land. It is not full parity, it is just incremental, but what a difference it would make. What a difference it would make for families that are struggling with mental illness. Mr. President, what a difference it would make.

I do not guess this is the most important reason, but what a difference it would make for all of the families that now are speaking for themselves and talking to Senators and talking to Representatives.

I see Senator CONRAD, and I talked about what the Senator said on the floor on April 18. I said I would never forget those words. I see he is here to speak. I do not want to cut into the time of others.

However, I think it is only old data and old ideas that have kept us from covering mental health the same way we cover other real illnesses, whether they are acute or chronic. Congress should pass this. The Senate should pass this amendment. We should pass it by a huge margin. It is a necessary and affordable step toward ending the stigma and discrimination against Americans suffering from mental illness.

Let me repeat one more time: This vote tonight, the larger the margin the better, will be a necessary and affordable step that we as Senators have taken toward ending the stigma of discrimination against Americans suffering from mental illness. Colleagues, Democrats and Republicans alike, to take that step is no small accomplishment.

I yield the floor.

Mr. KENNEDY. Mr. President, I ask unanimous consent that Sarah Vogelsberg, a fellow in my office, be given the privilege of the floor during the consideration of this amendment.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. KENNEDY. Mr. President, few forms of discrimination are crueller, more counterproductive, and more widespread than those inflicted on the mentally ill and their families. Lack of adequate insurance coverage for the severely mentally ill is a major factor leading to homelessness—and hopelessness. Illness is a tragedy for any family. Mental illness is a triple tragedy because the inevitable strain of coping with the illness is compounded by the unfair stigma associated with the illness and the lack of adequate insurance coverage to make treatment affordable.

Five million Americans suffer from serious mental illnesses every year. Few Americans do not have a family

member, a friend, or a coworker, who has been touched by these tragic illnesses.

The financial burden of serious illness can be crushing, whether the illness is mental or physical, whether schizophrenia, heart disease, or cancer. For the majority of Americans, health insurance provides protection against the cost of treating heart disease, cancer, or other physical diseases, but this protection is shamefully less available for mental illnesses. There is no discrimination in insurance coverage against victims of heart disease or cancer, but there is vast discrimination against those afflicted with mental illness, and it is time for Congress to end it.

Every year, one in five Americans is afflicted by severe mental illness. Even mental illnesses that are less severe in the sense they are not chronic or do not have a clear biological basis can be devastating to individuals and families. Transient depression can lead to suicide. Mental health problems can result in divorce, child abuse, job loss, failure in school, delinquency, and substance abuse. The health costs of treating severe mental illness is \$27 billion a year. The total cost of treating all mental illness is \$70 billion a year.

Even these figures are far from reflecting the true cost of mental illness because such illnesses are often inappropriately treated in the health care system at a high cost with poor outcomes. It is estimated that adequate treatment for mental illness would save 10 percent of overall medical costs.

And these are only the direct costs. The indirect costs of severe mental illness—lost productivity, disability, and premature death—exceed \$40 billion a year, and the indirect costs of all mental illnesses are far higher than that.

Mental illness is treatable and often curable. And treatments are becoming more effective every year. In fact, treatment for even very severe mental disorders is more effective than angioplasty, one of the most common treatments for heart disease.

Yet, insurance discrimination against mental illness is rampant, despite the fact that mental illness can be as devastating as any physical illness, despite the fact that good mental health care can actually save money, despite the heavy burden that mental illness places on millions of Americans and their families. Only about 11 percent of all employer-sponsored health plans cover treatment of mental illness as generously as treatment of other illnesses. Two-thirds of such plans place dollar limits on outpatient treatment. Eighty percent have more restrictive hospital coverage for mental illness.

Senator DOMENICI and Senator WELLSTONE offered a landmark amendment to end this injustice when the Kassebaum-Kennedy health insurance bill was considered by the Senate. Their full parity role made sense.

Five States have already adopted comparable laws. None has experienced

significant cost increases as a result. If it works for Maryland, Minnesota, Maine, Rhode Island, and New Hampshire, it can work for the rest of the country.

Here is what the Governor of New Hampshire said:

In the 2 years since I signed this bill, this has proven to be an affordable and effective piece of legislation. . . I urge you to pass similar health reform legislation on the national level.

The Governor of Minnesota said:

Since the enactment of [our] law, there has not been a significant cost increase. . . I encourage you to support the Domenici-Wellstone amendment.

The Governor of Maine said:

Our experience with serious mental illness has indicated that providing responsive and supportive coverage upfront. . . is not only the proper public policy, but also has positive economic impact with very little upfront costs for our State.

The Domenici-Wellstone amendment, as has been pointed out, was approved by the Senate by an overwhelming 69-30 bipartisan vote. President Bill Clinton urged that it be enacted into law. Unfortunately, it was dropped in the House-Senate conference because of the opposition of our House Republican conferees.

Now on this bill we have another chance to do the right thing. The pending amendment is a compromise—a worthwhile downpayment on this basic issue. Under the amendment, the annual dollar limit and lifetime dollar limit for mental health services covered by insurance could not be less than the limits set for other health services.

The amendment does not address many other special limits often imposed on mental health services, such as higher copayments, limits on outpatient visits, or limits on hospital days. Like the original amendment, it does not limit in any way legitimate cost containment steps to assure that care is necessary and effective.

The cost of this amendment is minimal. At most, it may lead to a rise of four-tenths of 1 percent in health insurance premiums, according to the Congressional Budget Office. Other analyses estimate the costs may even be lower. And none of these cost estimates take into account the savings that better mental health care will provide.

Opponents contend this proposal is an unjustified interference with the rights of employers. We heard the same objections to the minimum wage, to laws outlawing racial discrimination in employment, to the Americans With Disabilities Act, and to child labor laws. The opponents were wrong then, and they are wrong now.

Americans with mental illnesses and their families deserve a simple justice from employers, from the health insurance industry, and from their Government. This is the Congress that can begin to show the common sense, the compassion, and the basic fairness that

the mentally ill and their families deserve. I urge the Senate to adopt this amendment.

I join in paying tribute to my two colleagues and friends, Senator DOMENICI and Senator WELLSTONE for their efforts. They have fought long and hard to make this amendment a reality. Every family that will ever have a loved one who will need mental health care is in their debt. I also want to mention Tipper Gore, the Vice-President's wife, who has done so much to increase understanding of the need to improve mental health coverage and has worked so hard for mental health parity. Finally, President Clinton's untiring efforts in this cause deserve special commendation.

I urge the Senate to adopt this amendment—and I urge the Senate conferees to hold firm this time, so that the House extremists will fail, and that this long overdue measure will go to the President for signature.

This amendment has a special meaning for me and my family. In 1963, the first Presidential message on mental illness in history was sent to the Congress by President Kennedy. This message resulted in the passage of the first program to establish community mental health centers and provide community-based services for the mentally ill. And I am proud that, as chairman of the Committee on Labor and Human Resources, I had the opportunity to send to the full Senate President Clinton's Health Security Program, providing for full parity and comprehensive coverage of mental health services for every American. I believe the day will yet come when we will enact a program that assures the basic human right to health care for every American, whatever their wealth—and whatever their illness.

Mr. President, this Senate owes a great sense of appreciation to our two colleagues for fighting for this modest but enormously significant and most important program. I hope it will be carried by an overwhelming margin.

Mr. CONRAD addressed the Chair.

The PRESIDING OFFICER. The Senator from North Dakota is recognized. Mr. CONRAD. Mr. President, I want to join my colleague, Senator KENNEDY, in commending Senator DOMENICI and Senator WELLSTONE for offering this amendment.

The Senate has concerned itself with this issue several times in the past. Previously, when Senator DOMENICI and Senator WELLSTONE offered this amendment—a much broader amendment than this one—we got 68 votes on the floor of the U.S. Senate. In the reconciliation bill, I had this passed in the Finance Committee, and it passed on the floor of the Senate on reconciliation. So the Senate has considered a much broader version of mental health parity than we are considering tonight. This only relates to parity on lifetime and annual caps for mental illness. It is a small part of the parity provision that previously passed with an over-

whelming vote on the floor of the U.S. Senate.

Now, Mr. President, this is a beginning. It is an important beginning, and we ought to make the start. It is the right thing to do. We ought to treat a mental illness in the same way that we treat a physical illness.

Mr. President, the last time I spoke on this matter before my colleagues, I talked about an experience I had when I was the assistant tax commissioner in the State of North Dakota. We had a receptionist who was struck by a mental illness. I recounted her case. I don't want to take the time of my colleagues tonight to repeat the specifics of that matter, but I will simply say that she was a young, vibrant woman, who one day was healthy—perfectly healthy, radiantly healthy—and the next day she thought the pictures on the walls were talking to her. Her life was badly damaged. In fact, she ultimately tried to take her own life.

Mr. President, it was in dealing with that case that I learned that, in this country, insurance policies frequently discriminate against those with mental illness. And it is a very serious matter, this matter of discrimination, because if you are so unfortunate as to have a loved one or a family member or, God forbid, you yourself are stricken, you will quickly find out that the coverage in most policies is dramatically different for a mental illness than a physical illness.

For example, annual caps, typically, for mental illness are \$10,000 a year. For physical illness they are \$100,000 or \$250,000 a year, which is a dramatic difference. Believe me, if you are part of a family that has this awful thing happen to you, and you are up against those kinds of limits, you will find out very quickly that this can drain your family's finances. This can be devastating, not only in terms of the personal tragedy, but in terms of the financial tragedy that follows, as well.

Mr. President, this is a modest proposal. According to CBO, on average, this would increase health insurance premiums by .16 percent, not 16 percent, not 1.6 percent, but .16 percent.

Mr. President, this is the right thing to do. We ought to take this step. I hope my colleagues will join in on a bipartisan basis in passing the Domenici-Wellstone amendment. I thank the Chair and yield the floor.

Mr. SIMPSON. Mr. President, I am very proud to be a cosponsor of the Domenici-Wellstone amendment, which provides for just a small measure of mental health "parity." I am also a cosponsor of the freestanding bill, S. 2031, the Mental Health Parity Act of 1996, which was introduced on August 2. I am—and will remain—deeply committed to this cause. I sincerely believe that the manner in which we address this singular issue will speak volumes about the true nature of the 104th Congress.

I want to emphasize as clearly as I can that this amendment does not ask

for anything grand or far reaching. It would merely require health plans to provide parity with respect to lifetime caps and annual payment limits. In other words, if an existing health plan has a lifetime cap or an annual limit on what it will spend for medical or surgical services, that plan must either include services for mental illness in that total or have a separate ceiling for mental illnesses that is no more restrictive than the ceiling for medical and surgical services.

This very limited proposal would apply only in these two areas—for lifetime caps and for annual payment limits. It would not require "parity" for copayments or deductibles or any other aspects of health coverage.

Considering that the Senate has previously voted—on April 18, by a margin of 68 to 30—for an amendment that would have required a much more sweeping version of mental health "parity," it surely seems to me that the pending amendment—which is so very limited in scope—should pass by an even larger vote. I would look forward to that.

But those of us who have been involved in this cause have learned not to take a thing for granted. Even if we are to win this vote, we know that we will confront myriad further roadblocks as this measure works its way through the legislative process in the remaining weeks of this session.

I still have a bit of a hollow feeling about our failure to include this reasonable compromise in the health insurance reform bill. In a bill that was so packed full of "mandates"—which is exactly what the health insurance bill consisted of—somehow this mental health provision was singled out as some terrible mandate that would "cost too much."

As much as I don't want to believe this, my gut instincts tell me that this outcome most surely had something to do with discrimination against the mentally ill. This Congress should not make this mistake a second time. I urge my colleagues to support the pending amendment.

Mr. BROWN addressed the Chair.

The PRESIDING OFFICER. The Senator from Colorado is recognized.

Mr. BROWN. Mr. President, I rise with a heavy heart to address this subject. I say heavy heart because no one could fail to be moved by the very eloquent statements that the distinguished Senator from New Mexico has made on this floor concerning this problem, both now and in the past. He has brought to light the problem that, I think, affects many Americans and has focused our attention on a very difficult aspect of the current health care policy.

On the major tenet that suggests that there are differences in coverage in this area, I must say, the Senator is exactly right. That certainly conforms with my understanding. There are differences in coverage with regard to mental health. He has eloquently put

the case that many of the citizens who suffer from these infirmities suffer tremendous consequences because of the lack of insurance coverage in that area. I think he has done an excellent job in articulating the difficulties visited upon their families, not only because of the illness, but because of the nuances in the insurance policies.

Why would one rise to voice concerns? It is simply this, Mr. President. As this body requires coverage, or in this case sets limitations, fixes limitations, what we also do is not only help people out who are on the receiving end, but we establish the precedent that it is for the Government to decide what kind of coverage you purchase, not the person who is paying for it.

Mr. President, let us be very specific. If this amendment passes, consumers will be denied the right to pick the terms of coverage, or negotiate the terms of coverage they wish with an insurance company. We will have had the Government make that decision and not the consumers. Now, I put it to Senators that it is important for consumers to have choices. I must say that I think it is commendable that the Senators' underlying amendment does not mandate the mental health coverage. It still leaves that open. I do hear—and I think he and others have acknowledged it—that it may have a tendency to have people drop mental health coverage from their policies, if this passes in its present form.

What we do if we pass this is say that consumers are no longer allowed to make a choice as to the limitations on the mental health coverage that they purchase. What we are saying is, you are going to have to buy a policy that will conform with these guidelines, even though you don't want to. Now, Mr. President, I believe that consumers ought to retain that choice. I believe it is fair to require people to offer coverage, with the commensurate costs that it may involve, but I don't think it is appropriate for us to take that decision away from consumers. Thus, Mr. President, I do rise with an amendment that I think clarifies the issue.

AMENDMENT NO. 5196 TO AMENDMENT NO. 5194

Mr. BROWN. Mr. President, I send an amendment to the desk and ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows: The Senator from Colorado [Mr. BROWN] proposes an amendment numbered 5195 to amendment No. 5194.

At the appropriate place in the amendment, insert the following:

Notwithstanding the provisions of this title, consumers shall retain the freedoms to choose a group health plan with coverage limitations of their choice, even if such coverage limitations for mental health services are inconsistent with section 2 of this title.

Mr. BROWN. Mr. President, the amendment is very simple and it is very direct. It simply retains the matter of choice in the consumer. If you think the consumer ought to be able to purchase the protection that they

wish, you will want to vote for this amendment because it makes it clear that consumers can end up making that choice themselves. If you wish to deny the consumer the right to purchase the coverage that they prefer, you will want to vote against the amendment.

Mr. President, I think underlying this is a very important principle. Should we force people to buy coverage they do not want to buy? There are good arguments on both sides, incidentally. I will certainly concede that. I will concede that the case the distinguished Senator from New Mexico brings for his amendment is one of the most heart-rending and eloquent presentations I have ever listened to.

So, Mr. President, I also believe it is important in this land of freedom to retain freedom of choice for consumers. Thus, I offer my amendment here on the floor.

Mr. DOMENICI. Mr. President, I do not know if there are any other Senators who want to speak in behalf of the Domenici-Wellstone, et al., amendment. I understand the Chair would like to speak. I will personally relieve him shortly so he can speak. But let me make a comment about the Brown amendment, after which I will move to table it once Senators who want to speak have had an opportunity to do so.

Let me just make a case here. Fellow Senators, we just passed a Kassebaum-Kennedy health reform bill. What did we say in it with reference to preexisting conditions? We said insurance companies can no longer deny coverage because of preexisting conditions. We could have had a distinguished Senator like the Senator from Colorado—and he is distinguished—come to the floor and say, "But we ought to have the consumers retain the right to choose." So we could offer an amendment here that would have said it. But we need to protect the consumers' choice.

So we are saying you have to do this; you have to cover the preexisting conditions, but the consumer ought to have the choice, and he ought to be able to opt out. You see what that did. Nobody dared do it—not even my distinguished friend from Colorado—because that produced what we all call cherry picking. It permits people to offer coverage at the lowest possible rate denying coverage to many, many people and leaving those to somebody else.

I cited here on the floor where cherry picking came from. I thought it came from the basketball player where, when the fellow didn't want to get into the game of getting rebounds, he stood out on the side over there and let the other people do all the work. And he would run down, and they throw him the ball, and he would get to cherry pick the basket.

What the Senator is doing here in this amendment, which sounds great, is he is taking a provision that we are offering that says simply the following:

If an insurance company chooses to cover mental health—let me repeat: if they choose to cover mental health. Implicitly they do not have to cover mental health. I would assume they will offer policies without coverage for mental health. I assume that exists today. It will exist tomorrow. It will exist a year from now if this becomes law. Companies will offer policies with no mental health coverage, and that is available for those consumers who want to choose that. But it will also offer mental health coverage. All we are saying is, if you choose to offer that coverage, then you must offer two things—only two things: The annual amount to be paid for the illness and treatment must be the same for physical as for severe or mental illness. You can't have two different annual payments. As to the lifetime aggregate coverage, you cannot have two different ones, if you cover mental health.

So, in a sense, I say to my fellow Senators, this choice is already provided for because insurance companies are going to provide ample choice. They are going to say we are not covering mental health. Would you like to buy that kind of policy? We are only saying if they choose to cover mental health that these two characteristics, qualities, must be present.

If the Senator chooses to say, for those companies that choose to write insurance policies that have mental health and, therefore, have this kind of coverage, people ought to be able to say, "I opt out of a portion of it." Then I submit we are right back where we started where we do not have coverage for the mentally ill because people who do not have any problems will opt out of it, and there will not be coverage under even those cases where policies have it expressly because the decision has been made—because the decision has been made—to include it.

So from my standpoint, I will very soon move to table this. I say to everyone that I think, if it were adopted and implemented literally, I believe we will have done away with the kind of coverage we seek to provide within the confines of a policy that the offset chooses—coverage for mental illness.

I yield the floor.

Mr. WELLSTONE addressed the Chair.

The PRESIDING OFFICER. The Senator from Minnesota.

Mr. WELLSTONE. Very briefly, I say openly that I could go through in a kind of logical way all of the specifics of it. But I believe the amendment of my good friend from Colorado guts this amendment in the second degree. I think what he most objects to is the idea of any kind of standard. We just voted on a standard. That is what we just did. That is the vote we just took. It was 98 votes where we said, "Look, when it comes to the whole issue of the mother-child, we want to make sure there is at least a 48-hour period of time." That is what we just did. We are now saying in a very incremental way

that when it comes to the mental health area we ought to deal with this discrimination and we ought to make sure that, at least with the lifetime or annual caps, you have some parity. If you begin to say, "I am all for the plans, but I do not want to have a situation where in fact there has to be in mental health coverage an equality with caps," then you move away from the whole strength of this.

So this is the opposite of the perfecting amendment. This amendment guts this legislation. I hope that it will be defeated resoundingly.

Mr. BROWN addressed the Chair.

The PRESIDING OFFICER (Mr. DOMENICI). The Senator from Colorado.

Mr. BROWN. Mr. President, if I could, I would like to address the comments of the two previous speakers.

With all respect to my good friend from Minnesota, let me suggest that the vote we just had, at least in my view, is not quite the same as he implied. The record vote we just had was on the Frist amendment that perfected the Bradley amendment. I voted for that because it did improve the Bradley amendment. I certainly would confess to the Senator with regard to the underlying Bradley amendment that there are significant similarities, and I think he makes a valid point there. One difference, I might point out, is the cost differential for that very modest step, first, I might say, which is something that I hope would be in all policies, which is dramatically different than what I believe the cost impact with regard to the mental health coverage is.

Second, Mr. President, with regard to the statement of the distinguished Senator from New Mexico with regard to his point in regard to choice being still present, if his amendment passes, I think that is a valid point if either choice is retained. Unfortunately, the choice, though, as to whether or not you have any mental coverage, if you do not want to go with the higher limit, you have to drop all coverage, this amendment would make it clear that you retain the choice as to the level of coverage. I think that is the crux of it.

Why is that significant? It may be possible to afford 10,000 dollars' worth of coverage, or 100,000 dollars' worth of coverage, or 1 million dollars' worth of coverage. But it may not be possible to pay for \$10 million of coverage. Does that mean, if you can't go with the higher level, that you are not allowed to have any choice at all? Unless the Brown amendment passes, the second-degree amendment, that is exactly what it means. If the Brown amendment passes, it means that you are allowed to have choices as to the coverage levels you may wish for mental health.

It seems to me that is fundamentally a question of choice and an important part of it. And it is vital for our consumers to retain that option.

I yield the floor.

Mr. BENNETT addressed the Chair.

The PRESIDING OFFICER. The Senator from Utah.

Mr. BENNETT. I have listened to this debate with great interest. I find myself philosophically agreeing with the Senator from Colorado about the issue of choice, but I intend to oppose his amendment because it ignores the reality of our current health care structure and raises an issue that I have raised before and will raise again and again and again as we deal with the health care circumstance.

He uses in his amendment the word "consumers." The fact is that consumers do not buy health insurance. Individual consumers do not buy health insurance except in very rare cases. Companies buy health insurance. Employers buy health insurance.

In my view, that is one of the main things that is wrong with our health care system, that individual consumers are not allowed choice. We are forced to take whatever our employers decide to choose on our behalf.

I have said on this floor before I had a better health care plan before I came to the Senate than I have now. Why? Because the employer for whom I worked did a better job from my point of view than the U.S. Government does in choosing plans. If I were an individual consumer buying health care the way I buy an automobile, I would have chosen to bring that health care plan with me when I came from one employer to the other employer. But because of the way our health care system is structured, we are not allowed to do that. We, as individual consumers, are not allowed to make those kinds of choices. So let us understand that when the Senator from Colorado talks about consumers making choices, he is using the language of the marketplace that simply does not apply in health care.

We had a long battle on this floor for many weeks over the idea of allowing individuals to set up savings accounts from which they could purchase health services. We finally had a compromise saying that we would only allow 750,000 people to do that. If we cannot find a more dramatic statement than that fact that underlies that consumers, that is, individuals, are not allowed to make these kinds of decisions, then I do not know where we would find a more dramatic statement.

I would like in coming Congresses to restructure the system around medical savings accounts and around consumer choice. I think that is the ultimate solution, and if we get to that point, then I think we can consider the amendment of the Senator from Colorado. But when we are stuck with the circumstance we are stuck with now where decisions are made by somebody other than individuals, I think the amendment of the Senator from New Mexico is an appropriate one, and I intend to oppose the second-degree amendment and support the amendment of the Senator from New Mexico.

Mr. BROWN. Will the Senator yield for a question?

Mr. BENNETT. I would be happy to yield for a question.

Mr. BROWN. It is my understanding the Senator has favored letting employers give employees choices. Would I be fair and accurate in saying that, if the DOMENICI amendment passes, it would preclude employers offering making available to their employees a choice as to the various levels of mental health coverage if they differ?

Mr. BENNETT. It is my understanding, in response to the Senator's question, that an employer would not be precluded from offering whatever he wanted. From my own experience as an employer, let me describe to the Senator what we offered to our employees. Under the cafeteria plan proposal, we say to our employees that we have x number of benefit dollars. You tell us how you want us to spend them on your behalf. And under a cafeteria plan approach—a 125(c) plan, I think it is described in the Tax Code—an employer could say, here is a mental health care plan of x amount of coverage. Here is a mental health care plan of y amount of coverage. Here is a mental health care plan of z amount of coverage. And here is a physical health care plan of x amount of coverage, and you get to pick.

The employee under those circumstances could say, "I want \$10,000 of coverage in mental health care under this plan, and as a second option, I want a plan that has \$1 million worth of physical coverage."

Yes, I get, in effect, the same thing the Senator is talking about, but I have to buy two plans to do it and there is nothing in the current law or nothing in the Domenici-Wellstone amendment that would prevent an employer from offering that kind of circumstance.

Mr. BROWN. To follow up, if I may, my understanding of the reading of the Domenici amendment is that he does exempt from these limitations restrictions to small employers. That, I think, is a commendable aspect of his amendment. But I do not see an amendment that provides the exemption that the Senator just talked about. As a matter of fact, the way I read the amendment—and perhaps the Senator will want to clarify it or set me straight on it—the way I read it, it says precisely that you cannot do what the Senator describes, that you cannot have a plan that has \$1 million for physical coverage and \$100,000 for mental health coverage.

Mr. BENNETT. You cannot have a single plan that has that discrimination, but if under a 125(c) cafeteria plan you say we are going to offer separate plans and you buy both, you could get that effect if the employee made that kind of choice.

Mr. BROWN. I appreciate the Senator making that point. I think it is a very important point, that you do retain that option at least in the cafeteria plan.

Mr. BENNETT. That is right. An employer who does not have a cafeteria plan would not face that option. But if by passage of this we encourage employers to move to a 125(c) plan, a cafeteria plan, I think that is all to the good. My underlying point is that the consumer does not make these choices, which I think is wrong and needs to be changed at some point when we restructure our health care system.

Mr. BROWN. If the Senator would permit me another.

Mr. BENNETT. Surely.

Mr. BROWN. It is this Senator's view that the option that the Senator just described for the employer about the cafeteria plan, which I think is an important option, is the option that ought to be preserved for other consumers who do not fit in the small employer option.

Mr. BENNETT. I agree with the Senator, but I do not think this legislation is the place in which to do it.

Mr. GRAMM addressed the Chair.

The PRESIDING OFFICER (Mr. BENNETT). The Senator from Texas.

Mr. GRAMM. Mr. President, what we have before us is a very bad amendment with very good intentions. What this amendment in essence is saying is that we in the Senate know better than employers and workers what kind of health insurance coverage they need.

This amendment overrides the decision making of those workers who are affected by this amendment, and a very large portion of the population of the country will be affected.

We are going to say to them that we know better. You may think that you want different limits for traditional physical health insurance than mental health coverage, but we know better than you and are going to make you buy the coverage with increased mental health limits. The incredible paradox is that the only way you can escape this is to drop mental health coverage altogether.

This is an unfunded mandate. If we had a proposal before us tonight to raise taxes to provide this benefit, I doubt it would get 30 votes. But what we have is a proposal tonight where "Big Brother" Congress, know-it-all Congress, perfect-insight Congress, is going to say that even if you are a young worker and are having trouble buying health insurance and remaining competitive in the job market, we are going to force you to balloon your mental health coverage, as commendable as that might be.

How wonderful it would be if everybody in America could afford this coverage. But what we are saying is, if you have any mental coverage in your plan, we are going to make you pay for a coverage limit up to the amount you have for traditional physical ailments. In the process we are going to drive up the cost of health insurance. We are going to reduce the choices that people have. The Senator from Colorado is saying if you want to mandate that insurance companies offer the coverage,

then do it, but do not make people buy it if they do not want it.

I would like to remind my colleagues—none of whom are having difficulty buying health insurance—that even though this may sound great from our point of view, the problem with private health insurance is young working couples are having trouble paying for the health insurance they have. And, to the extent that this bill drives up the cost of hiring people, it will cost people their jobs, it will force companies who cannot afford to provide this benefit to eliminate all mental health coverage, and it will force working families to do without, because every penny that goes towards health insurance comes right out of the pocket of the worker. Every economic study done, including studies by the administration, count fringe benefits as part of the wage package. What we are doing to young couples who are trying to make ends meet, who want health insurance in case Johnny falls down the steps, is saying that you are going to have to pay for this extensive mental health coverage whether you want it or not. This amendment says that Congress supposedly knows what is better for you than you yourself do—it assumes that Congress is capable of making better decisions.

I totally and absolutely reject this. We adopted an amendment similar to this, but we adopted it when the majority leader, Senator Dole, made it clear that we were never going to see it emerge from conference—yet we ended up in conference with serious negotiations about really doing this.

I, frankly, think it is outrageous that, on an appropriations bill, we are getting ready to mandate that working people and businesses provide a benefit, whether they want it or not; that they pay for it, whether they want it or not; and we are doing exactly what the American people are continually outraged about: injecting our value judgments over theirs. We are saying that we know better than you know—that you really need this expanded mental health coverage, even if you do not want it and even if you can not afford it.

The point is, mental health care may be a wonderful thing. If we could snap our fingers and have everybody in America covered, it would be great. The truth, however, is that we cannot. This is expensive coverage. It is not an accident that private health insurance policies normally have differentials. In fact, in many cases, people do not have mental health coverage.

We have not had a tremendous amount of experience with mental health coverage under a third party payment system, where the insurance company is paying for it. I know we can get into a lengthy debate about experience of various States. I have seen estimates as high as 15-percent increase, if you force people to pay for mental care for alcohol and drug rehabilitation. I do not know how to pull

that apart. But the point is, whatever the costs, how dare we, in the freest society in the history of the world, attempt to play God by telling people what kind of health insurance they must have.

I think the amendment that has been offered by the Senator from New Mexico is perfectly reasonable—more than reasonable. It simply says to insurance companies: You do not really live in a free society, you can not decide what product you want to sell, instead we are going to mandate that you sell this policy. Indeed, we are going to use the police power of the State to make you sell this policy. But, at least the Senator from Colorado says: We are not going to force young working couples, whose jobs might be threatened, whose ability to afford physical health insurance might be threatened—we are not going to make them buy it.

It seems to me that is the issue. In terms of somehow relating this to medical savings accounts, that is the most contorted logic I have ever heard in my life. The point of medical savings accounts is that, under the current tax law, if you buy low-deductible insurance it is tax free. But if you buy high-deductible insurance and you put the difference in a savings account, then you have to pay taxes on that difference. In essence, we are making people, through the Tax Code, buy low-deductible insurance. We are putting people in a position where, when they are buying health care, it is like going to the grocery store and having a grocery insurance policy, where 95 percent of what you put in your grocery basket is going to be paid for by grocery insurance. Needless to say, if you had such a policy, you would eat differently, and so would your dog—this is part of the problem.

What medical savings accounts do is expand choices. What the Domenici amendment does is limits choices. What gives us the right to say that people should be forced to buy health insurance that provides coverage which they otherwise would not choose to buy? Who are we to say that we have made this value judgment, that mental health care and physical health care are equal? Furthermore, who are we to say that if you have a policy which has a certain limit on physical care, and if you have any element of mental care in that policy, you are going to be forced to have the same limits on mental health care as well?

Let me tell you what this amendment would do. This amendment would drive up the cost of health insurance, it would drive up payroll costs, it would increase the cost of employing workers, and, therefore, people would lose their jobs.

Some courageous Members were willing to stand up and be counted upon on the issue of the minimum wage. How is this issue any different? How is this at all different? The plain truth is, this is not different. What this amendment would do is impose an unfunded man-

date on workers and businesses. This will drive up unemployment. It will limit freedom. It will drive up the cost of health care. It will reduce the number of people who are covered by health insurance. And, finally, in the most perverted provision of this amendment, it will induce people to drop mental health coverage rather than face these expanded limits.

So, I know we have danced around this issue before. I know that, in a form people thought would go to conference and die there, we have voted on this before. I was proud to vote against it then and I am going to be proud to vote against it now. I think the Brown amendment is an amendment that makes the underlying amendment dramatically better. Because what the Brown amendment says, in its simplest form, is people have to offer this coverage for sale, but you do not have to buy it.

If you believe in freedom, if you believe in the right of people to choose you will vote for the Brown amendment. I would remind my colleagues who talked about lack of choice—there is a choice. If you do not like the health insurance your employer is providing, you do have an option. We do not have indentured labor in this country. We do not allow the enforcement of indentured labor contracts. People have a right to change jobs, and in fact people change jobs every day because of health insurance, because they want it and they want to expand their freedom.

This is an amendment that limits freedom. This is an amendment that is an unfunded mandate of the worst sort. This is an amendment which has the Congress choosing for consumers, choosing for their employers, and I think it is absolutely wrong. I strongly oppose the underlying amendment and I strongly support the Brown amendment, which simply tries to preserve consumer choice.

I would think that the authors of the underlying amendment would accept the Brown amendment because all the Brown amendment says is that, while the insurance coverage has to be offered, if the consumer does not want it, cannot afford it, feels it threatens his or her job, or if it threatens the viability of the company, you do not have to buy it. You either believe in freedom or you do not.

If you believe in freedom, you are not for the Domenici amendment. If you believe in freedom, you are for the Brown amendment. Those are strong words but they are words that exactly fit the case before us.

I yield the floor.

The PRESIDING OFFICER. The Senator from New Mexico.

Mr. DOMENICI. Mr. President, I have heard the distinguished Senator categorize the words of my good friend, the occupant of the chair, as "preposterous," or what was it you chose to say, Senator? I think that is probably a good paraphrase.

Let me suggest the entire debate by the Senator from Texas has been preposterous. First, it is wrong on the facts; and, second, it is wrong on the logic; and, third, it is a gross exaggeration if ever I have heard one. So, let me tell you the facts. And the Senator might do well to listen, because they are the facts.

Mr. GRAMM. I will listen.

Mr. DOMENICI. And I appreciate it, if you will.

First of all, the only way we have been able to judge the cost of these various insurance changes is to get the Congressional Budget Office to tell us. Let me tell you what they said about this amendment. Sixteen one-hundredths of 1 percent possible increase. Sixteen hundredths of 1 percent possible increase. Caveat, they said—caveat, we are not taking into consideration that it will probably be substantially less, if we know the effect of managed care and HMO's.

Would anybody gather from the argument of the distinguished Senator from Texas that we are talking about that? Let me convert it to an insurance policy's average costs: \$6 to \$8 a year. That is the choice between freedom and servitude, \$6 a year, or \$8.

That is freedom from being in jail or being forced to be indentured—\$6 or \$8 a year.

Let me talk about eliminating choice. I just asked what the conference report on the Kassebaum-Kennedy bill passed by, how many votes. I looked and found my good friend, the Senator from Texas, voted for that. Though I might suggest to him—and I am his good friend—when he makes an argument I do not agree with, I make it as forcible as he, perhaps not as intellectually as he.

Having said that, I noted he voted for that bill. Mr. President, if ever you wanted to make an argument about eliminating freedom of choice, that was the bill to do it on, because you no longer have any choice to say, "I don't want to buy insurance that covers the preexisting condition of my neighbor." Right? You say, "I want another insurance policy, because I want the right to choose between coverage of preexisting conditions or not."

Let me suggest, if there are degrees of freedom, you just waive freedom there in an astronomical way, and if you are losing some freedom here, you are losing it in a little, tiny, almost immeasurable quantity.

So let me repeat to the U.S. Senate what this issue is about. This issue is about whether or not you want to take a little tiny step toward providing some kind of parity of treatment under insurance policies in this land to those who suffer mental illness.

Let me tell you what it does not do. It does not require the kind of coverage, the amount of copayment, the deductibles. Those are all left up to the insurance companies. All it says, I say to my friend from Kentucky, is if you write an insurance policy that covers

mental illness, then write it for the aggregate coverage level that is identical to the coverage level for physical illnesses: Is that a monumental thing? Most policies aggregate between \$500,000 and \$1 million. That is what you are saying: If you write one with mental illness, do not put one in at \$50,000 and cancel at \$1 million. Just put 1 million dollars' worth of coverage.

I repeat, this is not a huge imposition of new costs on anyone. My friend from Texas says there is no experience with the coverage of mental illness. That is absolutely wrong. There is plenty of experience with the coverage of mental illness. There are all kind of insurance policies out there with coverage of mental illness without discrimination on the aggregate amount. Many companies already know what it will cost, and they know what it will save.

All we are suggesting is that there are a few million American families out there who think they have insurance coverage, and they find that their 17-year-old daughter away at college got depression in her freshman year—could not make a choice, all of a sudden could not sleep, all of a sudden gets deathly sick, and all of a sudden the doctors say she has severe depression.

All of a sudden they say, "Well, we have insurance." They wake up and ask somebody. Surely, if the father of the house had a heart attack, he can stay in a hospital 6 weeks. He can get 300,000 dollars' worth of surgery. But for that daughter, if you look at the policy, and it probably said \$50,000. And they thought they had insurance. If you have severe depression and get hospitalized and then have to have the treatment that follows it, \$50,000 is not even going to begin to care for them, just like \$50,000 will not touch bypass surgery and all of the rehabilitation that comes with it, or severe cancer with six operations and chemotherapy.

That is all we are saying. If you are going to write an insurance policy, insurance industry of America, businesses in America, if you are going to cover your employees and you are going to cover physical ailments and mental illness, just make sure that the aggregate amount is the same.

That is not making any huge, momentous decision for the populace of the United States. It is a very simple, forthright, practical approach to insurance coverage.

As a matter of fact, the only reason they are writing it out of the policies now and writing it lower is because it is cheaper. When people start finding out and asking about it and wanting it, then they will cover them, but in many instances, it is already too late. But if you make it that they must have these aggregates in all of the policies, I repeat, the denial of freedom is so insignificant and the cost is so insignificant that it is a trivialization, it trivializes the use of the words "denying freedom of choice." It is truly turning monu-

mental words that we cherish and worry about, like "freedom," and attaching those to something as insignificant as what we have just described here on the floor.

Mr. President, I move to table the Brown-Grann amendment and ask for the yeas and nays.

Mr. GRAMM. I ask the Senator to withhold so that I might respond.

Mr. DOMENICI. How much time would you like?

Mr. GRAMM. I want time to respond, or I can suggest the absence of a quorum.

The PRESIDING OFFICER. Does the Senator from New Mexico withhold?

Mr. DOMENICI. I will let the Senator respond.

The PRESIDING OFFICER. The Senator from Texas.

Mr. GRAMM. Mr. President, every Member of the Senate voted for the Kassebaum-Kennedy bill. I stood on the floor and made it very clear that by moving toward community rating, we were driving up health insurance costs.

What I wanted was medical savings accounts as a method to promote competition and empower the consumer to make rational choices. Like most bills, it represented a tradeoff: an expansion of freedom in one area, a reduction of it in another. I see no expansion of freedom here.

No. 2. If this provision really costs one-sixth of 1 percent, why isn't it a matter of course in insurance policies? If this provision is so cheap and so good, why is it not provided?

I will offer another amendment saying that if, under this provision, the cost of insurance rises more than 1 percent that this provision will be void, and we will see if that will be supported.

Everyone who has ever argued that we should diminish freedom to promote a political objective has said that the political objective is big and the diminution of freedom is small. The point remains and is irrefutable that under this amendment, we are going to make you buy coverage that you may not want. We are going to make employers provide coverage that they may not be able to pay for unless they drop mental health coverage altogether. I believe that this is clearly a step in the wrong direction.

Obviously, any of us can stand up and talk about things that any family would like to have. Wouldn't any family in America like to have comprehensive mental health care when a 17-year-old child in college comes down with severe depression? Obviously, they would. But there are also a lot of families who would like to have a 17-year-old in college.

There are a lot of people who would like to have better jobs than they have. The point is, life is about choices. Life is about choices that we have to make in a free society.

Senator BROWN says that we can require insurance companies to offer the policy. But the Domenici amendment says you also have to buy the policy.

You have to buy this coverage whether or not you want it, whether or not you can afford it, and whether or not it threatens your job or your company. Why? Because we, the Congress, in our infinite wisdom, have decided that this is something you need to have.

It seems to me, if there was just one clear message in the last election, it was stop making decisions for us in Washington, let us make decisions for ourselves.

If this policy really cost one-sixth of 1 percent, then let people choose to buy it, let companies decide to offer it. I do not believe it will cost one-sixth of 1 percent. I believe we are talking about a very expensive rider to insurance policies.

I think that this rider is going to drive up the cost of health insurance and, in effect, deny people who are having trouble buying insurance the ability to cover themselves or their child should he or she fall down, break an arm, or, God forbid, be in an accident. We are going to jeopardize their ability to have any health insurance at all. Further, we are going to jeopardize their ability to have a job, and are going to induce many companies to drop health coverage altogether. Soon people will find out that if they have a child that has a mental problem, they will not even have \$50,000 of coverage, let alone coverage equal to the rest of their policy.

The point is this, if this is so cheap, if this is so irrelevant from the point of view of cost, why not let people choose it on their own? Or better yet, why not have the insurance company be required to provide it and then let people decide if they want it based on their analysis of cost and benefits? Or are they so foolish, are the American people so naive, so unaware of their own needs and their own wants that they must have us tell them what they need? I do not think so.

It seems to me that the Brown amendment has the saving grace of letting people choose. You force the insurance companies to offer this coverage whether they want to offer it or not, but at least you let people decide if they want it. I cannot understand, for the life of me, why people are opposed to this. If really this coverage costs one-sixth of 1 percent, we would all want it; we would all choose it. The only reason you would not let people choose it on their own is if you do not believe that one-sixth of one percent number, or you believe that people would not choose it. The point is, freedom is the right to make wrong decisions as well as to make right decisions. I simply go back to a fundamental point which, in my opinion, despite all the wonderful speeches you can give about this—Bismarck once said, "Never does a socialist stand on stronger ground than when he argues for the best principles of health."

Who can stand and argue against somebody having coverage for a physical or mental ailment? No one can. We

all want it. We wish we could magically make it happen. But we should not make it magically happen by mandating that people have it, by forcing people to pay for it whether they want to or not, without knowing what it costs, without knowing the ramifications of this, all on an appropriations bill at 7:30 p.m. at night in the month that we are going to adjourn the Senate.

I think that this amendment violates everything that many of us claim that we stand for. I do not doubt the good intentions, nor have I ever doubted the good intentions, of the Senator who is offering this amendment. But this is bad public policy. It flies in the face of everything the 1994 election said because it denies people the right to choose.

If we want to preserve this right to choose, not for the insurance companies, but for the consumer, then it is critical that the Brown amendment be adopted.

I yield the floor.

Mr. BROWN addressed the Chair.

The PRESIDING OFFICER. The Senator from Colorado.

Mr. BROWN. Mr. President, I shall not prolong the debate. We have had excellent comments by both sides. I appreciate the very thoughtful comments that Senator DOMENICI has made and Senator GRAMM has made because I think they enlighten debate.

I hope Members, when they vote on this, will do one thing: look at the amendment and read it. And let me just read the words because I think they are important to focus on. Here are the words of this amendment:

Consumers shall retain the freedom to choose a group health care plan with coverage limitations of their choice even if such coverage limitations for mental health services are inconsistent with section 2 of this title.

Mr. President, that is all this amendment does. It retains, in the consumer, the right to choose.

I yield the floor, Mr. President.

Mr. DOMENICI addressed the Chair.

The PRESIDING OFFICER. The Senator from New Mexico.

Mr. DOMENICI. I believe we have had debate on this. I just want to, one more time, suggest that what is missing from the Senator from Texas' discussion is—I would put it this way—there was total misunderstanding as I listened to him talk about severe mental illness and the marketplace and the neighborhoods of America. Because that illness has been so stigmatized for so long, it has even stigmatized the insurance policies of this land.

We started out 30 or 40 years ago recognizing that we came out of the Dark Ages with reference to severe mental illness and crazies and loonies, and we started understanding that people really were sick. Yet, we dragged everybody kicking and screaming to understand that a mother or a father with a child with schizophrenia had nothing whatsoever to do by way of treatment or care with that child getting sick.

Pretty soon we got to recognize that even that famous old Dr. Freud was wacko because you could not talk people out of mental illness. You can have them on the sofa and chair and talk until you are blue in the face, and if you are a schizophrenic, you are sick. What happened is, society just resisted that. And I guess part of it is that every now and then somebody who is mentally sick kills someone and there we are again talking about "those people."

But let me tell you, there are millions of Americans who have members of their family with one of these dread illnesses. All we are suggesting in this measure, and I repeat, if an insurance company writes insurance that covers mental illness—now if you want choice, understand, they do not have to cover mental illness—but if they choose to, we just say, let us get rid of the stigma and cover them in total dollar coverage to the same extent you cover the other illnesses.

If they want to triple the copayment, I say to Senator KENNEDY, because they want to keep people away from psychiatrists, there is nothing in this measure that says they cannot do that. We are just saying, when you insure somebody that is mentally ill, and they get real sick, make sure they are the same limitations on total coverage that people who get cancer or diabetes or tuberculosis or triple bypass have. And that is all it says.

That is the reason it is not going to cost very much. The amendment that passed early on, where we mandated coverage and we mandated parity of actual literal coverage, was very, very different. And my friend from Texas might have made a very serious argument there, but in this case that is not the situation.

So I believe, to say if you are writing mental health coverage it has to have these limits and turn around and say, on the other hand, even if you have done that, insurance company, we have the right to say, well, lower the level and give us another kind of coverage with less of that because we want freedom of choice—the choice is clear.

You can buy an insurance policy without mental health coverage or you can buy in the manner discussed so eloquently on the floor by the Senator from Utah, if that applies. So having said that, I move to table and ask for the yeas and nays.

Mr. GRAMM. Mr. President, I ask the Senator on one point to allow me to respond.

Mr. DOMENICI. I would be pleased to.

Mr. GRAMM. I do understand. I grew up in a household with someone who had mental illness. I grew up in a household where nobody had health insurance. We did not have health insurance for physical or mental ailments. But the point is, if you are going to mandate coverage, then you will end up with more people who have no health insurance, and you are going to have more people without jobs.

The point is that under this amendment you lose your right to choose. To keep a policy that has limited mental health coverage, you either have to take no mental health coverage or take coverage equal to that set for physical illness coverage. The Brown amendment gives you choice. It seems to me that is what we want.

My problem here is not that I do not understand. My problem is that I do understand. My problem is that I do understand what this does economically. I do understand that this takes away from people the right to choose. That is why I am opposed to it. There certainly is no politics in opposing this amendment. We should all be for giving everybody everything. Unfortunately, we live in a world where people have to choose. When we choose for them, they not only have less freedom, they do not get to choose to spend their money as they would choose to spend it.

I believe families know better than we do. Even though our intentions may be wonderful and even though we may wish everybody had mental health coverage, families have to make hard choices when they have to pay. Businesses have to make hard choices. All I am saying is let them choose. If you want to make insurance companies provide the coverage, do not make people buy it. Have it available. Let them look at the cost. If it costs one-sixth of 1 percent, they will buy it if they want it. I would certainly buy it at that cost.

My fear is we are going to find out later this is a very costly add-on, and we are going to price people out of the health insurance they have now, and they are going to end up with both physical and mental ailments, and they will not be covered for either.

Mr. WELLSTONE. I know my colleagues are anxious to move forward. Although there is so much I want to say for the record, I yield.

Mr. DOMENICI. I move to table the amendment, and I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There is a sufficient second.

The yeas and nays have been ordered. The clerk will call the roll.

The assistant legislative clerk called the roll.

Mr. NICKLES. I announce that the Senator from Utah [Mr. HATCH], the Senator from Oregon [Mr. HATFIELD], and the Senator from Alaska [Mr. MURKOWSKI], are necessarily absent.

I further announce that, if present and voting, the Senator from Oregon [Mr. HATFIELD], would vote "yea".

The PRESIDING OFFICER. Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 75, nays 22, as follows:

[Rollcall Vote No. 273 Leg.]

[Rollcall Vote No. 273 Leg.]

YEAS—75

Akaka	Feingold	Moseley-Braun
Baucus	Felstein	Moynihan
Bennett	Ford	Murray
Biden	Frist	Nunn
Bingaman	Glenn	Pell
Bond	Graham	Presler
Boxer	Grassley	Pryor
Bradley	Harkin	Raid
Breaux	Heflin	Robb
Bryan	Hollings	Rockefeller
Bumpers	Hutchison	Roth
Burns	Inouye	Santorum
Byrd	Jeffords	Barbanes
Chafee	Kassebaum	Shelby
Cochran	Kennedy	Simon
Cohen	Kerry	Simpson
Conrad	Kerry	Snowe
Coverdell	Kohl	Specter
D'Amato	Lautenberg	Stevens
Daschle	Leahy	Thomas
DeWine	Levin	Thompson
Dodd	Lieberman	Thurmond
Domenici	Lugar	Warner
Dorgan	McConnell	Wellstone
Eron	Mikulski	Wyden

NAYS—22

Abraham	Gorton	Kyl
Ashcroft	Gramm	Lott
Brown	Grams	Mack
Campbell	Gregg	McCain
Coats	Helms	Nickles
Craig	Inhofe	Smith
Faircloth	Johnston	
Frahm	Kempthorne	

NOT VOTING—3

Hatch Hatfield Murkowski

The motion to lay on the table the amendment (No. 5195) was agreed to.

Mr. DOMENICI. Mr. President, I move to reconsider the vote by which the motion to lay on the table was agreed to.

Mr. FORD. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

Mr. LOTT. Mr. President, for the information of all Members, we are working now on getting a UC typed up that would lay out how the time will be used for the next hour. We are in the process now of typing up an agreement that would lay out the debate, and the votes over the next hour and a half. I think that would allow us to make good progress and be able to get to the conclusion of the VA-HUD bill, and either go to final passage after that, or, depending on a couple of other things, we are working on final passage and could have stacked votes Tuesday morning. But we will have that worked out momentarily.

The next thing we will do is to go to the next pending amendment for a vote. Senator GRAMM I believe has a second-degree amendment.

THE DEFENSE OF MARRIAGE ACT

Mr. LOTT. In the meantime, I ask unanimous consent that the Senate now turn to consideration of Calendar No. 499, H.R. 3396, the Defense of Marriage Act.

Mr. DASCHLE. I object.

The PRESIDING OFFICER. Objection is heard.

CLOTURE MOTION

Mr. LOTT. I move that the Senate proceed to the H.R. 3396, and I send a cloture motion to the desk.

The PRESIDING OFFICER. The cloture motion having been presented under rule XXII, the Chair directs the clerk to read the motion.

The legislative clerk read as follows:

CLOTURE MOTION

We, the undersigned Senators, in accordance with the provisions of Rule XXII of the Standing Rules of the Senate, hereby move to bring to a close debate on the motion to proceed to H.R. 3396, the Defense of Marriage Act:

Senators Trent Lott, Bob Smith, Conrad Burns, Rod Grams, Larry E. Craig, Judd Gregg, Jim Inhofe, Hank Brown, Don Nickles, Dan Coats, Chuck Grassley, Craig Thomas, Frank H. Murkowski, Lauch Faircloth, Richard Shelby, Slade Gorton, Phil Gramm.

Mr. LOTT. Mr. President, I want our colleagues to know that I have been discussing this back and forth with the Democratic leader. He was aware that I was going to do this. We are working on a number of other issues that are not directly related necessarily to this. We also have an understanding that we are working out on exactly what time this vote might occur.

But I have just filed a cloture motion on the motion to proceed to H.R. 3396. Under rule XXII, the cloture vote will occur—we will either have this occur on Monday or agree to a time on Tuesday. I believe we are going to agree to a time on Tuesday when this vote will occur. So I think we are getting cooperation on that.

If we continue to work toward an agreement on the VA-HUD appropriations bill, and go ahead and get started next on the Interior appropriations bill, then we would probably have this vote on Tuesday morning around 10 o'clock. But we will make that official later on.

I now withdraw the motion to proceed.

Mr. DASCHLE addressed the Chair.

The PRESIDING OFFICER. The motion is withdrawn.

The Democratic leader.

Mr. DASCHLE. I just wanted to take a moment to explain that it is not our desire necessarily to hold up this piece of legislation. There is support on our side as well. Unfortunately, the majority leader has not been able to work out an agreement with us to accommodate a number of Senators on our side who wish to offer amendments. It was for that reason that I objected tonight.

Obviously, we will have a good debate about the bill. It will be my hope we could offer amendments, but at least at this time it does not appear to be likely. We will continue to work together and try to find a way to resolve these issues, but at least tonight that has not been resolved.

I yield the floor.

Mr. LOTT. I yield the floor, Mr. President.

DEPARTMENTS OF VETERANS AFFAIRS AND HOUSING AND URBAN DEVELOPMENT, AND INDEPENDENT AGENCIES APPROPRIATIONS ACT, 1997

The Senate continued with the consideration of the bill.

Mr. DOMENICI addressed the Chair.

The PRESIDING OFFICER. The Senator from New Mexico.

Mr. DOMENICI. Mr. President, while the distinguished majority leader is here, I would just like to state I think Senator GRAMM is going to offer an amendment which I will accept, and then we will vote on the Domenici-Wellstone amendment as amended by the Gramm amendment.

AMENDMENT NO. 5196 TO AMENDMENT NO. 5194

Mr. GRAMM addressed the Chair.

The PRESIDING OFFICER. The Senator from Texas.

Mr. GRAMM. I send an amendment to the desk and ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows.

The Senator from Texas [Mr. GRAMM] proposes an amendment numbered 5196 to amendment No. 5194.

Mr. DOMENICI. Could we have order, Mr. President.

The PRESIDING OFFICER. The Senator will suspend.

The Senate is not in order. Senators will take their conversations to the cloakroom, please, so the Senator from Texas can be heard.

The Senator from Texas.

Mr. GRAMM. Mr. President, it is a very short amendment. It will minimize the debate if we just have it read.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

At the appropriate place in the amendment, insert the following: Notwithstanding the provisions of this title, if the provisions of this title result in a one percent or greater increase in the cost of a group health plan's premiums, the purchaser is exempt from the provisions of this title.

Mr. GRAMM. Mr. President, this amendment says that if Senator DOMENICI is wrong, and there are more than de minimis costs in expanding this coverage, and those costs exceed 1 percent, then the purchaser of that policy would be exempt.

I think this is a good stopgap measure. If the Senator is right and this coverage can be provided for one-sixth of 1 percent, then it will be provided. If it raises the cost of the policy more than 1 percent, the purchaser of the policy would be exempt.

I think it does improve the underlying amendment, and I am grateful the Senator has accepted it.

Mr. DOMENICI addressed the Chair.

The PRESIDING OFFICER. The Senator from New Mexico.

Mr. DOMENICI. Mr. President, consistent with everything I knew when I brought the amendment to the floor,



Bringing lifetimes of experience and leadership to serve all generations.

October 6, 1996

Dear Colleague:

Since passage of the Omnibus Budget Reconciliation Act of 1993 (OBRA '93), Congress has required states to try to recover the cost of Medicaid benefits from the estates of certain nursing home residents and older persons receiving home and community-based services. Prior federal law allowed, but did not require states to make such recovery.

This report examines how states have implemented the estate recovery mandate of OBRA '93. *Medicaid Estate Recovery: A Survey of State Programs and Practices* summarizes survey results from state officials and advocates on the scope of estate recovery, enforcement issues, hardship waivers, notice provisions, and the impact of estate recovery programs on low and moderate income families. The goal is to assist policy makers as they try to implement OBRA '93.

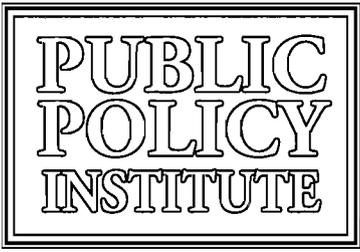
We hope that you will find this report of interest in light of the challenge states face in implementing this law. For further information, or to obtain additional copies of this report, please call the Long-Term Care and Public benefits Team, (202) 434-3860.

Sincerely,

A handwritten signature in cursive script that reads "Jane Tilly".

Jane Tilly
Manager
Long-Term Care and Public Benefits Policy Research





#9615
September 1996

**Medicaid Estate Recovery:
A Survey of
State Programs and Practices**

by

Charles P. Sabatino and Erica Wood



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The Public Policy Institute, formed in 1985, is part of the Division of Legislation and Public Policy of the American Association of Retired Persons. One of the missions of the Institute is to foster research and analysis on public policy issues of interest to older Americans. This paper represents part of that effort.

The views expressed herein are for information, debate, and discussion, and do not necessarily represent formal policies of the Association.

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AARP, 601 E Street, N.W., Washington, DC 20049



Foreword

Costs of the Medicaid program more than doubled between 1988 and 1992. A significant portion of that increase can be attributed to the cost of long-term care and the increasing number of individuals who depend on Medicaid to pay for it. In 1992, 68 percent of the residents in long-term care facilities had their care at least partially financed by Medicaid.

Faced with an escalating Medicaid budget, Congress enacted rules in the Omnibus Budget Reconciliation Act of 1993 (OBRA '93) that require states to seek recovery of Medicaid costs from the estates of certain Medicaid beneficiaries. Prior federal law allowed, but did not require, states to make such recovery. While OBRA '93 gives states some discretion in how they design estate recovery programs, it requires all states to have estate recovery programs in place no later than April 1, 1995.

How states have implemented (or failed to implement) the estate recovery mandate of OBRA '93 is the subject of this report. The goal is to provide policy makers and administrators with key information on variations in state law and practice. To that end, this report was commissioned by the Long-Term Care and Public Benefits Team of the Public Policy Institute of the American Association of Retired Persons (AARP), and prepared by Charles Sabatino and Erica Wood of the American Bar Association Commission on Legal Problems of the Elderly. AARP believes that as states move toward compliance with federal law, they should consider cost-effectiveness, fair implementation, and the effect of estate recovery on low and moderate income nursing home residents and their families. As policy makers look for ways to further reduce the cost of Medicaid programs, estate recovery will become and even more important issue. AARP believes it is useful to develop a clear picture of how states are implementing the current law before any legislative changes are undertaken.

Faith Mullen, Esquire
Senior Policy Analyst
Public Policy Institute

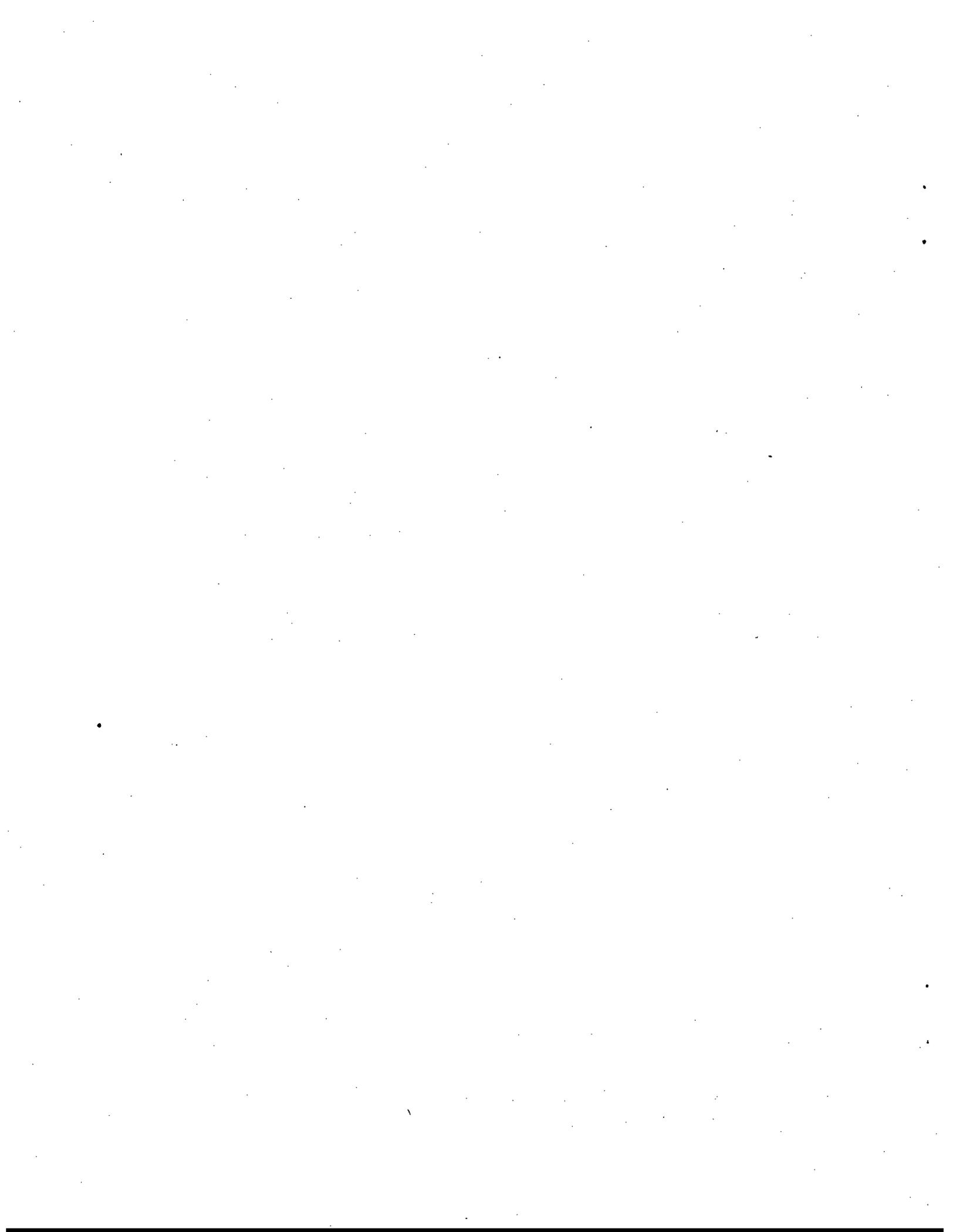


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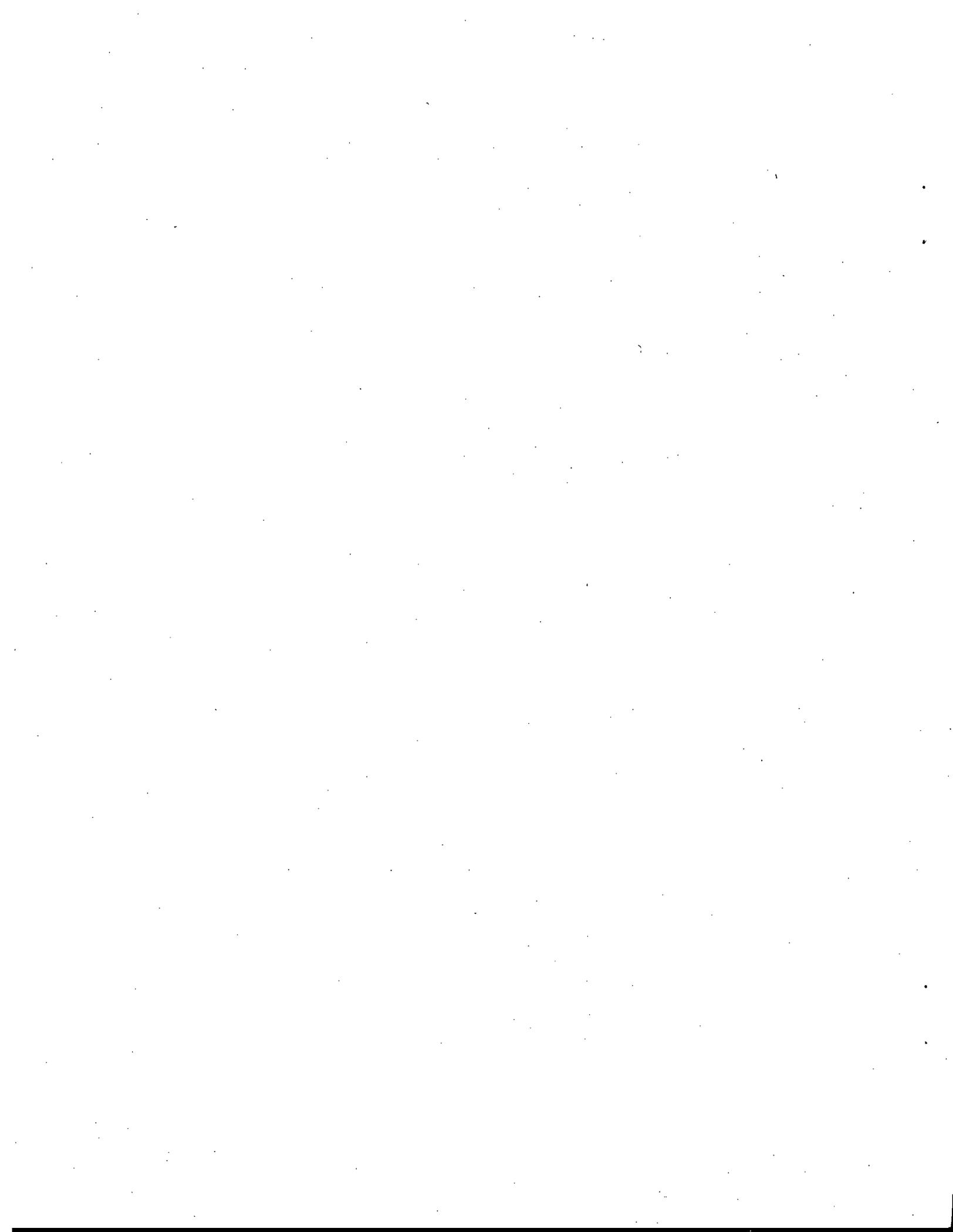
Acknowledgments

We are grateful to the state officials who completed questionnaires on their estate recovery programs, sent accompanying materials and patiently responded to our follow-up questions. We also appreciate the time and effort of the legal practitioners who responded to our survey.

Additionally, we thank those who reviewed earlier drafts of this work. Reviewers included Brian Burwell, The Medstat Group; Patricia Nemore, National Senior Citizens Law Center; Phillip Otto and Ingrid Osborne, Medicaid Bureau, Health Care Financing Administration; and Howard Bedlin and Mike Schuster at AARP.

This study of Medicaid estate recovery was conducted under a letter of agreement with the Public Policy Institute of the American Association of Retired Persons. We thank AARP for making funds available. Faith Mullen, Project Officer, was helpful and supportive throughout the project.

Charles P. Sabatino, Esquire
Erica Wood, Esquire
American Bar Association Commission on Legal Problems of the
Elderly



Medicaid Estate Recovery: A Survey of State Programs and Practices

Executive Summary

Background and Purpose

In 1993, Congress mandated that states implement estate recovery programs to recoup the costs of long-term care and related Medicaid services. In response, states have initiated efforts to recover funds from the estates of designated beneficiaries. However, this effort is still in its formative stages. As programs are developed and reassessed, it will be essential for states to examine their efficiency, cost-effectiveness, fair implementation, and impact on particular populations. To assist in this effort, the American Bar Association Commission on Legal Problems of the Elderly surveyed the state Medicaid estate recovery programs on behalf of AARP's Public Policy Institute. This report presents the survey findings.

Methodology

The survey was conducted during the period from November 1995 through February 1996. The survey was two-pronged. It targeted both state Medicaid officials and legal practitioners, to provide a complete picture of the operation of the recovery programs. A 35-question survey instrument was sent to key Medicaid officials in each state. **A total of 43 states (84%) responded to the survey.** States not responding were: Alabama, the District of Columbia, Massachusetts, Mississippi, Missouri, Oklahoma, Tennessee, and Texas.

The Commission designed a similar 27-question survey instrument for a legal practitioner in each state identified as an expert in Medicaid. **A total of 49 practitioners (96%) responded to the survey.** States not responding were Mississippi and Utah.

Findings

The picture that emerges from these survey results is that Medicaid estate recovery programs remain in a state of great flux as of the beginning of 1996. While only five states still have no program operational (Alaska, Georgia, Michigan, Tennessee, and Texas), many other states have programs operational only at a very rudimentary level. Eleven states reported that they have legislative changes pending; 19 states have no regulations in effect; and of these, twelve have regulations pending. The survey results of these programs include the following highlights:

Scope of Estate Recovery

- More than half of the responding state officials (24 of 43) stated that they recover in full for all services permissible under OBRA '93 and not just the minimum required. All the remaining states recover for at least one or more optional services.

- In states with operational programs, the scope of the estate liable for recovery is quite variable and often unclear. Of the 43 states responding to the survey, nineteen limit recovery to the "probate estate" (i.e., property owned by the individual that passes after death under a will or by intestate succession). This is a limited but fairly clear scope of recovery. States that have chosen to go beyond the probate estate most frequently target property held jointly with right of survivorship, especially residential property, since that is the most substantial asset a Medicaid beneficiary may retain. Nine states reported seeking recovery against life estate interests in real or personal property.

- Since recovery against real property may be delayed for years, there is some concern that state claims may cause problems in conveying property (e.g., because of "hidden claims"). While significant concerns were noted in a few states, the majority of officials and practitioners did not see this as problematic.

- Most states, including those that restrict recovery to the probate estate, seek recovery against personal property of the beneficiary, including bank accounts or other small cash funds that are considered exempt during the beneficiary's lifetime. State procedures and their aggressiveness in reaching these funds is variable.

- Several states set either minimum estate values (16 states) or minimum claim levels (15 states), below which they do not seek recovery. These thresholds span a broad range, from as little as \$50 to more than \$50,000.

- An overall incongruence between survey responses from state officials and practitioners indicates a substantial lack of clarity and understanding about the reach of estate recovery in the states.

Enforcement of Estate Recovery

- State policies and procedures on enforcement of estate recovery vary substantially from state to state. All responding states reported either waiving or deferring estate recovery when the beneficiary is survived by a spouse or minor or disabled child. In these situations, the Tax Equity and Fiscal Responsibility Act (TEFRA '82) requires deferral at a minimum. Some states used waivers where deferral might extend for an impractically long time, for example, when the survivor is a minor or disabled child who is likely to live for decades.

- Some states may not be complying with the OBRA '93 prohibition of recovery against a beneficiary's estate until after the death of any surviving spouse or a disabled child, or until a non-disabled child reaches age 21. The language includes no requirement that the survivor live in the home of the deceased beneficiary, yet some states responded that they required residency in the home as a prerequisite to deferral.

- The use of liens varies quite significantly among the states. Twenty-eight states responded that they use liens, and 15 of these use TEFRA or pre-death liens on the homes of permanently institutionalized individuals. Lien practices are, and may continue to be, in a state of flux.

- In those states that currently use pre-death TEFRA liens, there is concern that procedures for terminating liens on the property of institutionalized beneficiaries when they return home, as required by federal law, may be inadequate.

- Another concern regarding the use of liens is the extent to which a lien on property held by a survivor creates an undue burden on the survivor. Some practitioners noted that for a surviving spouse with few assets other than the home, a lien on that home can drastically limit the spouse's options for financial survival. However, the extent to which this may be a problem requires further research.

Permanent Institutionalization

- The states that place TEFRA liens on the homes of living permanently institutionalized beneficiaries base their determination of "permanent institutionalization" on one or more of four elements — the person's intent to return home, a physician's statement, an assessment by a third party, and the length of the institutional stay.

- Some states fail to track the number of such determinations.

Hardship Waivers

- Twenty-eight states reported having criteria for determining the existence of undue hardship, and eight reported that such criteria were not yet established. The survey findings fall into six broad categories of undue hardship criteria, focusing on: (1) estates consisting of income-producing property needed by the survivors, (2) estates consisting of the primary residence of the survivors; (3) homesteads of modest value; (4) the potential for forcing or keeping survivors on public assistance or medical assistance; (5) the potential deprivation of survivors' necessities; and (6) contributions made by survivors to the beneficiary's care and support. A variety of other criteria that did not fit neatly into any of these categories also appeared, including the catch-all "other compelling circumstances."

- Some states are quite specific about the income or asset criteria survivors must meet, while others describe their criteria only in terms of "factors" to be considered without sharply defining the threshold for undue hardship.

- When states make a finding of undue hardship, most use a repertoire of responses including waiving recovery, deferring recovery, or working out a modified recovery agreement with survivors. A question that arises is whether the statutory mandate permits the latter two options, since the OBRA '93 language refers only to waivers.

- The survey found little indication of within-state variation of enforcement practices, except in two jurisdictions where recovery was delegated to local agencies.

- Some states fail to track the frequency of hardship waivers.

Notice Provisions

- The states vary significantly in points in time at which they give a notice and information about estate recovery. All responding states give the required general notice at application for Medicaid benefits. Where a judicial claim is filed, all states provide service of notice as is routinely required under court rules. However, states differ widely in providing notice at intermediate points in time including: nursing home admission, determination of permanent institutionalization, receipt of home and community-based services, lien placement, and lien enforcement. For example, only half of the states using liens reported giving notice at the time of enforcement of a lien.

- A substantial number of states currently do not provide the required notice of the availability of hardship waivers. Fifteen of 40 respondents (officials and practitioners aggregated) reported that they do not give such notice, or they are in the process of developing notice of the availability of hardship waivers.

- Practitioners reported that estate recovery notices may be incomplete, inaccurate, or difficult to understand.

Impact of Estate Recovery Programs

- While the revenue generated by the program differs markedly among states, the aggregate revenue figures are modest compared with the overall Medicaid budget, but on target with original Congressional Budget Office estimates for OBRA '93. Policy makers must continue to assess whether the administrative effort is worth this financial outcome and worth the additional burden it places on the families of beneficiaries.

- Officials and practitioners surveyed were in agreement that the group most affected by the recovery programs were those who spent down their assets on medical care, and generally not those who engaged in Medicaid estate planning.

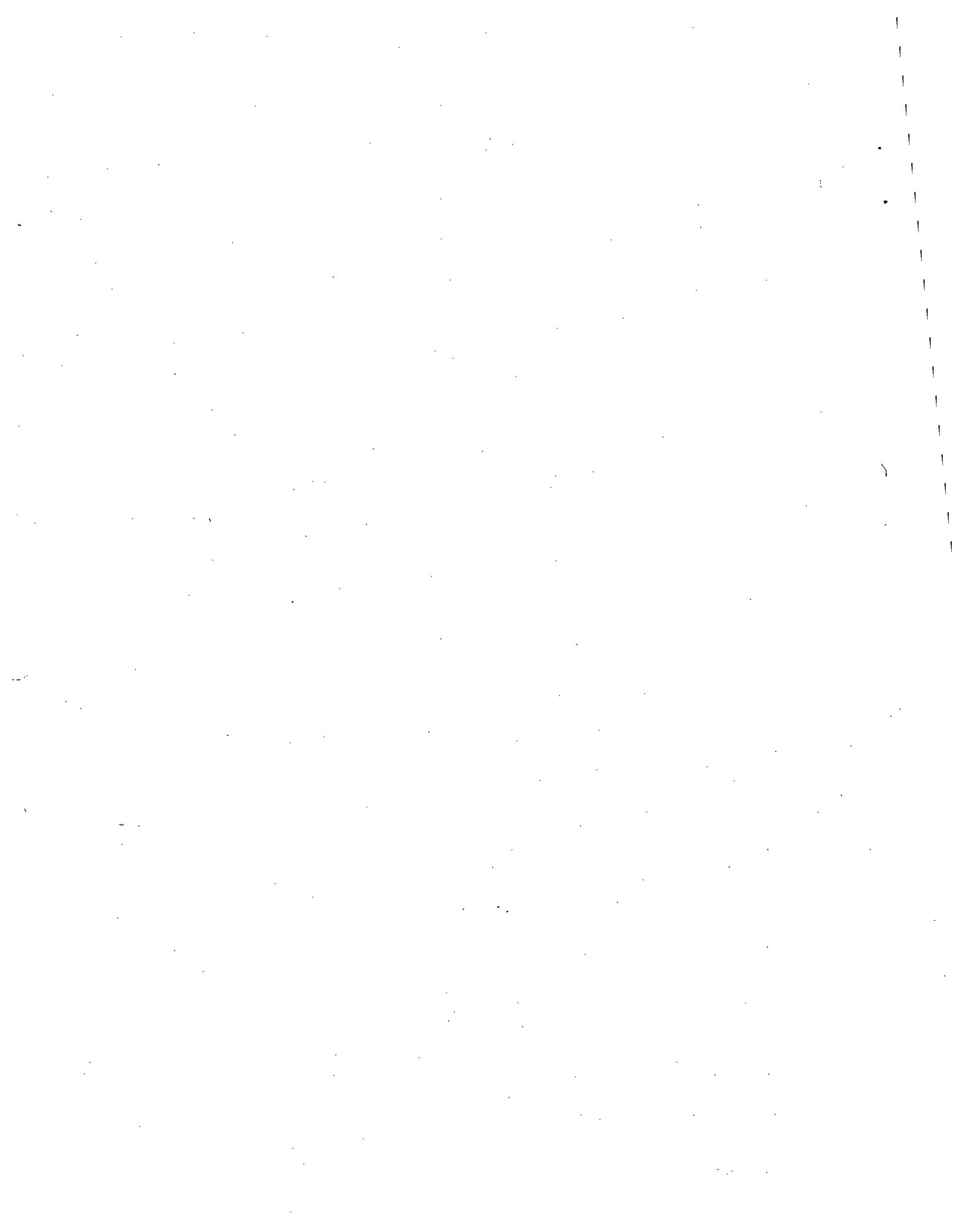
- Respondents differed as to the impact of recovery specifically on older poor persons, with many perceiving little impact. However, some respondents observed a possible chilling effect on the application for benefits for institutional and home- and community-based services.

- Respondents were in general agreement in their view that Medicaid estate recovery programs do not deter planning. This perception, however, needs to be substantiated with further research.

- A majority of responding officials predicted that the estate recovery program would not change significantly if Medicaid is converted to a block grant. Practitioners were more likely to predict the program would expand.

Conclusion

Since OBRA '93, Medicaid estate recovery programs have been undergoing rapid change. The survey provides a snapshot of current law and practices, set against a bigger picture of possible large-scale changes in the Medicaid program. As states assess their estate recovery efforts, it will be important to examine technical compliance with applicable law, financial impact, fair implementation, and impact on particular populations. This survey aims to contribute to that evaluation.



Medicaid Estate Recovery: A Survey of State Programs and Practices

I. Background

Introduction

A needy nursing home resident with Alzheimer's disease, a young person with mental retardation in an intermediate care facility, an older middle-income nursing home resident who has "spent down" private resources, a couple receiving home- and community-based care under a state "waiver" program — all may be beneficiaries of the federal-state Medicaid program. Medicaid is the main source of public funds for long-term care in the United States, and is jointly financed by the federal government and the states. Medicaid pays for over half of the nation's total nursing home care (52 percent) and 13 percent of all home health spending.¹

Who is eligible for Medicaid? Eligibility varies widely among the states, based on different state income and asset requirements. Most older people who are eligible for Supplemental Security Income are also eligible for Medicaid. To become eligible for Medicaid under SSI in 1996, an individual can have no more than \$470 in monthly income and \$2,000 in countable assets. For a couple, the figures are \$705 per month and \$3000 in assets. Most states have more liberal income requirements for people needing nursing home care, and for certain home- and community-based services. Also, many states chose to cover people with high medical costs who need long-term care — the "medically needy." In 1993, Medicaid paid for about 1.6 million beneficiaries in nursing homes, and 1.1 million who received home health services. While 3.7 million (11.5%) of all Medicaid beneficiaries were age 65 or over in 1993, aged beneficiaries accounted for 28.4% of all Medicaid expenditures.²

The costs of the Medicaid program have risen dramatically, with expenditures more than doubling from 1988 (\$51.6 billion) to 1992 (\$115.5 billion) and reaching \$137.6 billion by 1994. In 1993 Congress mandated that states implement an estate recovery program to recoup some of the costs of long-term care and related Medicaid services. In response, states have initiated legislative, regulatory and programmatic efforts to recover funds from the estates

1 The Kaiser Commission on the Future of Medicaid, "Medicaid Facts," December 1995.

2 AARP Public Policy Institute, "Medicaid and Long-Term Care for Older People," Fact Sheet N. 18R, 1995.

of designated beneficiaries. This recent state activity is set against a backdrop of possible broad-based changes in the Medicaid program. Current discussions underway at the federal level may result in loosening federal restrictions on state Medicaid programs, as well as reducing funding levels to meet budgetary constraints.

Because of these recent and anticipated changes, Medicaid estate recovery programs are in a state of flux. As programs are reassessed, it will be essential for states to examine their efficiency, cost-effectiveness, fair implementation, and impact on particular populations. Policy makers have an opportunity to re-think program goals and procedures to ensure they are equitable and that they accomplish the intended ends. To assist in this effort, the American Bar Association Commission on Legal Problems of the Elderly surveyed the state Medicaid estate recovery programs on behalf of AARP's Public Policy Institute. This report presents the survey findings.

Legislative Overview

Federal Law Prior to OBRA 1993

Medicaid law has always provided limited authority for states to recoup the cost of Medicaid benefits paid to beneficiaries. The original act permitted recovery of benefits correctly paid only in the case of individuals who were 65 or over when they received benefits, and then only after the death of any surviving spouse and when there were no dependent or disabled children.³ Lifetime liens were prohibited, except in the case of benefits incorrectly paid and for which a court judgment was obtained.

Substantial changes to the rules were made by the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982, codified in the first iteration of 42 U.S.C. §1396p, entitled "Liens, Adjustments and Recoveries and Transfers of Assets." The TEFRA lien rules are still good law today, but it is important to understand that the TEFRA rules apply only to liens imposed on real property during the lifetime of a beneficiary and to the enforcement of those liens. The TEFRA rules permit imposition of a lien when a court determines that benefits have been paid incorrectly (in which case, any of the recipient's property can be attached). The TEFRA rules also permit imposition of a lien for benefits correctly paid when (1) a nursing home resident pays a share of the cost, and (2) after notice and an opportunity for a hearing, the state determines the resident is not reasonably expected to return home (in which case, the home may be attached).⁴ A lien may

³ 42 U.S.C. §1396a(a)(18), included in Pub. L. 89-97 (1965).

⁴ 42 U.S.C. §1396p(a)(1)(A) and (B); 42 C.F.R. 433.36(g).

not be imposed on an individual's home, however, for payments correctly made if any of the following individuals reside in the home: the recipient's spouse, minor child, blind or disabled child, or sibling who has an equity interest in the home and has resided there lawfully for a year or more.⁵ Even these liens must be dissolved if the recipient returns home.⁶

Prior to 1993, Medicaid law also allowed, but did not require, a state agency to make a claim against the estate of individuals if they were 65 years of age or over or if their property was subject to a lien as described in the previous paragraph.⁷ Payments could only be recouped after the death of a surviving spouse and only when the beneficiary was not survived by a minor child or a blind or disabled child.⁸ In addition, a lien on a home could not be enforced as long as the home was occupied by a sibling or an adult child who established that he or she resided in the home for the period prior to the recipient's admission to the nursing home and in the case of an adult child, that he or she provided care allowing the person to remain at home longer.⁹

As of October 1, 1993, 28 states had Medicaid estate recovery laws. According to the Health Care Financing Administration, in fiscal 1992, approximately \$63 million was recovered under these programs in 26 states.

⁵ 42 U.S.C. §139(p)(a)(2); 42 C.F.R. 433.36(g)(3).

⁶ 42 U.S.C. §1396(p)(3).

⁷ 42 U.S.C. § 1396p(b)(1); 42 C.F.R. 433.36(h)(1). It is important to distinguish between the concepts of "lien" and "claim" in order to understand the limitations in the law. In its simplest form, a "lien" merely secures a right to enforce a charge against some property. All that may be required is the filing of a lien notice in the county recorder's office. In itself, a lien does not trigger any process for seeking actual recovery of the charge or debt. A "claim" actually triggers the process of seeking possession of the property or satisfaction of a debt. Usually, the process involves filing of a judicial action or submitting a claim as part of probate proceedings. A claim is not always required to enforce a lien. The lien may be satisfied voluntarily or by necessity. For example, it may be impossible to transfer title to a home unless a lien is satisfied.

⁸ 42 U.S.C. § 1396p(b)(2).

⁹ 42 U.S.C. § 1396p(b)(2)(B); 42 C.F.R. 433.36(h)(2).

OBRA 1993 Changes

In the Omnibus Budget Reconciliation Act of 1993 (OBRA), Congress mandated that states should seek recovery from estates of the following individuals:¹⁰

1. Individuals in nursing facilities, intermediate care facilities for the mentally retarded, or other medical institutions who pay a share of cost as a condition of receiving Medicaid and who cannot reasonably be expected to be discharged and return home. This provision references the non-mandatory lien provision (42 U.S. § 1396p) and requires that the state determine, after notice and hearing, that the individual cannot reasonably be expected to return home.
2. Individuals, who were age 55 or over when they received Medicaid. The state must recover only for payments made for nursing facility services, home- and community-based services, and "related hospital and prescription drug services."¹¹
3. Individuals who received Medicaid by having additional resources disregarded in connection with receipt of benefits under a long-term care insurance policy. The state must seek recovery for benefits paid for nursing facility and "other long-term care services." Exempted from this category are those who received Medicaid services under a state plan amendment approved as of May 14, 1993. (They are residents of California, New York, Iowa, Indiana, and Connecticut.)

The amendments also provide that the state may recover from individuals 55 or older payments for any items or services covered under the state Medicaid plan and received after age 55.¹²

The new law requires states to establish procedures for determining when to waive recovery due to hardship. These procedures must be established "in

¹⁰ P.L. No. 103-6, § 13612, amending 42 U.S.C. § 1396p(b).

¹¹ The change in the new law from age 65 to 55 (42 U.S.C. § 1396p(b)(1)(B)) did not appear in either the House or Senate versions of P.L. 103-66, and is not discussed in the Conference Report. Thus, there is some speculation that this age change in the new law is in error.

¹² 42 U.S.C. § 1396p(b)(1)(B)(ii).

accordance with standards specified by the Secretary” of HHS, and criteria upon which hardship would be determined are also to be established by HHS.¹³

The House Report accompanying the estate recovery amendments provides in this regard that, in developing hardship standards, HHS must address: (1) adequacy of notice to, and representation of, affected parties; (2) the timeliness of the process; and (3) the availability of appeals.¹⁴ With respect to establishing criteria for states to apply in determining whether to waive recovery, the Report states that the Secretary should provide for special consideration of cases in which the estate subject to recovery is: (1) the sole income-producing asset of survivors; such as a family farm or other family business; (2) a homestead of modest value; or (3) cases in which there are other compelling circumstances.¹⁵

The OBRA '93 estate recovery amendments also provide a specific definition of the term “estate.” It is defined to include “all real and personal property and other assets included within the individual’s estate, as defined for purposes of state probate law.” The state has the option, however, to expand this definition to include:

any other real and personal property and other assets in which the individual had any legal title or interest at the time of death (to the extent of such interest), including such assets conveyed to a survivor, heir, or assign of the deceased individual through joint tenancy, tenancy in common, survivorship, life estate, living trust, or other arrangement.¹⁶

OBRA 1993’s estate recovery amendments apply to Medicaid payments made on or after October 1, 1993,¹⁷ regardless whether HCFA has promulgated regulations. They do not apply, however to individuals who have died before that date.¹⁸ States can delay implementation if they require state legislation. They had until the first quarter following the close of the first legislative session that begins

¹³ 42 U.S.C. § 1396p(b)(3).

¹⁴ H. Rep. No. 111, 103rd Cong, 1st Sess. (1993), at 209; found in 1993 U.S.C.C.A.N. 536.

¹⁵ *Id.*

¹⁶ 42 U.S.C. § 1396p(b)(4)(B).

¹⁷ § 13612(d)(1)(A) of P.L. 103-66.

¹⁸ § 13612(d)(2) of P.L. 103-66.

after October 1, 1993.¹⁹ This translates into a latest possible deadline of April 1, 1995.

HCFA has not promulgated any estate recovery regulations as of this writing. Instead, it issued implementing guidelines through a HCFA State Medicaid Manual transmittal, known as Transmittal No. 63, "New Implementing Instruction on Estate Recovery," dated September 1994.

Survey Procedure

With the support of the AARP Public Policy Institute, the American Bar Association Commission on Legal Problems of the Elderly conducted a nationwide survey of state Medicaid estate recovery programs and practices. The survey was conducted during the period from November 1995 through February 1996. The aim of the survey was to provide federal and state policy makers with key information on four issues: (1) technical compliance with applicable federal law; (2) variation of practices; (3) financial impact on state Medicaid budgets; and (4) any adverse and inequitable consequences of estate recovery on subgroups of beneficiaries and on the administration of the Medicaid program.

The survey was two-pronged. It targeted both state Medicaid officials and legal practitioners, to provide a complete picture of the operation of the recovery programs. First, the Commission designed a 35-question survey instrument for state Medicaid officials (APPENDIX A). The Commission identified a responsible Medicaid official in each state through contacts with the federal HHS Health Care Financing Administration's Medicaid Bureau. In cases where no state contact was identified, the survey was sent directly to the director of the state Medicaid agency. An accompanying letter from the Director of the HCFA Medicaid Bureau urged states to respond, to build a body of information useful to policy makers in assessing estate recovery programs and practices. **A total of 43 states (84%) responded to the survey.** States not responding were: Alabama, the District of Columbia, Massachusetts, Mississippi, Missouri, Oklahoma, Tennessee and Texas.

The second prong of the survey sought to elicit an additional perspective. The Commission designed a similar 27-question survey instrument for legal practitioners (APPENDIX B). The Commission identified a knowledgeable legal practitioner in each state through contacts with state bar association elder law committees and sections, state legal assistance developers for the elderly in state units on aging, and members of the National Academy of Elder Law Attorneys. **A total of 49 practitioners (96%) responded to the survey.** States not responding were Mississippi and Utah.

¹⁹ § 13612 (d)(1)(B) of P.L. 103-66.

II. Survey Findings

Status of Estate Recovery Programs

Programs in Existence

Medicaid officials from 39 of the 43 responding states reported having a Medicaid estate recovery program in operation. Three states (Alaska, Georgia, Michigan) reported no program operating as of the end of 1995. North Carolina has enacted enabling legislation and has regulations pending. (Note: While the Texas and Tennessee officials did not respond to the survey, neither state had a program in operation as of early 1996).²⁰ Thus, these five states are out of compliance with federal law because they have not yet implemented a program. Louisiana currently is in the process of implementing a program.

Of the programs operating, the oldest was Oregon's, dating back to 1947. Three of the state programs began in the 1960s, three in the 1970s, and seven in the 1980s. The remainder of the programs were initiated since 1990. Of the 20 programs begun since 1990, one started in 1991, four in 1992, two in 1993, ten in 1994 and five in 1995. (See TABLE 1.)

Estate Recovery Legislation and Regulations

In the Omnibus Budget Reconciliation Act of 1993 (OBRA '93), Congress expanded and mandated recovery that had been authorized since 1965. Although more than half the states had estate recovery programs before 1993, the new OBRA requirements created an impetus for legislative and regulatory changes in most jurisdictions.

The ABA survey found that 32 of the 43 responding states had enacted legislation since the passage of OBRA '93. In addition, 11 states had legislation currently pending. The pending legislation would accomplish three purposes. It would:

- Bring states into compliance with OBRA '93 (e.g., by adding hardship provisions, or changing the age reference to 55);
- Expand recovery as authorized by OBRA '93 (e.g., by imposing liens, extending the definition of estate); and
- Enact provisions to facilitate the recovery process (e.g., tracking the death of Medicaid recipients, excluding the state from statutes of limitations for probate estates, directing the promulgation of regulations).

²⁰ Interview with Phil Otto, HCFA Medicaid Bureau, May 1996. (Practitioners from both Texas and Tennessee responded. The Texas practitioner reported no program in operation. In Tennessee, the practitioner's response was based on initial state efforts to implement a program.)

TABLE 1 - STATUS OF ESTATE RECOVERY PROGRAMS AS OF JANUARY 1996

State	Have Est. Rec. Program?	Date Started	Legis. Enacted post-OBRA?	Legis. Pending?	Current Regs?	Pending Regs?
AK	N	Pending	Y	N		N
AL						
AR	Y	1993	N	N	N	Y
AZ	Y	1994	N	N	Y	Y
CA	Y	1981	Y	N	Y	Y
CO	Y	1992	Y	Y	Y	N
CT	Y	Early 19980's	N	N	Y	N
DC						
DE	Y	1995	Y	Y		Y
FL	Y	1993	N	Y	N	N
GA	N		N	N	N	N
HI	Y	1972	Y	N	Y	Y
IA	Y	1994	N	N	Y	N
ID	Y	1988	Y	Y	Y	Y
IL	Y	1965	Y	Y	Y	Y
IN	Y	1992	N	N	Y	Y
KS	Y	1992	N	N	Y	N
KY	Y	1994	Y	N	Y	N
LA	Y	Pending	Y	N	N	Y
MA						
MD	Y	1976	N	Y	Y	N
ME	Y	1993	Y	N	Y	N
MI	N		Y	Y	N	N
MN	Y	1967	Y		N	N
MO						
MS						
MT	Y	1953	Y	N	N	Y
NC	N	Pending	Y	N	N	Y
ND	Y	1966	Y	N	N	N
NE	Y	1994	Y	Y	N	N
NH	Y		Y	N	N	N
NJ	Y	1970	N	Y	Y	Y
NM	Y	1995	Y	N	Y	N
NV	Y	1994	Y	N	Y	N
NY	Y	1992	Y	Y	Y	Y
OH	Y	1995	Y	N	N	N
OK						
OR	Y	1947	Y	N	N	N
PA	Y	1995	Y	N	N	Y
RI	Y	1982	Y	N	Y	Y
SC	Y	1994	Y	N	N	N
SD	Y	1994	Y	N	Y	N
TN						
TX						
UT	Y	1984	Y	N	N	N
VA	Y	1984	Y	N	N	N
VT	Y	1994	N	N	Y	N
WA	Y	1987	Y	Y	Y	Y
WI	Y	1991	Y	N	Y	N
WV	Y	1995	Y	N	Y	N
WY	Y	1994	Y	N	Y	N

Source: ABA Commission On Legal Problems Of The Elderly. Analysis Of 1996 State Survey.

Proposed legislation in some states has been the subject of controversy. For example, in Massachusetts, a bill to expand recovery to the maximum extent permitted by federal law drew opposition from title companies, estate planners, and organized bar groups. The bill that eventually passed was more limited than originally envisioned. In New Mexico, a 1996 bill to repeal estate recovery passed the legislature, but then was vetoed by the Governor.

Of the 43 responding states, 24 reported regulations currently in effect, and 19 reported no regulations in effect. Of the 19, twelve had regulations pending, and seven had no rulemaking process underway. In addition, four states with existing regulations had additional regulations pending, bringing the number of states with pending regulations to 16. (See TABLE 1.) Proposed rules addressed matters such as procedures for the program as a whole; and specific areas such as the age 55 reference, hardship provisions, and exceptions to liens and claims. The proposed rules in one state, Hawaii, are part of a larger proposal to implement a statewide Medicaid managed care program.

Program Operation

The vast majority of the states (38 states) reported that the estate recovery program is operated by a state agency, such as the designated Medicaid agency. In Ohio, the program is run by the Attorney General's office. In Minnesota and New York, local agencies are responsible for estate recovery.

Some states enter into contractual arrangements with private contractors to perform third party liability recovery activities. The scope of work for such contractors may vary. For example, an earlier study reported that the Colorado program was designed to use contract personnel, in accordance with the terms of the state legislative appropriation. The state awarded a fixed fee contract to the lowest acceptable bidder to handle recovery and the filing of "TEFRA liens" (see pages 25-26 regarding TEFRA liens), but the state retains responsibility for monitoring the program.²¹ The ABA survey found that five states contract with a private entity to operate their estate recovery program (Arizona, Colorado, Florida, Iowa, West Virginia). In Florida, activities have been contracted with a private attorney since 1994, and the state was seeking contractors through a competitive bidding process at the time of the survey. In addition, Montana was in the process of obtaining a contractor. In Hawaii, a contractor has been retained to pursue TEFRA liens.

²¹ American Public Welfare Association. Medicaid Management Insurance in collaboration with U.S. Department of Health and Human Services Health Care Financing Administration. Medicaid Bureau. Estate Recovery Reference Guide, October 1994.

Scope of Estate Recovery

Services Recoverable

The OBRA '93 estate recovery provisions mandated states to seek recovery for payments made for nursing facility services, home- and community-based services and "related hospital and prescription drug services." States must recover from the estates of individuals who were age 55 and over when they received the services. In addition, at their option, states can choose to recover for any other items or services under the state Medicaid plan, as long as the services were received at age 55 or thereafter.

To determine the scope of services for which state programs seek recovery, the survey asked both Medicaid officials and legal practitioners whether each of the following services is recoverable in whole or in part: nursing facility services, intermediate care facilities for the mentally retarded, home- and community-based services, hospital services, prescription drug services, physician services and any other services. The results are summarized in TABLE 2. A total of 24 Medicaid officials and 16 practitioners said the state recovers in full for all of these services. (States in which no program is operating or is just getting underway — Arkansas, Georgia, Louisiana, Michigan, Texas — did not respond to this portion.) The discrepancy between the answers of the officials and the practitioners suggests the scope of services recoverable in practice may not be fully understood in the legal community.

Nursing Facility Services. All of the responding Medicaid officials with programs currently in operation indicated that their state seeks recovery for nursing facility services, up to the total amount spent on the individual's behalf, as required by federal law. The legal practitioners echoed this, reporting full recovery of such services, except that North Carolina indicated that for nursing facility services (as well as other services listed below) recovery is only for "an equitable portion" as per state statute.²²

Intermediate Care Facilities for the Mentally Retarded (ICF/-MR). Recovery for services of intermediate care facilities for the mentally retarded is not required by OBRA '93. Although wording in HCFA Transmittal No. 63 defines nursing facility services as including such institutions, the statutory definition of "nursing facility" in the Medicaid law does not.²³ Thus, recovery of ICF/MR costs is optional for persons age 55 and older. Thirty-seven responding Medicaid officials said their state recovers for ICF/MR services, while two states did not show recovery. One state, Nebraska, noted that no payments for ICF/MR services have been recovered to date.

²² NCGS 108A-5(a).

²³ 42 U.S.C. Sec. 1396d(f).

TABLE 2
SERVICES RECOVERABLE UNDER ESTATE RECOVERY PROGRAMS AS OF 1/1/96

(State Medicaid Officials' Responses)

● = All such services are recoverable ○ = Part of such services are recoverable

State	Nursing Facility Services	ICF-MR	Home & Comm-based Care	Hospital & Prescription Drug	Physician Services	Other Services
AK						
AL						
AR	●	●	●	●	●	●
AZ	●	●	●	●	●	●
CA	●	●	●	●	●	●
CO	●	●	●	●	●	●
CT	●	●	●	●	●	●
DC						
DE	●	●	●	●	●	●
FL	●	●	●	●	●	●
GA						
HI	●	●	●	●	●	●
IA	●	●	●	●	●	●
ID	●	●	●	●	●	●
IL	●	●	●	●	●	●
IN	●	●	●	●	●	●
KS	●	●	●	●	●	●
KY	●	●	●	●	●	●
LA						
MA						
MD	●	●	●	●	●	●
ME	●	●	●	●	●	○
MI						
MN	●	●	●	●	●	●
MO						
MS						
MT	●	●	●	●	●	●
NC	●	●	●	●	●	●
ND	●	●	●	●	●	●
NE	●	●	○	●	●	○
NH	●	●	●	●	●	●
NJ	●	●	●	●	○	○
NM	●	●	●	●	●	●
NV	●	●	●	●	●	●
NY	●	●	●	●	●	●
OH	●	●	●	○		○
OK						
OR	●	●	●	●	●	●
PA	●		●	○		
RI	●	●	●	●	●	●
SC	●	●	●	○		
SD	●	●	●	●		
TN						
TX						
UT	●	●	●	●	●	●
VA	●	●	●	●	●	●
VT	●		●	○	○	○
WA	●	●	●	○	●	○
WI	●	●	○	○	○	○
WV	●	●	●	○		
WY	●	●		●	●	●
Total	37	35	37	37	32	

Source: ABA Commission On Legal Problems Of The Elderly, Analysis Of 1996 State Survey.

Home- and Community-Based Services. Home- and community-based services include a complex matrix of services, some of which may be part of the regular Medicaid state plan (e.g., home health care, personal assistance, skilled therapy, services for functionally disabled older individuals under §1929,²⁴ and community supported living arrangement services under §1930²⁵), and some of which are termed “1915(c) waivers” which permit states to provide a variety of services for people who otherwise would qualify for institutional care.²⁶ The Medicaid officials in all responding states with operating programs stated they recover for home- and community-based services, with some noting recovery specifically only for “waivered services.”

Hospital and Prescription Drug Services. While a substantial portion of hospital costs for older persons and persons with disabilities are covered by Medicare Part A, Medicaid also has a role in funding acute care, as well as prescription drugs. OBRA '93 requires that states recover for “related hospital and prescriptions drug services” paid for by Medicaid. HCFA Transmittal No. 63 defines “related” services as any services “provided to an individual while receiving nursing facility and home- and community-based services.” It does not specify a medical connection between these kinds of services but only a concurrence in time. Almost all of the responding officials in states operating programs reported seeking recovery for hospital and prescription drug services. West Virginia noted that hospital care required for chronic or terminal care is not considered related to nursing home- or community-based care. South Carolina specified that “inpatient” hospital services are recoverable. State officials interpreted “related services” as those provided “while receiving,” “during,” or “as part of” nursing facility or home- and community-based services. Overall, the results indicate a sweeping interpretation of “related.”

Physician Services. Physician services are not mentioned in the OBRA '93 provisions or the HCFA transmittal. However, OBRA permits recovery for “any items or services under the State plan.”²⁷ Thirty-four Medicaid officials reported seeking recovery of costs for physician services, with several specifying that recovery is only if the services are related to nursing home or home- and community-based services.

²⁴ See 42 U.S.C. § 1996t.

²⁵ See 42 U.S.C. § 1996u.

²⁶ See 42 U.S.C. § 1396n.

²⁷ 42 U.S.C. § 1396p(b)(1)(B).

Other Services. A total of 32 Medicaid officials indicated recovery for “other” services, with 24 making full recovery and eight partial recovery, including:

- All long-term care services as provided under the state plan (Arizona)
- All other services (California)
- Dental (Nebraska)
- Adult day health, private duty nursing, and Medicaid personal care (Washington)
- Private duty nursing and home health therapy (Wisconsin).

HCFA Transmittal No. 63 also addresses recovery for Medicare cost-sharing for QMBs. QMB refers to the “Qualified Medicare Beneficiary” program under which state Medicaid programs are required to pay Medicare premiums, deductibles, and co-payments for persons with incomes below the federal poverty level and with few assets. SLMB, or the “Specified Low-Income Medicare Beneficiary” program is similar, but requires that states pay only the Part B Medicare premium for those at slightly higher income levels than QMBs. According to HCFA Transmittal No. 63, states should seek recovery for Medicare cost-sharing for qualified Medicare beneficiaries, to the extent that the cost-sharing was for nursing facility or home- and community-based services or related hospital and prescription drug services. Ohio specifically noted recovery of this cost. Maine reported recovery for “everything except QMB and SLMB and Medicare buy-in.”

The Probate Estate

The OBRA '93 estate recovery amendments present states with a clear choice as to the scope of property for recovery. States must recover from the “probate estate” as defined by state law but have the option of expanding recovery far beyond this. Several questions on the survey targeted state policy and practice concerning the scope of the estate subject to recovery.

OBRA '93 specifically defines the term “estate” as “all real and personal property and other assets included within an individual’s estate, as defined for purposes of state probate law.”²⁸ Probate is a court proceeding to clear title to property passing from a deceased person to those named in a will or entitled to take property under the laws of intestacy. A probate estate is the property that is administered by the probate court after a person’s death. Assets constituting the probate estate are listed in an inventory filed with the court. Assets that are considered part of the probate estate may differ somewhat from state to state, but generally if the deceased person is the sole owner of an asset and title is vested completely in the person’s name, the asset is subject to probate. Consistent with the Uniform Probate Code, adopted by many states, property that generally is considered outside of the probate estate, and that does not pass by will or by the laws of intestacy, includes:

- Property held in joint tenancy “with right of survivorship”
- Life insurance payable to a named beneficiary;

²⁸ 42 U.S.C. Sec. 1396p(b)(4).

- Property held in a trust;
- Retirement plans payable to a named beneficiary;
- Pay-on-death bank accounts and trust arrangements on bank accounts payable to a named beneficiary at death; and
- Deeds in which the deceased held only a life estate, with the property going after death to a named beneficiary who holds the “remainder” interest in the property.

According to this definition, 19 of the 43 states responding to the survey limit the scope of their estate recovery program and practice to the probate estate, and thus do not recover the funds listed above. (See TABLE 3.) In addition, Alaska, which does not yet have a program in operation, indicated the scope of recovery will be limited as well. In some cases, the limitation to the probate estate is specified in law or in regulations. For example, the Arizona regulations track OBRA language by defining estate as “all real and personal property and other assets included within the individual’s estate, as defined for purposes of state probate law.”

The survey included two questions that focused on the reach of the programs within the bounds of the probate estate. First, the survey asked whether in practice states seek to collect cash assets that were exempt under Medicaid because they were below the Medicaid asset limit. For instance, this might include minimal bank accounts or resident accounts held by nursing homes. A total of 34 states reported they seek to collect such assets. Second, the survey asked whether in practice states seek to recover other personal property owned outright by the beneficiary prior to death. For example, this might include automobiles, jewelry, or furniture. A total of 32 states reported they seek to collect such property. (See TABLE 3.)

Beyond the Probate Estate

OBRA ‘93 provides states with the option of expanding the definition of estate beyond the probate estate, to include:

any other real and personal property and other assets in which the individual had any legal title or interest at the time of death (to the extent of such interest), including such assets conveyed to a survivor, heir, or assign of the deceased individual through joint tenancy, tenancy in common, survivorship, life estate, living trust, or other arrangement.²⁹

Joint tenancy is a legal term that means “co-ownership.” The most common form of joint tenancy is “joint tenancy with right of survivorship.” Each of the joint owners or “joint tenants” owns the entire asset. Each party has an undivided equal interest in the whole and a right to use and manage the whole jointly. When one joint owner dies, ownership immediately passes to the remaining individual or individuals. Thus, title does not pass through the will or through intestacy. The property passes “outside the probate estate.”

Joint tenancy with right of survivorship is distinct from “tenancy in common,” in which property is held in the name of two or more individuals, and each has an undivided specific (not

²⁹ 42 U.S.C. Sec. 139p(b)(4)(B).

necessarily equal) interest in the whole — for example, a one-half interest or a two-thirds interest. The undivided interest of a deceased tenant passes by will or by intestacy. Thus, a deceased tenant's share of tenancy in common property is subject to probate.

In the ABA survey, a total of 24 states reported that in practice they seek recovery against property which the beneficiary owned jointly prior to death. However, six of these (Colorado, Connecticut, Delaware, Kentucky, Maryland and New York) also claim to limit recovery to the probate estate. Thus, when they target "joint property," they may be referring to tenancy in common and not joint tenancy with the right of survivorship. Therefore, it appears that 18 states seek to recover property in joint tenancy with right of survivorship.

The survey also revealed other variations regarding joint property. For example, Wisconsin and Maine indicate that they recover against personal but not real property owned jointly. Moreover, in some states, such as Idaho, legislative language merely tracks the wording of OBRA '93, while in other states such as Florida, the reach of recovery is not specifically defined in law, and is a matter of practice.

A life estate is an asset a person has the right to possess and use only for as long as the person lives. A life estate passes directly to the remainder owner after the user dies. It is not, therefore, an outright transfer of ownership. Under OBRA '93, a life estate in which the deceased recipient had an interest "at the time of death" can be subject to recovery.

Strictly speaking, a life estate owner has no interest "at the time of death" because that interest is extinguished by the death. However, HCFA and the states have loosely read this language to mean the moment just before death. The ABA survey showed that nine states (Maine, Montana, Nevada, Ohio, Oregon, Pennsylvania, Utah, Washington and Wyoming) seek recovery against property in which the beneficiary had a life estate. As several of the practitioner comments note, valuation of such property is difficult. Although mortality tables are commonly used to value life interests, one may argue that as a practical matter, in the moment just before death, a life estate is worth zero dollars.

TABLE 3
SCOPE OF "ESTATE" AGAINST WHICH RECOVERY IS AUTHORIZED

State	Recovery Limited to Probate Estate	Recovery Against Exempt Cash	Recovery Against Other Personal Property	Recovery Against Joint Property	Recovery Against Life Estates
AK	Y				
AL					
AR	Y	Y	Y	N	N
AZ	Y	Y	Y	N	
CA	N	Y	N	Y	N
CO	Y	Y	Y	Y	N
CT	Y	Y	Y	Y	N
DC					
DE	Y	Y	Y	Y	N
FL	N	Y	Y	N	N
GA					
HI	Y	N	Y	N	N
IA	N	Y	Y	Y	N
ID	N	Y	Y	Y	N
IL	N	Y	Y	Y	N
IN	Y	Y	Y	N	N
KS	Y	Y	Y	N	N
KY	Y	N	Y	Y	N
LA					
MA					
MD	Y	Y	Y	Y	
ME	N	Y	Y	Y	Y
MI					
MN	Y	Y	N	N	N
MO					
MS					
MT	N	Y	Y	Y	Y
NC	Y				
ND	N	Y	Y	Y	N
NE	Y	Y	Y	N	N
NH	N	Y	Y	Y	N
NJ	Y	Y	Y	N	N
NM	Y	Y	Y		N
NV	N	Y	Y	Y	Y
NY	Y	Y	Y	Y	N
OH	N*	Y	Y	Y	Y
OK					
OR	N	Y	N	Y	Y
PA	N*	Y	Y	Y	Y
RI	Y	Y	Y	N	N
SC	N*	Y	Y	Y	N
SD	N	Y		Y	N
TN					
TX					
UT	N*	Y	Y	Y	Y
VA	Y				
VT	Y	Y	Y	N	N
WA	N	Y	Y	Y	Y
WI	N	Y	N	N	N
WV	N	N	Y	Y	N
WY	N	Y	Y	Y	Y

Source: ABA Commission On Legal Problems Of The Elderly, Analysis Of 1996 State Survey.

* "Yes" response changed to "No" to conform to a standard definition of "probate estate."

Finally, several states described other ways in which the scope of recovery exceeds probate definitions. In Colorado, the state may attempt to recover on a small estate that does not require probate filing. In Florida, recovery includes various kinds of trusts. In Iowa, state law allows for recovery of property in which recipient's surviving spouse or minor child had an interest. In Montana, nursing facilities that hold personal funds of a resident must pay any balance directly to the state agency after the resident's death. In addition, any excess burial funds also must be paid directly to the state agency. In Oregon, banking statutes allow the state to collect up to \$15,000 directly from bank accounts without going through probate. Washington and Wisconsin both collect not only on joint bank accounts but "payable on death" accounts as well. Nevada reports collection on a range of probate and non-probate assets including patient trust fund monies, patient liability refunds, bank accounts, motor vehicles, living trusts, and property divided by court order.

Understanding of Scope of Recovery

A clear understanding of assets targeted in recovery is critical for state officials, legal practitioners, consumers and the public. The ABA survey asked legal practitioners if the scope of recovery was understood in practice. Eighteen practitioners reported that the scope was understood, while 28 responded that it was not well understood.

Practitioners particularly lacked understanding in states where the recovery program is still new. A number of practitioners looked to forthcoming regulations to clarify its scope and process. In addition, practitioners expressed more uncertainty in states that used an expanded definition of probate. Areas of noted uncertainty included:

- Evaluation of life estates (How will the state determine what the estate was worth at the time of death? Will a life expectancy annuitization be used?)
- Application to joint tenancy and trusts (How would a lien be enforced against a joint owner?)
- Application to personal property and cash (What procedures does the state use to collect such property?)
- Multi-party accounts and pay-on-death accounts (How does recovery relate to state banking laws, multi-party account laws?)
- Recovery of nursing home accounts.

Practitioners remarked, for example, that "the program is still new and not well understood" (Arizona); "how liens and claims would operate with respect to joint property is unclear" (Delaware); "the expanded scope of recovery is so new that what is subject to recovery...is completely unknown" (Idaho); and "there is a great deal of confusion even in the estate planning organized bar about the scope of the claim" (Massachusetts).

Also notable is the significant discrepancy in answers by Medicaid officials and legal practitioners regarding the scope of recovery. For example —

- Regarding recovery of personal property owned by the beneficiary prior to death, officials and legal practitioners answered differently in 16 states. (In 13 states, officials answered that the state recovered on such property while the practitioner answered that the state did not recover, and in the other three states vice versa).

- Regarding recovery of jointly owned property, officials and practitioners answered differently in 11 states. (In six states the officials answered “yes” and the practitioners “no,” but in the remaining five states the officials answered “no” and the practitioners “yes.”)
- Concerning life estates, officials and practitioners differed in nine states. (In six states officials said life estates were not included while practitioners said they were, and in three states vice versa.)
- Finally, concerning exempt cash, the responses differed in six states (with officials reporting recovery in five states where practitioners thought there was no recovery).

Thus, for personal property and exempt cash recovery, practitioners seemed unaware of the extent of recovery attempted by the state. For joint property and life estates, the disparities followed no particular pattern and suggest a general ambiguity in the parameters of state programs and practices.

Title Conveyancing Concerns

Expansion of recovery beyond the probate estate bears on the titling of real property. Generally state law provides, for instance, that where real property is held by joint tenants with a right of survivorship, the surviving co-tenant takes clear title. The debts of the deceased tenant are not enforceable against the property. This principle is important in tracing the chain of title. However, estate recovery against jointly owned property could mean that the property is saddled with the Medicaid debt of the deceased recipient. Yet this would not be revealed in a title search, particularly if the state had not filed a lien. Thus, trust and estate lawyers have raised the concern that “hidden” Medicaid claims could cloud title. Similarly, hidden claims could adversely affect life estate property and trusts.

The survey asked legal practitioners whether they had encountered any title conveyancing problems. Five of the 49 responding practitioners reported encountering such problems (Colorado, Illinois, New Hampshire, South Carolina, Tennessee). They commented that:

- Liens have been challenged by attorneys representing sellers (Colorado).
- Title companies and the probate bar are concerned because there is no limitation period on Medicaid claims (Illinois, Tennessee).
- There are problems with the state seeking to use liens to collect from the surviving spouse if the spouse seeks to sell the home (New Hampshire).

In addition, three other practitioners said the program was still new but that conveyancing problems were anticipated (Massachusetts, South Dakota, Wyoming). The Massachusetts practitioner indicated that the state title conveyancing bar successfully opposed recent unsuccessful legislative attempts to expand recovery beyond the probate estate with the argument that the proposed expansion “would have led to huge title problems, clouding title to all property with a joint tenancy or a life estate or trust in the chain of title.”

Procedure for Tracking Estate Recovery Claims

To initiate the estate recovery process, state agencies must receive notice of beneficiary deaths and match this against information on beneficiary assets and property. An October 1994 estate recovery report by the American Public Welfare Association described procedures from

selected states for tracking deaths and identifying assets.³⁰ The ABA survey sought updated information on tracking from state Medicaid officials.

Tracking Deaths. The 43 state respondents listed a variety of methods through which the estate recovery unit learns of the death of beneficiaries or their survivors. The approaches listed below are relevant primarily to tracking deaths of beneficiaries' survivors (i.e., spouse, children, siblings), since state payment and eligibility files will usually reflect the deaths of beneficiaries themselves. Several states use multiple systems for tracking deaths. Examples of procedures used include:

- Caseworker referrals (for example, Delaware, Hawaii, Indiana, Kentucky, Nebraska, New Hampshire, Oregon, Virginia and other states)
- Review of probate filings (Delaware, Illinois, Maryland, Maine, Minnesota, Nebraska, Nevada, New Hampshire, South Dakota, Vermont, Washington, Wisconsin)
- Review of death records in the vital statistics bureau (Florida, Iowa, Kentucky, Maine, Wisconsin)
- News clippings from obituary pages (Idaho, Illinois, Washington, Wyoming)
- Final accountings by guardians and conservators (Minnesota)
- Information from nursing homes (New Jersey, South Dakota)
- Notification by estate representatives (Arizona, Arkansas, California, North Dakota)
- Notification by estate attorneys (California, New Jersey)
- Notification by relatives (Idaho, Nebraska, New Jersey, Washington).

In several states that rely on notification, the states have mandatory notification laws or policies. In Arkansas, estate representatives are required to give notice to the Department of Human Services when an estate administration is opened. California has mandatory reporting provisions requiring estate attorneys to notify the Department of Health Services if the decedent was a Medi-Cal beneficiary. In North Dakota, state law requires notice to the Department of Human Services when a probate is initiated. Proposed legislation in Colorado would require attorneys, personal representatives and public administrators to notify the Department or the contractor when they are handling the estate of a former Medicaid recipient.

Tracking Assets. According to the survey respondents, once estate recovery units receive information on recipient deaths, they generally match this with eligibility data to identify assets and property. These data originate at the time of application, and may be updated through re-certification. Further information comes from letters of inquiry sent to estate representatives, as well as information from nursing homes and banks.

A number of states reported that their estate recovery tracking is implemented by a contractor (Arizona, Colorado, Florida, Iowa). Contractors are essentially private collection agencies whose profits may depend in large part on how much debt they recover. In Montana, a contractor was in the process of developing a tracking process. In Ohio, the Office of Human Development Services forwards information on recipients deaths to the Attorney General's office,

³⁰ American Public Welfare Association, *supra* note 21.

which tracks assets. Several states indicated they use computerized information systems in tracking cases.

Once assets of deceased Medicaid beneficiaries are identified, the estate recovery unit files a claim in probate and/or places a lien on property. In at least one state, Oregon, the state collects directly from bank accounts pursuant to state legislation. A letter to the bank includes an indemnity agreement so the bank holds no liability to other creditors who may have priority on the state's claim. If a creditor with priority status requires payment, the state pays the creditor from the bank account.

Minimum Estate and Claim Thresholds

Either officials or practitioners in 16 states reported use of a minimum estate value threshold below which recoveries were not sought. The reported thresholds included nominal figures as low as \$50 (Wisconsin) and as high as \$50,500 (Kentucky, for a homestead). One state uses a formula amount based on the size of claim (West Virginia) and another on the average value of homes (New Mexico) as shown in TABLE 4. Several states explained that they use a cost-effectiveness analysis on a case-by-case basis to determine whether it is worthwhile to seek recovery.

TABLE 4 - STATES WITH MINIMUM ESTATE VALUES BELOW WHICH RECOVERIES WILL NOT BE MADE

(Columns are joined if official and practitioner provided same response)

	Officials' Response	Practitioners' Response
CA		\$500
CO		\$500
ID		\$500
KY		\$5,000 estate not include home \$50,500 home
MT		\$2,000
NC		\$5,000
NE		\$5,000
NJ		\$3,000
NM		50% of average price of homes in county where homestead is located.
NV	\$100	
PA	\$1000	
SC	\$5,000 personal property \$5,000 home	\$5,000
VA	\$1,000	
WA		\$2,000
WI	\$50	
WV	\$5,000 above value of state's Medicaid lien	

Source: ABA Commission On Legal Problems Of The Elderly, Analysis Of 1996 State Survey.

Fifteen states (counting official and practitioner responses together) reported using a minimum recovery claim threshold below which recoveries were not sought. Several other states reported that they use a case-by-case cost-effectiveness analysis to decide whether to pursue a recovery claim. The reported thresholds again included nominal figures as low as \$50 (Hawaii, Nebraska, Oregon, Pennsylvania, Wisconsin) but high-end thresholds topped out at \$3,000 (North Carolina) as shown in TABLE 5.

**TABLE 5 - STATES WITH MINIMUM CLAIM VALUES BELOW
WHICH RECOVERIES WILL NOT BE MADE**

(Columns are joined if official and practitioner provided same response)

	Officials' Response	Practitioners' Response
CA	\$500	
CO	\$500*	\$500
HI	\$50	
ID	\$500	
KS	\$350-500	
NC		\$3000
NE	\$50	
NJ		\$500
NV		\$100
OR	\$50	
PA	\$50	
SC	\$500	
VA	\$1,000	
WA	\$100	
WI	\$50	

Source: ABA Commission On Legal Problems Of The Elderly, Analysis Of 1996 State Survey.

* Threshold disregarded if probate is opened, since there is no cost for filing a claim.

Enforcement of Estate Recovery

Waivers and Deferrals

OBRA '93 provides that recovery can be made only after the death of the surviving spouse, and when there is no surviving child under age 21, blind or disabled. As to recovery against a homestead, the mandatory deferral under OBRA does not require that the spouse or child live in the home. It requires only that they be alive. Because these deferrals could last for a lengthy period, some states choose to waive recovery altogether when the beneficiary is survived by a spouse, minor or disabled child.

The survey of officials produced 36 responses to questions about waiver and deferral. All responded that they either waive or defer recovery if a spouse, minor or disabled child survive the beneficiary. Twenty-five states reportedly waive recovery.

TABLE 6
WAIVER AND DEFERRAL OF ESTATE RECOVERY

[When beneficiary is survived by spouse or child under 21/blind/or disabled]

State	Waive Recovery	Defer Recovery	Residence Required*	May Offer Settlement
AK				
AL				
AR				
AZ	Y	Y	N	Y
CA	Y	Y	N	Y
CO	Y	Y		Y
CT	Y	N	Y	N
DC				
DE				
FL				
GA				
HI	Y	N	Y	N
IA				
ID	N	Y		Y
IL	N	Y	Y	Y
IN	Y			
KS	Y†	Y†	N	
KY	Y	N	Y	Y
LA				
MA				
MD	Y	N	N	N
ME	Y	N	N	Y
MI				
MN	Y	Y	Y	Y
MO				
MS				
MT	Y	N	N	N
NC	Y	N	Y	Y
ND	Y	Y	N	Y
NE	Y	N	N	N
NH	N	Y		N
NJ		N	N	N
NM	Y	Y	N	N
NV	N	Y		
NY	Y	N	N	N
OH				
OK				
OR	Y†	Y†	N	N
PA	N	Y	N	N
RI	Y	N	N	N
SC	N*	Y	N	N
SD	Y			
TN				
TX				
UT	Y††	Y††	N	Y
VA	Y	N		Y
VT	N	Y	N	N
WA	N	Y	N	Y
WI	Y	N	N	Y
WV	N	Y	Y	N
WY	Y†	Y†	N	N
Total	25 Yes 9 No	19 Yes 12 No	6 Yes 21 No	15 Yes 16 No

Source: ABA Commission On Legal Problems Of The Elderly, Analysis Of 1996 State Survey.

* Spouse or child must reside in homestead in order for state to waive or defer recovery.

† Waiver granted for surviving minor or disabled child. Deferral granted for surviving spouse.

†† Waiver granted for disabled child only. Deferral granted for surviving spouse or minor child.

Twenty states defer recovery according to officials. Officials in eleven states report that they waive or defer recovery, depending upon the circumstances (Arizona, California, Colorado, Kansas, Minnesota, New Jersey, New Mexico, North Dakota, Oregon, Utah, Wyoming). For example, Kansas, Oregon, and Wyoming may waive recovery if the beneficiary is survived by a disabled or minor child, while deferring recovery where the survivor is a spouse. The distinction may be motivated in part by the difficulty in tracking the resource over a period that could span decades.

Of note is the fact Medicaid officials in seven states reported that they would seek recovery if the surviving spouse, minor or disabled child did not live in the home (Alabama, Connecticut, Hawaii, Illinois, Minnesota, North Carolina, West Virginia). Requiring residence in the home by the survivor raises a compliance question under federal law, since the legislative language of OBRA '93 does not make residence in the home a prerequisite.

The survey also queried respondents whether they consider negotiating settlements of amounts due or payment schedules with heirs when recovery is permitted. Thirteen states report doing so. Seventeen states report that they do not do so.

As in other areas, practitioner responses varied significantly from official responses. In 17 states, responses about waiver and deferral practices contradicted each other. The high rate of inconsistency is an indicator of a significant level of confusion plaguing estate recovery policies and practices.

Use of Liens

States may choose whether to use liens to protect the state's interest in the property of Medicaid beneficiaries. A great deal of confusion is evident even among persons who manage Medicaid estate recovery programs over the terminology of liens and estate claims. In simplest terms, a lien is nothing more than a piece of paper filed somewhere that merely serves to give an owner of property and all potential buyers notice that there is an encumbrance against the property. The lien itself is not a claim. To become a formal claim against the property, the creditor must usually do something more. Typically, the creditor must file a judicial action of some sort to create a claim that may then be granted or denied by a court. This may occur as part of probate proceedings or as a separate collection proceeding. In reality though, liens against real property are often "enforced" without going to court at the time property is sold. Since it is impossible to convey clear title to property if a lien is attached, the seller is faced with the choice of either satisfying the lien as part of the sale or going to court to seek removal of the lien so that the property can be sold.

Estate recovery programs use two types of liens to protect the interest of the state — pre-death and post-death liens. Pre-death liens are those imposed upon the homes of living beneficiaries who have been determined (after notice and an opportunity for a hearing) to be "permanently institutionalized" and not likely to return home (see pages 29-30 regarding permanent institutionalization procedures). Medicaid liens against the homestead of such living institutionalized individuals are called TEFRA liens, since these liens must follow rules set out in

the Tax Equity and Fiscal Responsibility Act of 1982.³¹ Post-death liens, often a part of the probate process, follow state law, although federal law dictates certain notice requirements (see pages 36-41 regarding notice requirements).

The survey asked whether states use either pre-death TEFRA liens or post-death liens. Officials in 19 states responded they use liens (see TABLE 7). This total rises to 23 if practitioners' responses are used for states in which officials did not respond. In three additional states, although officials reported that liens were not used, practitioners responded that liens were indeed used (North Carolina, Pennsylvania, South Carolina). Thus again, some fundamental confusion over practices is evident.

Respondents' descriptions of the processes used for placing liens were not detailed enough to make in-depth comparisons. But in general terms, 13 state officials (plus an additional seven practitioners) report using probate proceedings to impose at least some liens. Eight states reported using "other liens." These generally referred to non-judicial processes for imposing liens, such as filing of a lien notice in county clerks or recorders offices.

Thirteen state officials reported using pre-death TEFRA liens. According to HCFA, two non-responding states also use TEFRA liens, bringing the total to 15 states.³² Some states (Hawaii, Montana, New Hampshire) are just getting their TEFRA lien program underway. Wyoming is not yet placing TEFRA liens, but intends to begin soon. California previously used TEFRA liens, and still has some that are outstanding, but no longer places such liens. The survey did not ask officials to report the number of TEFRA liens placed.

³¹ 42 U.S.C. § 1396(a)(1)(A) and (B). 42 C.F.R. 433.36(g).

³² In addition to the 13 states shown in Table 7, Alabama and Missouri also use TEFRA liens, according to the HCFA Medicaid Bureau, but neither responded to the ABA survey. Interview with Phil Otto, May 1996.

TABLE 7
LIENS USED BY STATES IN MEDICAID ESTATE RECOVERY PROGRAMS

State	Liens Used?	TEFRA Liens?	Probate Liens?	Other Liens?
AK				
AL				
AR				
AZ		N		
CA				
CO	Y	Y	Y	Y
CT	Y	Y	Y	N
DC				
DE				
FL				
GA				
HI	Y	Y		
IA				
ID	Y	Y	Y	Y
IL	Y	Y	Y	Y
IN	N			
KS	N			
KY	N			
LA				
MA				
MD	Y	Y	Y	N
ME	N			
MI				
MN	Y	Y		
MO				
MS				
MT	Y	Y	N	N
NC	N			
ND	N			
NE	N			
NH	Y	Y	Y	Y
NJ	Y	N	N	Y
NM	N			
NV	Y	Y	Y	Y
NY	Y	Y	Y	N
OH	N			
OK				
OR	N			
PA	N			
RI	Y	N	Y	N
SC	N			
SD	Y	Y	N	N
TN				
TX				
UT	Y	N	N	Y
VA	N			
VT	N			
WA	Y	N	Y	Y
WI	Y	Y	Y	N
WV	Y		Y	
WY	Y	N	Y	N

Source: ABA Commission On Legal Problems Of The Elderly, Analysis Of 1996 State Survey.

Enforcement and Removal of Liens

If states use liens on beneficiaries' homes to protect the state's recovery interest, they may collect upon sale of the home, by law, only if the TEFRA lien deferral protections (for spouse, minor/disabled children, siblings, and caretaker children) do not apply. Most of the responses from officials and practitioners in those 23 states reporting some use of liens generally indicate that if a lien has been properly placed on the home, enforcement of the lien most often occurs in one of two ways. First, enforcement may occur through the eligibility process if the beneficiary is still alive. That is, the proceeds from sale of the property become a countable resource which terminates the beneficiary's eligibility for Medicaid until the excess resources are spent down. Second, enforcement may occur through the real estate closing process. In the closing process, encumbrances on the property must be satisfied in order to convey clear title to a buyer.

Federal law requires that a TEFRA lien placed on the home of a living institutionalized individual must terminate if the beneficiary returns home. All of the states using TEFRA liens reported having a process for releasing the lien as soon as the department or recovery unit is notified that the beneficiary has returned home. The process usually involves filing a release of lien document in county recorders' offices.

However, these responses leave open several questions about meaningful state compliance with TEFRA provisions intended to protect beneficiaries. None of the states explained whether they have a reliable process for learning when beneficiaries return home. In other words, are status changes or payment changes automatically communicated to estate recovery units, or is it common for beneficiaries to return home without the estate recovery unit knowing? If the latter is common, then compliance with TEFRA may fall short. The survey results do not provide an answer to this concern. However, two states noted that there is no process for release of liens in practice, although the lien theoretically dissolves on return home (West Virginia, Wyoming). Practitioners in three states remarked that their states seldom take initiative to release liens unless prompted by family members or counsel (Alabama, Massachusetts, Wisconsin). Another state (Montana) requires a "written request" before filing a release of lien. And one state does not consider a return home to have taken place until the beneficiary has been home for more than 90 days (Oklahoma, according to the practitioner response).

Variation in Practice

The survey revealed variation in the kinds of estates frequently targeted. While many states appear to focus heavily on homesteads and real estate, at least two states have set up administrative mechanisms outside the probate process to capture personal funds, including very small sums that in the aggregate can significantly add to recovery revenue. Both Oregon and Washington channel estate monies directly to the Medicaid agency. Oregon sends letters of recovery to bank accounts of the deceased beneficiary. Under state law, the banks must remit any balances directly to the agency. Washington requires long-term care facilities to remit the balance of deceased residents' personal funds to the Medicaid agency. These states did not provide any explanation about how these processes affect payment of burial or other estate administration expenses.

The survey also sought to determine whether enforcement of estate recovery varies by local jurisdiction within states. All but two of the Medicaid officials responding to this question reported no variation by local jurisdiction. Minnesota said there is variation because the state has delegated estate recovery to the county human services agencies, and each county develops its own procedures and practices. Also in New York, recovery activities are decentralized. Filing and tracking procedures are locally developed; and decisions concerning the cost-effectiveness of efforts and the efficacy of compromising claims are made locally.

However, legal practitioners saw somewhat more variation, with 10 noting in-state differences and 27 finding uniformity. They attributed this uneven enforcement in 10 states to differences in local human services offices, eligibility workers, attorneys and probate judges, as well as in local technology. For example, the New Jersey practitioner explained that some counties refer all cases for tracking to the state's recovery unit, while others refer none at all. Some counties are automated, while others perform research on an irregular basis (New York). Lawyers in some jurisdictions routinely notify the state of a recipient's death, while others do not (Tennessee). Wisconsin reported significant variety in how local agencies handle TEFRA liens.

Permanent Institutionalization

The federal estate recovery provisions require that states seek recovery from an individual's estate if the person is determined, after notice and an opportunity for a hearing, to be *permanently* institutionalized.³³ However, for persons over age 55, receipt of any nursing facility care, among other services, triggers the estate recovery mandate, although it does not require the state to use liens. Thus, a determination of permanent institutionalization (PI) is not necessary to recover against beneficiaries 55 years of age and older. However, if the state uses TEFRA liens on this population (i.e., liens against real property owned by living beneficiaries), the TEFRA rules require a finding of PI. If the state does not use TEFRA liens, there is no requirement in the law that determinations of PI be made. The survey sought information about the criteria and processes states used to determine PI. The results are summarized in TABLE 8.

Twenty-one states (of 34 responding to this question) reported making PI determinations. Twelve states responded that they did not use "permanent institutionalization" as a criterion for estate recovery. One state responded that criteria were under revision (Delaware), and one state noted that while their statute refers to permanent institutionalization, it provides no specific criteria (Wyoming).

³³ 42 U.S.C. § 1396p(b)(1)(A) incorporates the TEFRA lien language at 42 U.S.C. § 1396p(a)(1).

TABLE 8
STATES MAKING DETERMINATIONS OF PERMANENT INSTITUTIONALIZATION (PI)
(21 State Officials reporting)

State:	AR	CA	CO	CT	HI	IA	ID	IL	KY	MN	MT	NC	NE	NH	NM	NY	OR	SD	WI	WV	WY	
Criteria same as SSI				•	•					•			•			•	•					
Principle Evidence:																						
• Physician's Statement	•		•	•	•					•		•		•	?	?				•	?	
• Person's Declaration		•												•				•				
• Assessment by 3rd party			•		•	•	•					•							•			
• Length of stay Presumption				30 days		Any #		120 days	2 yrs.		6 mo.	6 mo.	6 mo.						3 mo.			
Applied only to those under age 55	•					•			•	•		•						•			•	
Applied to persons of all ages		•	•	•	•		•	•			•		•	•	•	•		•	•		•	
# P.I. determinations made in last 12 mo.	?	35	282	?	0	0	0	1000	0	?	0	?	?	?	?	?	?	?	0	?	2	0

Source: ABA Commission On Legal Problems Of The Elderly, Analysis Of 1996 State Survey.

? = Unknown or information not reported by respondent.

The 21 states reporting a process for PI determinations reported relying on one or more of four principle elements of evidence in establishing permanent institutionalization in their decisions:

- A physician's statement that the resident is considered permanently institutionalized;
- The person's declaration of intent to return or not return home;
- An assessment by a third party (e.g., peer review organizations in Colorado, Iowa, and Maryland; the facility's plan of care in North Carolina; or nurse surveyors in Wisconsin);
- Presumptions about the length of stay in the institution, placing the burden of proof on residents to rebut (e.g., 30 days in Connecticut; three months in South Dakota; 120 days in Illinois; six months in Montana, Nebraska, and North Carolina; two years in Kentucky).

Iowa has a combination of the third and fourth approach above. In Iowa, a stay of any length triggers a presumption that the resident is permanently institutionalized, unless the resident requests a formal determination, in which case the state's peer review organization will make a determination.

To further explore the process by which states make the determination of PI, the survey asked officials whether the criteria were the same as the eligibility criteria for finding a home exempt under the Supplemental Security Income (SSI) program. SSI uses a subjective "intent to return home" test. HCFA Transmittal No. 63 provides that states are not required to use the subjective SSI test and could go beyond this criterion to incorporate other factors. Six states (Connecticut, Hawaii, Minnesota, Nebraska, New York, Oregon) replied that their criteria for determination of PI were the same as the SSI standard, while 16 states answered that their criteria were not the same.

Of the 21 states reporting PI determinations, seven reported that they apply the criteria only to residents under age 55, and 14 apply the criteria to persons of all ages. The states that apply the criteria to persons of all ages generally are states that use TEFRA liens (which are based on determinations of PI), although Nebraska and New Mexico do not use TEFRA liens, so it is not clear why they would apply the criteria to all ages. California did use TEFRA liens at the time of the survey but no longer does so as of 1996.

Most of the states either did not make any determinations of PI within the last 12 months, or they did not know how many were made. Only four states reported determinations, ranging from only two in West Virginia, to 1,000 in Illinois, to intermediate numbers (282 in Colorado, 35 in California). Practitioners in seven additional states report that they are aware of at least some instances of PI determinations (Massachusetts, Maryland, North Carolina, New Hampshire, New York, Oklahoma, Wisconsin).

Hardship Waivers

Hardship Waiver Criteria

OBRA '93 requires states to waive recovery in situations where it would work undue hardship.³⁴ The statute requires the states to have hardship procedures, and requires the federal government to specify standards for the procedures and criteria for the determination of hardship. The Health Care Financing Administration (HCFA) has not established mandatory criteria for states. Instead, in Transmittal No. 63, it has provided examples that states may consider in establishing criteria. Echoing the legislative history of OBRA '93, HCFA suggests that states give special consideration to cases in which the estate subject to recovery is: "(1) the sole income-producing asset of survivors (where such income is limited), such as a family farm or other family business, (2) a homestead of modest value, or (3) other compelling circumstances."³⁵

States are precluded from granting undue hardship waivers in cases where the state has disregarded assets because the beneficiary had long-term care insurance, except in the long-term care insurance demonstration states grandfathered in by OBRA '93 (California, Connecticut, Indiana, Iowa, New York). The HCFA Transmittal also makes clear that states may impose a rebuttable presumption that undue hardship does not exist if the beneficiary obtained estate planning advice from legal counsel and followed this advice.³⁶

³⁴ 42 U.S.C. § 1396p(b)(3).

³⁵ Transmittal No. 63, § 3810(C).

³⁶ Id. at § 3810(C)(1).

TABLE 9 on the next page shows that 28 state officials reported the establishment of hardship criteria. Eight responded that hardship criteria were not yet established. Fifteen states gave no response. In the states reporting undue hardship regulations, their criteria fell loosely into six broad, sometimes overlapping, categories with multiple variations. Some states cast their criteria only in terms of "factors" to be considered in determining hardship, rather than as substantive standards. The six categories of criteria and states indicating use of these criteria are shown below. The specific state criteria are described in greater detail at APPENDIX C.

1. The estate consists of an income producing asset (business, including farm or ranch), and recovery would cause loss of livelihood (22 states).

Arkansas	Kentucky	New York
Arizona	Maine	South Carolina
California	Minnesota	Utah
Colorado	Montana	Washington
Florida	North Carolina	Wisconsin
Hawaii	New Jersey	Wyoming
Idaho	New Mexico	
Kansas	Ohio	

2. Property is the primary residence of the survivors (12 states).

Arizona	Maryland	North Carolina
Florida	Maine	Oregon
California	Minnesota	South Carolina
Hawaii	Montana	Washington

3. Only asset is homestead of modest value (four states).

Florida	Hawaii
Kentucky	New Mexico

TABLE 9 - UNDUE HARDSHIP CRITERIA

STATE	Have Criteria	No Criteria	No Answer
AK			X
AL			X
AR	X		
AZ	X		
CA	X		
CO	X		
CT		X	
DC			X
DE			X
FL	X		
GA			X
HI	X		
IA	X		
ID	X		
IL		X	
IN		X	
KS	X		
KY	X		
LA			X
MA			X
MD	X		
ME	X		
MI			X
MN	X		
MO			X
MS			X
MT	X		
NC	X		
ND	X		
NE		X	
NH		X	
NJ	X		
NM	X		
NV			X
NY	X		
OH	X		
OK			X
OR	X		
PA			X
RI		X	
SC	X		
SD		X	
TN			X
TX			X
UT	X		
VA		X	
VT	X		
WA	X		
WI	X		
WV	X		
WY	X		
Total:	28	8	15

Source: ABA Commission On Legal Problems Of The Elderly, Analysis Of 1996 State Survey.

- 4a. Without receipt of estate proceeds, the survivor would become eligible for public and/or medical assistance (eight states).

California	Montana	Oregon
Colorado	New Jersey	Wisconsin
Idaho	New Mexico	

- 4b. Allowing the survivor to receive the estate would enable him/her to discontinue eligibility for public and/or medical assistance (four states).

California	Montana
Colorado	New Mexico

5. Recovery would deprive the survivor of necessities of life, e.g. food, shelter, clothing (eight states).

Arizona	Iowa	Washington
California	Kansas	West Virginia
Florida	Montana	

6. The survivor made substantial personal contributions to the property or to the care of the beneficiary so beneficiary could remain at home (three states).

Florida	Kansas	Maine
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At least eight states adopted rebuttable presumptions that no undue hardship exists if the decedent beneficiary or survivor used estate planning methods to divert or shelter assets: California, Idaho, Minnesota, Montana, New Jersey, New Mexico (if used within one year of death), South Carolina, and West Virginia.

The survey did not question Medicaid officials about how often they make findings of undue hardship. However, it included a brief subsample to assess the frequency of waivers requested, granted and denied by state agencies. The results are shown at APPENDIX D.

State Responses to Finding Undue Hardship

OBRA '93 directs that where states find undue hardship, the state agency "shall waive the application of" estate recovery.³⁷ Normally, "waiver" implies a relinquishment of a right. However, HCFA in its Transmittal 63, seems to interpret the term also as a deferral, since it

³⁷ 42 U.S.C. § 1396p(b)(3).

TABLE 10 - STATE RESPONSES TO FINDING UNDUE HARDSHIP

STATE	May Waive Estate Recovery	May Defer Estate Recovery	May Negotiate Modified Recovery
AK			
AL			
AR	X	X	X
AZ	X		X
CA	X	X	
CO	X		X
CT			
DC			
DE		X	
FL	X		X
GA			
HI	X		
IA		X	
ID	X	X	X
IL			
IN	X	X	X
KS	X		
KY	X		
LA			
MA			
MD	X	X	
ME	X		X
MI			
MN	X	X	X
MO			
MS			
MT	X	X	X
NC	X		
ND			
NE	X	X	X
NH			
NJ	X	X	X
NM		X	
NV			
NY	X	X	X
OH	X	X	
OK			
OR	X	X	X
PA	X	X	X
RI		X	
SC	X		
SD			
TN			
TX			
UT	X	X	X
VA	X		X
VT	X		
WA	X		
WI	X		
WV	X	X	
WY		X	
Total:	28	20	16

Source: ABA Commission On Legal Problems Of The Elderly, Analysis Of 1996 State Survey.

permits states to “limit the waiver to the period during which the undue hardship circumstances continue to exist.”³⁸ Many states have interpreted their options even more flexibly to include the ability to negotiate partial compromises or payment schedules in response to hardship circumstances. Of 33 states responding to this question, 28 included waiver of estate recovery in their repertoire of responses to undue hardship, 20 included deferral of estate recovery, and 16 included negotiation of modified recovery agreements. Practitioner responses were largely congruent with the state responses. The state responses are detailed in TABLE 10.

Notice Provisions

A key obligation of states in implementation of estate recovery programs is ensuring adequate notice to beneficiaries. Notices should clearly convey information about the scope of the program, how it affects individual estates, and procedures for review. Notice is important at several key trigger points throughout the estate recovery process — at the time of Medicaid application, at admission to a nursing home or receipt of home- and community-based care, upon determination of permanent institutionalization, at the time of intended recovery action, at placement of a lien on the property and enforcement of the lien. Also critical is notice of the availability of a hardship waiver. A significant federal case, addressing California law, Roy DeMille et al v. Kimberly Belshe et al.³⁹ emphasizes the importance of due process rights to receive notice. It holds that if a state files a post-death lien against property in the hands of the surviving spouse or other survivor, the state must give the survivor pre-attachment notice and an opportunity to be heard.

HCFA Transmittal No. 63 requires that states provide both a general notice of estate recovery at the time of application, and a notice of specific recovery. The survey asked respondents about both kinds of notice.

Notice at Application

HCFA provides that at application for Medicaid services, states must give a general notice to potential recipients that explains the estate recovery program. Thirty one Medicaid officials replied that their state gives such a notice in writing. Eight states did not respond. Montana noted that a contractor would soon be developing notices. New Mexico was developing an application notice at the time of the survey.

Some states provide only a one-line reference to estate recovery in the application form. It may be included in a list of many beneficiary “rights and responsibilities,” as in Florida, California, Connecticut and other states. In some cases the recovery notice is repeated at the time of re-determination (Oregon). A number of states (Colorado, Illinois, Nebraska, South Carolina, South Dakota, Wyoming) have brief pamphlets for the public setting out basic information about their

³⁸ Transmittal No. 63, § 3810(C).

³⁹ 1995 WL23636 (N.D. Cal.), Medicare and Medicaid Guide (CCH) ¶ 43,082.

Medicaid estate recovery program. (See an example from Nebraska in APPENDIX E.) Ohio was re-writing its brochure at the time of the survey. Several additional states (Hawaii, Iowa, Idaho, Kentucky, Maine) have concise one- or two-page question and answer fact sheets. The fact sheet from Iowa shown as an example is very concise and basic (see APPENDIX E). It does not include some key information — for example, on hardship waiver and scope of recovery — yet it communicates clearly that there is a program for recovery of estates. The spacing and large print make it easy to read. Washington has Medicaid materials in Cambodian; Arizona and California in Spanish. Vermont has a one-page notice about recovery that Medicaid beneficiaries must sign to acknowledge they are aware of the possibility of an estate claim. Notices and pamphlets prepared by states vary considerably in print size and readability.

Recovery Notice

HCFA Transmittal No. 63 directs the states to give a specific notice to individuals affected by the recovery. If the recipient has died, the notice must be served on the executor or legally authorized representative of the estate. This person is required to notify others who would be affected. If there is no executor or authorized representative, the state should notify the family or heir.

The survey asked respondents to indicate whether Medicaid beneficiaries and families are given notice at several key trigger points. Responses of Medicaid officials are shown in TABLE 11. (Note: Not all officials responded to all questions.)

Two states (Idaho, South Dakota) reported giving notice at all the points in time described in TABLE 11. Six states (Maryland, Maine, Montana, North Dakota, New Mexico, South Carolina) reported giving notice at none of these points. Montana and Wyoming were developing notices at the time of the survey. Of the 18 states that use liens, 13 said they give notice on placement of the lien and nine on enforcement of the lien. As the table shows, several states (Maine, North Carolina, North Dakota, New Hampshire, New Mexico, Vermont) specified they give notice at the time a claim on the estate is proposed or made; and certainly notice is a part of the judicial claim procedure in all states. Regarding notice on “placement of a lien,” the survey did not ask specifically whether this notice was given before or after the actual filing of the lien, so there is no indication of whether or how states have responded to the DeMille case requiring California to provide pre-attachment notices.

Other states reported notice: upon an agreement to sell the home because recipient is permanently institutionalized (Nebraska); at the determination of eligibility for home- and community-based services (Pennsylvania); or when recipients turn age 55½ (Wisconsin). Virginia indicated that notice is not a function of the Medicaid agency but the Department of Social Services. In many cases, the responses of legal practitioners varied significantly from the responses of the officials, showing a general ambiguity about notice and due process protections in place.

TABLE 11 - TIMING OF ESTATE RECOVERY PROGRAM NOTICE

Notice Provided at Time of...	Yes	States	No	States
Admission to a Nursing Home?	11	ID, KY, MN, NC, NE, NH, PA, SD, VT, WA, WV	19	AZ, CA, CO, CT, IL, IN, KS, MD, ME, MT, ND, NJ, NM, NV, OH, OR, RI, SC, WI
Receipt of Home- and Community-based Services?	8	ID, KY, OH, PA, SD, VT, WA, WV	20	AZ, CA, CO, CT, IL, IN, MD, ME, MT, NC, ND, NE, NH, NJ, NM, NV, OR, RI, SC, WI
Placement of Lien on Property?	14	CA, CO, CT, HI, ID, MN, NJ, NV, RI, SD, UT, WA, WI, WV	11	IL, MD, ME, MT, ND, NE, NH, NM, OH, PA, SC
Enforcement of Lien on Property?	11	CA, CO, CT, ID, NH, NJ, NV, RI, SD, WA, WY	11	IL, MD, ME, MT, ND, NE, NM, OH, PA, SC, WI

Source: ABA Commission On Legal Problems Of The Elderly, Analysis Of 1996 State Survey.

Both federal law and HCFA Transmittal No. 63 require notice upon determination of “permanent institutionalization.” The survey asked about such notice for persons under age 55. Eight states (Colorado, Idaho, Illinois, North Carolina, Nebraska, New Hampshire, Nevada, South Dakota) replied they give this notice. While the remaining states did not indicate such notice, most of these do not place pre-death TEFRA liens on the property of permanently institutionalized individuals, and thus do not need to make such determinations.

Content and Clarity of Notice.

The HCFA Transmittal requires that the notice include the action the state intends to take, the reason for the action, procedures for applying for a hardship waiver, and the amount to be recovered. It does not suggest a uniform format or guidelines for readability. In addition, existing federal Medicaid regulations include requirements on the content of notice if the state Medicaid agency takes action to suspend, terminate or reduce services.⁴⁰ Under this regulation, notice must contain: a statement of what action the state intends to take; the reasons for the action; the specific regulations that support the action; and an explanation of the right to request a hearing. The DeMille case underscored the importance of these due process notice requirements as to estate recovery.

The survey asked the legal practitioners whether from their perspective the notices are accurate and are understandable to beneficiaries and families. Almost two-thirds of the practitioners answering this question (21 of 32) responded that the notices are not understandable and/or accurate. Several pointed out specific inaccuracies, inconsistencies or omissions:

- The exceptions to recovery are not explained (Indiana, Illinois);
- Information on waiver and hardship is incomplete (Maine);

⁴⁰ 42 C.F.R. § 431.210.

- Notice fails to include amount of the claim (New Hampshire);
- Notice fails to explain the bar to recovery while spouse is alive (New Hampshire);
- There is no explanation of the personal property exemption (Wisconsin); and
- There is no explanation of appeal rights (New Jersey).

A number of practitioners characterized the notices as generally problematic: “No adequate detail and misleading” (California); containing “some inconsistency” (Kentucky); “contains boilerplate language” (Wisconsin).

The notices often did not specifically assure families that the claim would not exceed the value of the estate and would not be enforced pending appeal, nor inform families they could request an itemized accounting. Finally, the notices often did not clarify that the estate representative is responsible for notifying other individuals affected.

The “notice of statutory claim” from Idaho is shown in APPENDIX E as an example. It is understandable, gives the claim amount and reason for the recovery, includes the hardship criteria, and states the procedure for applying for a waiver. It assures the authorized representative that the claim is on the estate of the deceased beneficiary and not upon the representative personally. It does not, however, list the federal exceptions to recovery. It mentions a possible lien without explanation.

Hardship Waiver Notice

Twenty-three states reported that they provide written notice of the availability of the undue hardship waiver, although not all described when or how they give the notice. Nine states responded either that they do not give written notice or their notice procedures were in development. If practitioner responses are used for those states where officials did not respond, these totals rise to 25 states giving written notice and 15 giving no notice.

However, as elsewhere in these results, caution is required in supplementing “official” responses with practitioner responses because of significant incongruence between official and practitioner answers in those states where both responded. In 11 states, officials and practitioners gave opposite responses to this question. In eight of these cases, practitioners stated that no notice is given in direct contradiction to the official response that notice is supplied (Arkansas, Florida, Nebraska, Ohio, Oregon, Rhode Island, South Dakota, Vermont). More puzzling is the fact that in three cases where officials reported that no written notice is given, practitioners reported that written notice is given (Maryland, Maine, New Mexico).

Most of the states providing notice give it after the death of the Medicaid beneficiary or when a recovery claim is filed (20 States). Eight states report that notice is given at the time of Medicaid application or is included in the program’s brochure. TABLE 12 provides a state-specific summary of responses. The claim notice for Minnesota in APPENDIX E gives a complete listing of hardship criteria, tells how to apply for a waiver and how to appeal. (It does not, however, give notice of deferral of recovery if there is a spouse or dependent or disabled child.)

TABLE 12 - NOTICE OF THE UNDUE HARDSHIP WAIVER OPTION

STATE	Provide Written Notice?	Timing of Notice		
		When Claim Filed	Time of Application	In Program Brochure
AK				
AL				
AR	Yes	X	X	
AZ	Yes	X		X
CA	Yes	X		
CO	Yes	X		X
CT				
DC				
DE	Yes	X	X	
FL	Yes			
GA				
HI	Yes		X	
IA				
ID	Yes			
IL	No			
IN	No			
KS	No			
KY	Yes	X		
LA				
MA				
MD	No			
ME	No			
MI				
MN	Yes	X		
MO				
MS				
MT	No			
NC	Yes	X		
ND	Yes	X		
NE	Yes	X		
NH				
NJ	Yes	X		
NM	No			
NV				
NY	No			
OH	Yes	X		
OK				
OR	Yes	X		
PA				
RI	Yes	X		
SC	Yes			X
SD	Yes		X	
TN				
TX				
UT	Yes	X		
VA	Yes	X		
VT	Yes	X		
WA	No			
WI	Yes	X		
WV	Yes			X
WY	Yes	X		
Total	25 Yes 9 No	20	4	4

Source: ABA Commission On Legal Problems Of The Elderly, Analysis Of 1996 State Survey.

Impact of Estate Recovery Programs

Revenue to State

The survey asked Medicaid officials about the approximate revenue to the state generated by the estate recovery program. Of the 24 states reporting revenue during the past fiscal year, the highest was California at \$28 million and the lowest was Nebraska at \$19,000. The average revenue in those 24 states reporting recovery amounts in this survey was \$2,989,485.54; and the median revenue was \$651,658. The sum of the 24 responses — indicating total funds generated by Medicaid estate recovery across the country — was \$71,747,653. As a proportion of the state's total Medicaid expenditures (using FY 1994 figures for state and federal total expenditures by state), estate recovery revenues ranged from less than .01 percent of total expenditures in several states, to .54 percent of total expenditures in Oregon. These figures are shown in TABLE 13, along with corresponding figures for expected revenue from recovery during the current fiscal year and during the next fiscal year.

Deterrence to Planning

Policy analysts and advocates have raised the issue of whether estate recovery programs have an effect on "Medicaid estate planning" — the legally permissible sheltering or divesting of assets accomplished for the purpose of becoming eligible for Medicaid.⁴¹ The question is whether possible state recovery from estates of Medicaid beneficiaries discourages planning strategies to achieve eligibility by making eligibility less desirable. Further, planning strategies might be blunted by the allowance in HCFA Transmittal No. 63 for states to impose a rebuttable presumption against finding undue hardship if the beneficiary obtained and followed estate planning advice from legal counsel.

To target this issue, the survey asked both Medicaid officials and legal practitioners to indicate their opinion on whether estate recovery deters Medicaid estate planning. Both groups responded that estate recovery does not deter such planning. A total of 29 officials said that it does not deter planning, while only three (Hawaii, Kansas, Montana) said it does. Of the practitioners, 36 stated recovery does not deter planning, while only three (Arizona, Maine, South Dakota) stated it does. One official (Connecticut) noted that estate recovery actually may encourage the sheltering and transferring of assets. Four practitioners also voiced this theme, suggesting that the program is a "primary motivation for seeing a lawyer" and "adds another planning objective" (California), "promotes inadvisable divestment-oriented estate planning" (Massachusetts), causes "inappropriate poorly-planned transfers" (South Carolina) and "encourages Medicaid planning" (Wisconsin). However, the data are limited in that the survey asked only for opinions, and did not ask for explanations or elaborations of these opinions.

⁴¹ See e.g., Roger A. Schwartz & Charles P. Sabatino, Medicaid Estate Recovery Under OBRA '93: Picking the Bones of the Poor? (American Bar Association, Commission on Legal Problems of the Elderly, 1994).

TABLE 13
REVENUES PRODUCED BY ESTATE RECOVERY PROGRAMS (IN DOLLARS)

State	Revenue Past Fiscal Year (N=24)	Percent of Medicaid Expenditure FY '94*	Expected Revenue Current Fiscal Year (N=19)	Expected Revenue Next FY (N=14)
AR	45,000	<.01		
AZ	132,164	<.01	225,000	236,000
CA (Highest)	28,000,000	.19	31,000,000	32,000,000
CO	883,217	.08	1,200,000	1,350,000
FL	1,175,590	.02	3,000,000	3,300,000
HI	33,960	<.01		
ID	1,500,000	.49	1,800,000	2,000,000
IL	12,400,000	.24	18,600,000	22,000,000
KS	1,224,006	.13	1,500,000	1,750,000
ME	2,000,000	.09		
MT	380,000	.16	600,000	600,000
ND	242,568	.09	242,600	242,600
NE (Lowest)	19,000	<.01	139,000	139,000
NJ	1,912,000	<.01		
OH	150,000	<.01		
OR	6,000,000	.54	7,000,000	7,000,000
PA	420,152	<.01	1,392,763	1,411,200
RI			400,000	725,000
SC			250,000	
SD	261,231	.09	575,099	
UT	1,500,000	.29		
VA	130,265	<.01	250,000	
VT	217,795	.08		
WA	4,719,660	.18	6,763,000	
WI	8,331,195	.36	9,516,600	10,000,000
WV			8,000	
WY	69,850	.05		
SUM	71,747,653	—	84,462,062	82,753,800
MEDIAN	651,658	—	600,000	1,580,600
AVERAGE	2,989,486	—	4,445,372	5,910,986

Source: ABA Commission On Legal Problems Of The Elderly, Analysis Of 1996 State Survey.

* Based on FY '94 total state and federal expenditures. Source: Health Care Financing Administration, Medicaid Bureau, Office of Financial Management.

Effect on Low-Income Older Individuals

An objective of the Medicaid estate recovery program is to help low and moderate income people by recouping funds to ensure the solvency of the program or to expand medical assistance services. Yet at the same time, estate recovery may adversely affect people of modest means. To determine the populations most affected by recovery, the survey requested respondents to rank by frequency four population groups over age 55 from whom recoveries are made. These groups were:

- People who engaged in Medicaid estate planning;
- People who spent down their assets on medical care;
- People who had always been poor; and
- Other.

Only 15 officials and 23 practitioners provided rankings, but they were in general agreement that the group most affected was individuals who spent down their assets on medical care — often middle class individuals. Excluding the ranking of “other” groups, which refers to a variety of designations aggregated together, this group ranked first both in total number of points assigned and in the mean ranking. TABLE 14 provides the mean (average) rankings for these groups.

TABLE 14
Populations Most Frequently Affected by Estate Recovery

	State Officials' Rankings (N=16)	Practitioners' Rankings (N=23)
	Average Rank Order* (Mean)	Average Rank Order* (Mean)
Group A: Persons who engage in Medicaid estate planning	3.0	3.1
Group B: Persons who were always “poor”	2.9	2.2
Group C: Persons who spent down their assets on medical care	1.7	1.8
Group D: Other (Miscellaneous)	2.0	1.3

Source: ABA Commission On Legal Problems Of The Elderly, Analysis Of 1996 State Survey.

*The four groups listed were rank ordered 1, 2, 3, and 4 with no option for equal ranking. A ranking of “1” means that the group is perceived as the most frequently affected.

After those who spend down, the officials ranked frequency of recoveries from those who engaged in planning and those who were always poor about equally. The practitioners rated the poor as second in frequency, and the planners as last. Both groups also emphasized the prevalence of recoveries from those who owned a home at the time of death. Additionally, in an attempt to determine the income of beneficiaries most affected by estate recovery, the survey asked Medicaid officials to indicate the proportion of beneficiaries with incomes in different categories at the time of death. However, states did not have sufficient information to respond.

Finally, the survey asked both officials and practitioners to describe briefly how they believe the estate recovery program affects low-income older individuals. Their varied responses were opinions only, and suggest a need for further research. A substantial number of officials (17) believe that recovery has little or no impact on low-income older persons. They pointed out that these recipients have already died at the time of recovery, and that the poor generally have very little estate from which to recover. This is somewhat at odds with the earlier answer rating the frequency of recovery on the poor. However, most of the comments appeared to talk of "impact" in terms of broad social significance rather than in terms of immediate personal monetary impact or frequency. One official (Idaho) observed that most poor people are "grateful to keep their home and use Medicaid for medical expenses" and another (Pennsylvania) added that the program "allows the elderly to maintain their feeling of independence" by keeping their property while receiving services. Others stated that recovery "allows recipients to retain their home and minimal other resources while providing high-cost long-term care for the elderly" (Colorado), and that "the majority of families believe the recovery law is fair and cooperate" (South Carolina).

Eight officials stated that the estate recovery program helps low-income older individuals by buttressing funding for the Medicaid program, to allow more services for more poor people. The survey did not collect information on whether recovery funds are returned to the Medicaid program or go into general state revenue.

Six state officials commented that the program may have a chilling effect on applications for benefits. For example, the Georgia official reported that while the program is not yet in effect, some families in anticipation of recovery may be "refusing to get the medical care they need." Maine reported that fear of estate recovery had caused many "to drop or not seek Medicaid coverage." South Carolina expressed concern that the program may prevent some from applying and "has caused some recipients to withdraw." Wyoming commented that people are "delaying applying for and receiving benefits." A larger number of practitioners (13) asserted that the poor are so frightened of losing their home that they forego needed services. New Mexico, for instance, noted that many low-income older individuals own modest homes and may hesitate to institutionalize spouses or relatives because they do not want to lose family lands. The Ohio practitioner maintained that the program "conjures up a fear of the unknown that discourages the elderly poor from seeking Medicaid assistance." The Nevada practitioner claimed the idea of recovery "scares the elderly and effectively delays their entry into the program until they are in crisis."

Practitioners viewed the impact on low-income older individuals somewhat more negatively than officials. Twenty respondents expressed concerns, with the majority of these (13) emphasizing the loss of family homes and the psychological effect on older persons of not being able to pass it on to their children. For example, the Massachusetts practitioner described the "specter of losing the home, which represents [for older persons] their security, their dignity, their autonomy, their family and one of their life's proud achievements." North Carolina said estate recovery "robs [older persons] of hope of leaving virtually any legacy to their children." In contrast, seven practitioners commented that the effect on older poor persons is insignificant.

In addition, two practitioners (New Hampshire, Washington) noted problems for the surviving spouse with a lien on the home. According to the New Hampshire practitioner, “surviving spouses feel trapped in their homes with their principal asset frozen. If they have health problems or can’t afford to stay or can’t maintain their homes, they’re frightened and panicked.”

Practitioner Insights

To gain additional perspective on how Medicaid estate recovery is working overall, the survey asked legal practitioners to comment generally on their state’s program. Several practitioners noted the program is still too new to evaluate, and they had little experience with it. Two remarked that the state’s current lack of compliance with the federal estate recovery mandate works to the benefit of recipients (Alabama, Michigan). Three observed the program thus far has proceeded slowly — “cautiously” (Delaware), in a “low key” manner (Nebraska), or with “a conservative approach” (Tennessee). The Kentucky practitioner reported that “I have very few calls about it and am not aware of problems.” Four practitioners commented that the program has a positive effect in helping pay for care for others in need (Iowa, Maryland, New Mexico, Washington).

A number of practitioners commented on negative aspects of estate recovery. They noted especially:

(1) Emphasis on collection. Estate recovery programs may operate like collection agencies (California, Massachusetts), with the goal of bringing in more money driving the system, at the risk of unfairness to beneficiaries.

(2) Erosion of inheritance. Estate recovery may destroy the modest inheritance of adult children whose parents need long-term care (Massachusetts, Montana, New Mexico).

(3) Unfair operation. Estate recovery may lack sufficient procedural due process (Nevada), is vague in regulations (Vermont), is not effectively managed (Florida), ignores federal law (California), gives erroneous information to recipients (South Carolina), and is “unfair in practice” (Massachusetts). The Wisconsin practitioner highlighted the failure of the state hearing examiners “to check abusive practices by local agencies in placement of TEFRA liens,” and attached examples of hearing decisions on the issue of “reasonable expectation of returning home.”

(4) Risk to individuals. Estate recovery impacts negatively on individuals in that it concentrates the risk of catastrophic costs of long-term care (Massachusetts), may cause deterrence in application for benefits (Tennessee), and encourages adult children to refrain from placing ill parents in nursing facilities.

Looking Ahead: Impact of Possible Block Granting

In the face of uncertainty about the Medicaid program at the federal level, the survey asked both officials and legal practitioners to predict the impact of possible block granting on the estate recovery provisions. Specifically, given the freedom to design their own programs, would states be likely to expand or contract the present program, or would it probably remain the same?

The majority of officials predicted the program would remain the same, while the majority of practitioners thought it would expand in scope. A total of 16 responding officials said the program would remain the same, while only eight (California, Connecticut, Delaware, Indiana, Minnesota, Montana, North Carolina, Washington) said the program would be likely to expand. In contrast, 24 responding practitioners thought the program would expand, while 13 thought it would stay the same. Of the practitioners predicting expansion, comments ranged from "expand ferociously" to "may expand a little." Practitioners thought expansion might be in the areas of joint tenancy, life estates, trust recovery, and spousal recovery. One state observed that while the governor is committed to expansion of the program, legislative proposals to accomplish this have been defeated (Massachusetts). Another remarked that some of the pressure that has staved off expansive recovery may keep the program from growing greatly (Indiana).

Officials in three states indicated the program probably would be constricted in scope if federal mandates were removed (South Carolina, Virginia, West Virginia). South Carolina predicted that the state legislature would repeal estate recovery if it is not mandatory, and West Virginia reported that given a choice, the state "will likely abolish it." Only one practitioner thought the program would be reduced with block granting (Wyoming).

III. Discussion of Findings

The immediate picture that emerges from these survey results is that Medicaid estate recovery programs remain in a state of great flux as of the beginning of 1996. While only five states still have no program operational (Alaska, Georgia, Michigan, Tennessee, Texas), many other states have programs operational only at a very rudimentary level. Eleven states reported that they have legislative changes pending; 19 states have no regulations in effect, and of these, 12 have regulations pending.

One problem faced in making sense of these survey results is that Congress provided little explanation of the policy goals and values underlying the estate recovery amendments, other than the obvious goal of containing costs. For purposes of analyzing these data, we consider not only the degree of technical compliance with OBRA '93, but also the financial impact of estate recovery programs, the fairness of their implementation, and their impact on particular populations.

Technical Compliance

The Recoverable Estate

In states with operational programs, the scope of the estate liable for recovery is quite variable and often unclear. Nineteen (of 43 responding) states have chosen to limit recovery to the "probate estate," i.e., property owned by the individual that passes after death under one's will or by intestate succession. This is a limited but fairly clear scope of recovery. States that have chosen to go beyond the probate estate, as permitted by OBRA '93, most frequently target property held jointly with right of survivorship, especially residential property, since that is the most substantial asset a Medicaid beneficiary may retain. At least 18 states seek recovery against such property. Since recovery against real property owned by Medicaid beneficiaries may be delayed for years, there is some concern that state claims may cause problems in conveying property, e.g., because of "hidden" claims. This could arise where, for example, the Medicaid agency is granted a statutory claim against a beneficiary's estate but no recording of the claim or lien appears in the land records. While significant concerns were noted in a few states, the majority of officials and practitioners did not see this as problematic.

Most states, including those that restrict recovery to the probate estate, seek recovery against personal property of the beneficiary, including bank accounts or other small cash funds that are considered exempt during the beneficiary's lifetime. State processes for reaching these funds are variable. Some states may not seek recovery unless probate proceedings already have been initiated. Other states, such as Oregon, aggressively rely on legislation that requires, for example, banks to pay account balances directly to the state agency without going through probate.

The greater the reach of estate recovery into ownership interests, the greater the complexity faced by states in tracking claims, complying with TEFRA lien and collection restrictions, valuing property, and providing adequate notice to involved parties. The survey does not provide state-specific conclusions on success in addressing these complexities. However, the overall incongruence between survey responses from state officials and practitioners indicates either a substantial misunderstanding of the survey questionnaire itself or a substantial lack of clarity and understanding about the reach of estate recovery, even among the "experts." Telephone follow-up with a number of respondents after receipt of the questionnaire leads the researchers to believe it is the latter. Increased dialogue between Medicaid officials and legal practitioners might sharpen the picture and enable the public to be better informed.

Recoverable Services

Another component that determines the scope of estate recovery is the range of services for which states may seek recovery. More than half of the responding state officials (24 of 43) stated that they recover in full for all Medicaid services, and all the remaining states recover for at least one or more optional services. Practitioner responses to this query were quite different from officials' responses, indicating a substantial lack of clarity within the states. Home- and community-based services can be particularly ambiguous with respect to their estate recovery status, since they can involve many permutations of services — some funded under the regular Medicaid state plan, some funded under special waivers, and some funded by state monies.

Additional questions beyond the scope of this survey concerning services subject to recovery are likely to arise as states move toward managed care systems under Medicaid. Under capitated models, it becomes more difficult to quantify the actual amount due for estate recovery purposes. Even if states continue to track itemized costs for services received, it is not clear whether and how itemized costs would be recovered if a state pays a capitated rate to providers, or if the state provides additional services not normally covered under Medicaid.

Estate Recovery Procedures and Liens

The survey examined waiver and deferral practices of states, including hardship waivers, and the use of liens for enforcement purposes. All responding states reported either waiving or deferring estate recovery when the beneficiary is survived by a spouse or minor or disabled child. In these situations, TEFRA '82 requires deferral at a minimum where a home is involved. A waiver, if used, permanently releases the claim of the state rather than merely deferring it. Some states use waivers where deferral might extend for an impractically long time, for example, when the survivor is a minor or disabled child who is likely to live for decades.

One substantive area of inconsistency concerns the OBRA '93 prohibition of recovery against a beneficiary's estate until after the death of any surviving spouse or a disabled child, or until a non-disabled child reaches age 21. The language includes no requirement that the survivor live in the home of the deceased beneficiary (although such a residence requirement does apply to deferrals for siblings and adult care-taker children). Contrary to the statutory language, five states responded that they required residency in the home as a prerequisite to deferral. If practitioner

responses are relied upon in non-responding states, an additional four states imposed the same requirement. Because the practice of requiring the survivor to live in the home may be directly contrary to the language of OBRA '93, it is a matter on which HCFA may need to provide stronger guidance.

The use of liens also varies quite significantly among the states. Twenty-eight states responded that they use liens, and 15 of these (13 surveyed, plus two additional) use TEFRA liens. While the survey did not ask about the number of TEFRA liens placed, tracking this will best enable the states and HCFA to evaluate the program and its impacts. Comparisons of practices among the 15 states using TEFRA liens would provide valuable insight about program operation.

Lien practices are, and may continue to be, in a state of flux, as demonstrated by the California legislature's decision to repeal its TEFRA and spousal lien provision in the state code, effective January 1, 1996.⁴² The repeal was brought about in part by federal district court litigation which ruled that California was constitutionally required to provide notice and an opportunity for a hearing before the state could impose a lien on property held by a surviving spouse of a beneficiary.⁴³ The state appears to have concluded that the required due process obligations were not worth the effort, since the state's notice of intent to impose a lien might instead encourage survivors to transfer the home prior to actual placement of the lien.

How these developments will affect other states is unclear. However, the effect of liens and claims against the property interests of survivors is a complicated matter. In a recent Wisconsin Court of Appeals decision, Estate of Budney v. State Dept. of Health & Social Services, the court ruled that the state's statute allowing recovery of medical assistance benefits from the estate of a Medicaid recipient's surviving spouse exceeded the authority provided by the federal Medicaid statute (specifically 42 U.S.C. §1396p(b), the section containing the estate recovery mandate and restrictions).⁴⁴ Grace Budney was a resident of a nursing home and a recipient of medical assistance. She died after residing in the home for over a year. A year after her death, her husband Paul Budney died. After his death, the state filed a claim against his estate. The estate objected on the ground that federal law prohibits the recovery of medical assistance benefits paid on behalf of a predeceased spouse. The trial court concluded that the Wisconsin estate recovery statute violated 42 U.S.C. s 1396p(b) (1995) and granted summary judgment in favor of the estate. The Wisconsin Court of Appeals upheld the trial court decision, reasoning that §1396p(b) plainly prohibits a state from recovering medical assistance benefits except in certain situations. Because the statute does not counter the initial blanket prohibition by specifically authorizing the state to recover medical assistance benefits paid on behalf of a recipient from a surviving spouse's

⁴² S.B. 412, enacted October 6, 1995, repeals California Welfare and Institutions Code § 14006.7 (the TEFRA lien section) and § 14009.5 (the spousal lien section), effective January 1, 1996.

⁴³ DeMille v. Belshe, *Supra* note 39, at 35.

⁴⁴ 541 N.W.2d 245 (Wis. Ct. App. 1995).

estate, it concluded that the Wisconsin statute which allows such recovery exceeded the authority provided by the federal statute.

Taken to its fullest, the reasoning of Budney could eliminate state authority to recover against survivors once probate of a beneficiary's estate is closed. At that point, the estate belongs to the survivor, and the beneficiary no longer has an "estate" from which to recover. Budney is not the prevailing view among the states, but it is likely to precipitate more challenges to recoveries against survivors' estates.

Permanent Institutionalization

While the majority of responding states make determinations of permanent institutionalization (PI) for purposes of estate recovery, a significant number (12) do not. If the state does not use TEFRA liens (which are conditioned upon a finding of PI), it has no obligation to make PI determinations. All the states that use TEFRA liens, plus others, have criteria and procedures for PI determination. However, most report that they either have not made any PI determinations, or they do not know how many determinations have been made. The general lack of state data indicates a need for states to keep records on determination of permanent institutionalization, tracking the frequency of determinations, the frequency of hearings, and the kinds of beneficiaries involved.

The survey found that the majority of states go beyond a subjective standard of "intent to return home" in making the determinations. The trend is not surprising, since the "intent to return home" standard markedly weakens the state's ability to find anyone's institutionalization permanent. Objective standards used by states include assessment by a third party or presumptions based on length of stay. Presumptions based on length of stay raise a danger of arbitrariness if too rigid or too short. For example, the presumption in one state where a stay of any length triggers a finding of PI probably goes too far. If a very short stay triggers a presumption of permanent institutionalization, this may place an unwarranted burden on beneficiaries who must then establish that they can return home.

Hardship Waivers

Only 28 states reported having criteria for determining the existence of undue hardship. Eight reported that criteria were not yet established. The hardship waiver, which states have broad discretion to define, serves to establish a remedy for individuals when strict application of estate recovery policies is deemed unfair or counter-productive. The criteria used by states generally fall into six broad categories described on pages 32-34. The most common criterion, used in at least 22 states, requires a finding that the estate consists of income-producing property needed by the survivors. Variations on this theme include requirements such as: the property is the sole income source, the survivor's income is limited, or the property is also the survivor's home. The other categories focus more heavily on the asset being the primary residence of the survivors (12 states) or that the homestead is of modest value (four states); the potential for forcing or keeping survivors on public assistance or medical assistance if recovery is made (12 states); the potential deprivation of necessities, e.g., food, shelter, clothing (eight states); and

whether contributions made by survivors to the beneficiary's care and support (three states). A variety of other criteria that did not fit neatly into any of these categories also appeared, including the catch-all "other compelling circumstances."

Some states are quite specific about income or asset criteria survivors must meet in order to qualify for a hardship waiver. For example, North Carolina requires that where the estate consists of the primary residence of the survivor, the survivor must have income below 75 percent of poverty level and assets below \$12,000 for recovery to be waived. Kentucky established a hardship criterion that grants a waiver of recovery from estates below \$5,000 in personal property and to homesteads valued below \$50,500. The state selected the latter figure because it represented the state's median home value. Formula income/asset criteria such as these have the advantage of clarity and predictability, although such tests may also lack flexibility unless the established criteria allow room for evaluating compelling cases that do not meet the formula. A few states described their criteria only in terms of "factors" to be considered without really attempting to describe the threshold for undue hardship. This approach gives the state far more flexibility, but may encourage abuse of discretion because of its looseness.

When states make a finding of undue hardship, most use a repertoire of responses including waiving recovery, deferring recovery, or working out a modified recovery agreement with survivors. One question that arises in reviewing these responses is whether the statutory mandate permits the latter two options. The estate recovery provision requires the establishment of procedures "under which the agency shall *wave* the application of [estate recovery]"⁴⁵ Transmittal No. 63 explicitly states that states may "limit the waiver to the period during which the undue hardship circumstances continue to exist,"⁴⁶ thus treating the waiver as a deferral of the claim rather than as a relinquishment of the claim. To date, the question has not been raised in litigation nor clarified in rulemaking.

The survey found that some states do not track the number of hardship waivers requested or granted. Monitoring waiver information would help policy makers to assess how the program is working.

Financial Impact

If cost-containment is a major goal of estate recovery, then recovery dollars are an important measure. The current revenue generated by the program differs markedly among states. Twenty-four states reported some revenue from estate recovery in their last fiscal year (FY 1994 in most cases) for an aggregate total of almost \$72 million. The Health Care Financing Administration's official national total for estate recovery in FY 1994 was \$99.6 million which amounts to less than .07 percent (i.e. seven hundredths of one percent) of the \$143.2 billion in

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⁴⁶ Health Care Financing Administration, U.S. Department of Health & Human Services. Financial Report, Fiscal Year 1994, p. 25; and Medicaid Financial Management Reports (HCFA-64).

total federal/state Medicaid expenditures for FY 1994. For FY 1995, HCFA reports that estate recovery totals rose significantly to \$124.8 million.⁴⁷ Additional significant jumps in recoveries during the next few years might be expected as the remaining states put their programs into full operation. The Congressional Budget Office estimated \$300 million in savings for the five-year period 1994-1998 resulting from Medicaid estate recovery⁴⁸ — an amount significant in actual dollars but still based on a recovery potential of approximately .1% of Medicaid expenditures. Many states responding to the survey recovered far less than .1% of their total state/federal Medicaid expenditures, and some recovered more. Oregon, which has been very aggressive in recovery efforts, represents the upper potential of estate recovery at .54% of total expenditures (based on FY 1994 expenditures as the comparison mark).

The financial impact of estate recovery on states is also influenced by the administrative overhead of estate recovery and by the fact that, for every dollar recovered, part is returned to the federal government in an amount determined by the federal share of Medicaid expenditures (which ranges from 50 percent in many states to approximately 78 percent in Mississippi). Since this study did not survey state program costs, further research is needed to assess this aspect of cost-effectiveness.

Finally, the financial impact of estate recovery may be measured by the extent to which it deters Medicaid estate planning. Medicaid estate planning has been defined as “the manipulation of Medicaid eligibility rules by non-poor older persons, their heirs, and their attorneys to obtain Medicaid coverage for nursing home care while protecting significant amounts of wealth.”⁴⁹ There is considerable disagreement about the extent to which Medicaid estate planning occurs, and indeed, the difficulties of objectively measuring the phenomenon are daunting.⁵⁰ This survey sought only opinion data from the officials and practitioners who are in a better position than most to make a reasonable judgment about the impact of estate recovery on Medicaid estate planning. By large margins, both officials and practitioners expressed the opinion that estate

⁴⁷ Health Care Financing Administration, U.S. Department of Health & Human Services. Financial Report, Fiscal Year 1994, p. 25; and Medicaid Financial Management Reports (HCFA-64).

⁴⁸ Letter from James L. Blum for Robert D. Reischauer, Director, Congressional Budget Office, to Hon. John Dingell, Chairman, Committee on Energy and Commerce. U.S. House of Representatives (May 14, 1993).

⁴⁹ Brian Burwell, Middle-Class Welfare: Medicaid Estate Planning for Long-Term Care Coverage 1 (SystemMetrics/Mcgraw-Hill, September 1991).

⁵⁰ Little hard evidence exists regarding the extent to which Medicaid estate planning occurs. A 1993 study by the General Accounting Office in Massachusetts found that 54 percent of applicants converted some of their countable assets to non-countable assets, and 13 percent transferred assets to others. Asset transfers accounted for approximately two-thirds of the dollar amount of these transactions. However, 52 percent of these applications were denied, accounting for 67 percent of the dollar value of the transfers. Thus, the GAO report presents mixed messages about the extent of Medicaid estate planning. See General Accounting Office, Medicaid Estate Planning (GA)-HRD-93-29R (1993); see also, Brian Burwell, State Responses to Medicaid Estate Planning (SystemMetrics, Cambridge, MA, 1993); Brian Burwell, Middle-Class Welfare: Medicaid Estate Planning for Long-Term Care Coverage (SystemMetrics, Lexington, MA, 1991).

recovery does not deter Medicaid planning. A few suggested that it may in fact promote it. However, these data are limited to respondents' opinions and do not include further elaboration or explanation.

Fair Implementation (Due Process)

The fair implementation of Medicaid estate recovery concerns not only advocates for the poor, but also policy makers and administrative officials. The survey sought information on four specific implementation issues that can raise due process problems: variability of states' practices, the use of private contractors, notices of estate recovery, and the use of liens.

Variability

While estate recovery practices vary significantly among states, the survey findings show little evidence of within-state variation, except in two jurisdictions where recovery was delegated to local agencies. In most states, the program is centralized and operates state-wide. However, even in these programs, the states and HCFA need to monitor for potential variability due to differences in workers, county referrals, attorneys, and local technology.

Contractors

While most states run recovery programs through designated state agencies, five contract with private entities to operate the program, and two others either contract out part of the program or were in the process of contracting the program. It is unclear whether privatizing estate recovery will become a significant trend. It will be incumbent on states and on HCFA to ensure necessary procedural protections are maintained if recovery programs are removed from government, since private collection agency tactics run a risk of overstepping the procedural restraints to which government agencies are accustomed. State Medicaid agencies will need to monitor contractors to ensure appropriate due process and consumer protection.

Notice

A key obligation of states in implementing estate recovery programs is ensuring adequate notice to beneficiaries and families throughout the process. The survey found the notice provisions uneven. Responses showed that states vary significantly in points in time at which they give a notice and information about estate recovery. All responding states give the required general notice at application for Medicaid benefits. In judicial proceedings, notice is less problematic since court rules require specific notice to parties. However, there are many points in time prior to judicial action where an explanation of estate recovery liability is crucial to individual and family decision making. These intermediate points in time include nursing home admission, determination of permanent institutionalization, receipt of home- and community-based services, lien placement, and lien enforcement. Indeed, only half of the states using liens reported giving notice at the time of enforcement of a lien. Providing notice at most or all of these key trigger points will best inform beneficiaries of potential claims, so they or their families will not be surprised when a specific claim is made.

While HCFA directs states to include information about hardship waivers in the recovery notice, currently not all states provide hardship waiver notice. Twenty-six state officials reported that they do indeed give written notice, but nine officials reported that they do not, or that they are in the process of developing notice of the availability of hardship waivers. Such notice is essential to preserve the procedural due process rights of beneficiaries.

Responding practitioners maintained that some recovery notices have incomplete or inaccurate information. Recovery notices do not always completely explain the claim, the required federal exceptions, the state exemptions, the procedure for obtaining a hardship waiver, or the procedure for contesting a claim. A thorough and accurate description of each of these factors is critical for beneficiaries and families who need to know as soon and as straightforwardly as possible whether they fall within the scope of recovery. It also is critical for the state to effectively identify appropriate cases and efficiently administer an appeals process. Moreover, notices often do not assure families that the claim will not exceed the value of the estate and will not be enforced pending appeal.

Finally, timely notice to beneficiaries and families will be of little use unless it is readily understandable. Many practitioners noted that the notices frequently are difficult to understand. Sometimes the notices use boilerplate language and complex legal terms. Readability and print size vary. States should review notices with an eye toward making them as "user friendly" as possible. States could benefit from examples of clear and complete recovery notices, so that each jurisdiction does not have to rethink the content and format from scratch.

Liens

In those states which currently use liens, the survey findings raise some concern about the adequacy of procedures for terminating liens on the property of institutionalized beneficiaries when they return home, as required by the federal lien provisions.⁵¹ Problems were suggested in the responses of officials and/or practitioners in at least seven states, specifically: the lack of any process for release of liens; failure to release liens unless prompted by family or counsel; requiring a written request for release; or requiring a 90-day home stay before release. In states that reported no problems with lien releases, none provided enough information to determine the reliability or promptness of their process. Further development of the lien termination process is needed.

Impact on Particular Populations

Even if Medicaid estate recovery is implemented with scrupulous procedural due process, fairness concerns may still arise if particular populations bear a disproportionate share of the burden of estate recovery. For example, recovery against small accounts or small estates consisting of only personal property raises a question about which subpopulation bears the

⁵¹ 42 U.S.C. § 1396p(a)(3).

monetary brunt of estate recovery, and whether the burden falls equitably. Aggressive recovery against small caches of personal property may fall most heavily on beneficiaries who never had significant assets nor engaged in Medicaid estate planning, rather than on those who sheltered assets and engaged in planning. If the goal of estate recovery is simply to recoup as much as possible, then the source of recoupment may not be much of a concern to policy makers. But if other factors — such as fairness and deterrence of Medicaid estate planning — are important, then the impact on particular subpopulations bears further scrutiny.

Measuring the impact of estate recovery on particular populations is exceedingly difficult. The approach used by this survey was subjective in nature — the opinion of officials and practitioners. While imperfect as a measure, the perspective of these respondents should not be overlooked, since they are “in the trenches” dealing with real people dependent on Medicaid and real families who are left behind when the beneficiary dies. Interestingly, officials and practitioners surveyed were in general agreement that the group most affected by the recovery programs were those who spent down their assets on medical care — typically people of modest means who most likely did not engage in Medicaid estate planning. They were hard hit by the double jeopardy of spend-down and recovery. Additionally, some of the practitioners remarked on the loss of the family home, the psychological effect of not passing on a legacy, and the symbolic loss of the homestead as central to family life.

Respondents differed as to the impact of recovery specifically on the low-income older persons, with many perceiving little impact. However, some respondents observed a chilling effect on the decision to apply for benefits. Interpretation of these results requires caution, since the public’s reaction to estate recovery may be confounded by widespread uncertainty and misunderstanding about estate recovery programs, which in turn may cause families to conjure up excessive alarm. The question deserves further study especially because, if the chilling effect indeed occurs, it not only adversely impacts the people who need Medicaid services, but it also undermines the cost-effectiveness of the program, since those who forego needed care early may require more costly care later.

One other population that merits special concern is the survivors of Medicaid beneficiaries. Congress recognized this fact by requiring a hardship exemption to ensure their welfare. In addition, the TEFRA lien restrictions also seek to ameliorate undue burdens on survivors. However, a few practitioners asserted that for a surviving spouse with few assets other than the home, a lien on that home can drastically limit the spouse’s options for financial survival. Because of the lien, it may be impossible to refinance the home — an option that may be needed to maintain the home or meet unexpected expenses. It may be impossible to obtain a reverse mortgage. A reverse mortgage is a financial tool that is becoming increasingly available nationwide and that could enable the spouse to convert equity into a needed income flow. Reverse mortgage qualification usually requires the home to be substantially free and clear of encumbrances. Even access to routine lines of credit for credit cards or credit purchases is impeded by the existence of an encumbrance against the survivor’s most significant asset.

The burden that a Medicaid lien places on the property rights of survivors is emphasized by the federal court in the DeMille decision.⁵² While upholding the placement of such liens, the court recognized that the lien reduces the economic benefit to the surviving spouse during his or her lifetime, and thus requires pre-attachment notice. Medicaid officials did not raise concerns about liens burdening survivors. The extent to which these problems arise needs further research.

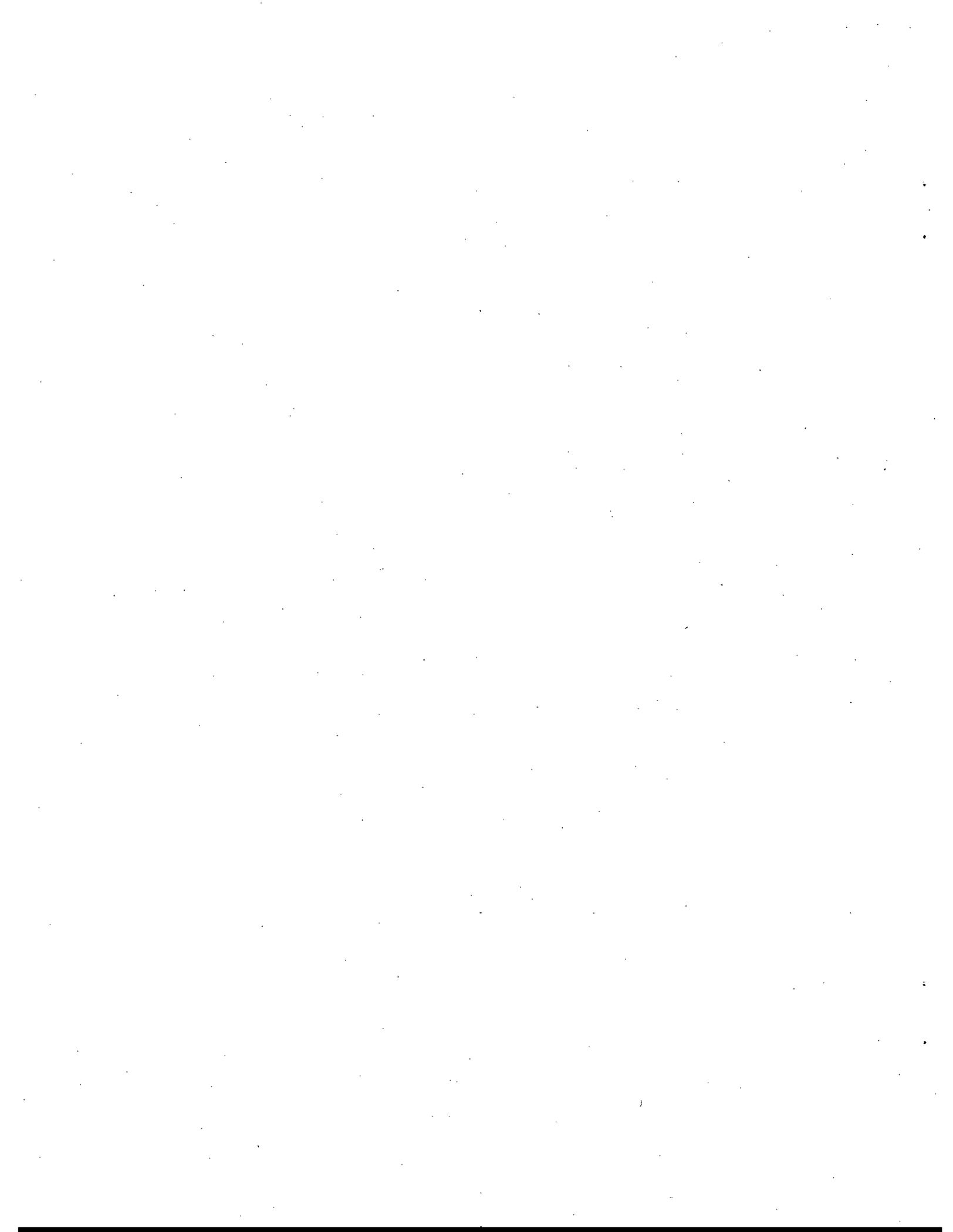
The Broader Perspective

The Medicaid program has fueled a continuing debate about the limits and responsibilities imposed by means-tested entitlement programs. There is nothing new about this debate, and indeed, it is the kind of debate that is important to the development of public policy on many levels. A full discussion of policies such as Medicaid estate recovery requires an appreciation of multiple social values, goals, and consequences at stake. What for example, is the societal importance of inheritances and legacies? Is their importance different for the rich and poor? What is the trade-off between these values and cost-constraints demanded by state and federal budgetary needs? To what extent should society encourage, or even enforce, filial responsibility and family caregiving? To what extent can and should Medicaid estate planning be proscribed? Is it fundamentally different from other forms of preserving wealth, such as tax planning, that society condones?⁵³

All these values and goals compete in a context of possibly rapid change in the Medicaid program, as the Congress considers options such as block granting Medicaid and eliminating its entitlement status. Interestingly, a majority of responding officials predicted that their estate recovery programs would not change significantly if Medicaid is converted to a state block grant. Regardless of the future structure of Medicaid, estate recovery policies and practices will need continuing evaluation. This survey is intended to contribute to that ongoing evaluation. Its findings provide a snapshot of the current status of Medicaid estate recovery practices, yet still leave many questions and concerns unabated — the cost-effectiveness of these programs, whether recovery deters unjustified Medicaid estate planning, whether the burden of estate recovery is fairly distributed, and whether notice and due process protections are adequate. The answer to many of these questions will require more thorough tracking and record-keeping by state Medicaid programs and more intensive monitoring by the federal government. Finally, evaluation will require something we still lack, consensus in the guiding values for providing and financing health and long-term care.

⁵² DeMille v. Belshe, 1995 WL 23636 (N.D. Cal.), *Medicare & Medicaid Guide* (CCH) ¶ 43,082.

⁵³ For further discussion of the societal issues raised by Medicaid, see Rosalie A. Kane, Louise Starr & Mary Olsen Baker (eds.) Who Owes Whom What? Personal, Family, and Public Responsibility for Paying for Long-Term Care 35 (Minneapolis: National Long-Term Care Resource Center, January 1995).



APPENDICES:

APPENDIX A. Survey Instrument - Medicaid Officials

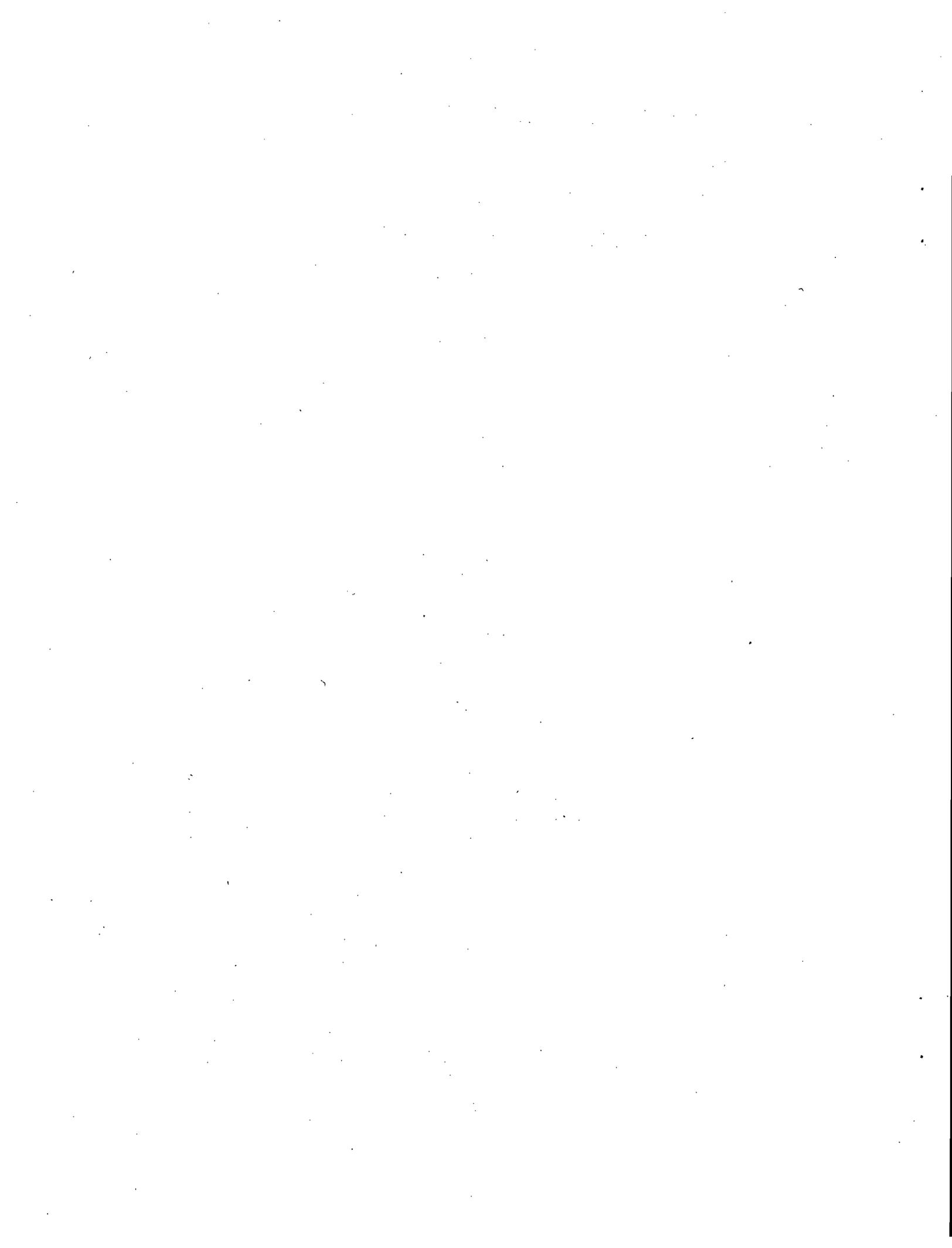
APPENDIX B. Survey Instrument - Legal Practitioners

APPENDIX C. Undue Hardship Criteria

APPENDIX D. Frequency of Hardship Waivers

APPENDIX E. Examples of Estate Recovery Notices

- Nebraska Department of Social Services Brochure:
- “Medicaid Estate Recovery Program”
- Iowa Department of Human Services:
- “Estate Recovery Program” Flyer
- Idaho Department of Health and Welfare, Division of Medicaid:
- “Notice of Statutory Claim”
- Minnesota “Notice of Claim for Medical Assistance in Decedent’s Estate”
- (Includes Notice of Undue Hardship Waiver)



ESTATE RECOVERY PRACTICES SURVEY [Legal Practitioner]

Please return by November 22, 1995 to: STATE _____

Erica F. Wood
Commission on Legal Problems of the Elderly
American Bar Association
740 15th Street NW
Washington, DC 20005-1009
202-662-8690

Feel Free to explain or comment on your answers and, if needed, continue your comments on the back of the page or on additional sheets.

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1. Does your state have a Medicaid estate recovery program in operation?

___ Yes ___ No

If Yes, How long has it been operating?

It has been operating since: (Date) _____

2. Is there any pending or anticipated state legislation or regulation regarding Medicaid estate recovery?

___ Yes ___ No

If Yes, describe its substance and status _____

DEFINITION OF ESTATE

3. Is the estate recovery program limited to the probate estate?

___ Yes [SKIP TO QUESTION 5]

___ No

4. If the estate recovery program reaches beyond the probate estate, what other assets does the state target?

5. Is the scope of property subject to estate recovery clearly understood in practice?

Yes No

If No, please describe the areas of uncertainty: _____

6. In practice, does the program seek recovery against:

Yes No Cash assets that were exempt because they were below the Medicaid asset limit.

Yes No Other personal property owned outright by the beneficiary prior to death

Yes No Personal or real property which the beneficiary owned jointly prior to death

Yes No Personal or real property in which the beneficiary had a life estate prior to death

7. Are you aware of any instances of problems with title conveyance due to estate recovery?

Yes No

If Yes, please describe the problems: _____

SERVICES FOR WHICH RECOVERY IS SOUGHT

8. For Medicaid beneficiaries age 55 or over, please check off all services listed below for which the state currently seeks recovery and note the scope of recovery?

Nursing facility services

All

In part (explain): _____

ICF/MR facility services

All

In part (explain): _____

Home and community based services

All

In part (explain): _____

Hospital services

All

In part (explain): _____

____ Prescription drug services

____ All

____ In part (explain): _____

____ Physicians' services

____ All

____ In part (explain): _____

____ Other Medicaid services

____ All other

____ Some other (explain): _____

LIENS/WAIVERS/DEFERRALS

9. **When a surviving spouse or minor or disabled child lives in the deceased recipient's home, does the state:**

a. **Waive recovery**

____ Yes ____ No Any explanation: _____

b. **Defer recovery until after the death of the spouse or disabled child.**

____ Yes ____ No Any explanation: _____

c. **Offer to negotiate a settlement of the claim and/or a payment schedule.**

____ Yes ____ No Any explanation: _____

d. **Is there any change in your above answers if the surviving spouse or disabled child does not actually live in the deceased beneficiary's home?**

____ Yes ____ No

If Yes, please explain: _____

10. Does your state use any type of liens to enforce estate recovery?

Yes No [IF NO, SKIP TO QUESTION #13]

If Yes, which of the following kinds of liens are used?

a. TEFRA liens (i.e., liens placed on the beneficiary's home while he/she is still alive)?

Yes No

b. Liens on deceased beneficiary's real property obtained through probate court proceedings

Yes No

c. Other Liens:

Yes No

If Yes, please explain: _____

11. When the home of a living Medicaid beneficiary is sold, is a lien on the home enforced at that time?

Yes No

Any explanation: _____

12. Is there a process in place for ensuring immediate removal of a lien on the home when a Medicaid beneficiary returns home?

Yes No

If Yes, please describe: _____

13. Is there an established estate value below which recoveries will not be made?

Yes No

If Yes, describe: _____

14. Is there an established claim level below which the State will not seek recovery?

Yes No

If Yes, describe:

NOTICE & HEARING ISSUES

15. Are Medicaid applicants given notice in writing of the estate recovery process at the time of application?

Yes No

16. At what other times are Medicaid beneficiaries and families given notice of estate recovery?

a. Upon admission to nursing home as a Medicaid beneficiary?

Yes No

b. For those under age 55, upon determination that they are considered permanently institutionalized?

Yes No

c. Upon receipt of non-institutional long-term care services?

Yes No

d. Upon placement of a lien?

Yes No

e. Upon enforcement of a lien?

Yes No

f. Other

Yes No

If Yes, Please explain: _____

17. In your opinion, are the notices accurate and understandable?

Yes No

If No, what are the problems with notice? _____

*** IF POSSIBLE, PLEASE ATTACH EXAMPLES OF PROBLEM NOTICES  ***

PERMANENT INSTITUTIONALIZATION

18. Are you aware of:

a. Any state initial determinations finding that a Medicaid beneficiary is "permanently institutionalized" for purposes of estate recovery?

___ Yes ___ No

b. Any state administrative appeals hearings on the issue of whether a Medicaid beneficiary is "permanently institutionalized" for purposes of estate recovery?

___ Yes ___ No

UNDUE HARDSHIP

19. Has your state established criteria for waiving estate recovery based on undue hardship?

___ Yes ___ No

___ If Yes, what are the criteria: _____

20. Does the state provide beneficiaries or their family written notice of an undue hardship exemption to estate recovery?

___ Yes ___ No

If Yes, a. When and how is notice given? _____

b. In your opinion, are the notices accurate and understandable?

___ Yes ___ No

If No, what are its shortcomings? _____

21. If undue hardship is established, does the program:
(Check all that apply)

Waive estate recovery

Defer estate recovery

Negotiate a modified estate recovery

Other action (please explain): _____

IMPACT OF PROGRAM

22. Do estate recovery practices vary by local jurisdiction within the State?

Yes No

If Yes, describe: _____

23. In your opinion, does Medicaid estate recovery effectively deter persons from "Medicaid estate planning," i.e., intentionally sheltering substantial assets for purposes of becoming eligible for Medicaid?

Yes No

24. Please rank order (From 1 to 4) the populations over age 55 from whom recoveries are most frequently made

Persons who engaged in Medicaid estate planning

Persons who were always "poor"

Persons who spent down their assets on medical care

Other (describe): _____

25. Briefly describe how you believe the estate recovery program affects the elderly poor?

26. If Medicaid is converted to a block grant program by the Congress, do you expect the estate recovery program to change in any of the following ways?
(CHECK ONE):

____ Expand in scope

____ Contract in scope

____ Stay about the same

____ Other (Please describe): _____

27. Please share any other insights you have on the positive or negative aspects of the Medicaid estate recovery program in your state:

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE!

Your Name: _____

Title: _____

Agency: _____ Phone: _____

Address: _____

IF YOU WOULD LIKE A COPY OF THE REPORT BASED ON THIS SURVEY, PLEASE CHECK THIS BOX. YOU SHOULD EXPECT IT IN EARLY 1996



Please remember to return:

√ _____ This questionnaire (A postage-paid envelope is provided for your convenience.)

√ _____ Copy of any notices or other attachments supplementing your answers

THANK YOU!

surv-adv.fm

APPENDIX B

ESTATE RECOVERY PRACTICES SURVEY [Medicaid Officials]

Please return by November 22, 1995 to: STATE _____

Erica F. Wood
Commission on Legal Problems of the Elderly
American Bar Association
740 15th Street NW
Washington, DC 20005-1009
202-662-8690

Feel Free to explain or comment on your answers and, if needed, continue your comments on the back of the page or on additional sheets.

©1996, American Association of Retired Persons and the Commission on Legal Problems of the Elderly, The American Bar Association

1. Does your state have a Medicaid estate recovery program in operation?

___ Yes ___ No

If Yes, How long has it been operating?

It has been operating since: (Date) _____

2. Is there any pending or anticipated state legislation or regulation regarding Medicaid estate recovery?

___ Yes ___ No

If Yes, describe its substance and status _____

DEFINITION OF ESTATE

3. Is the estate recovery program limited to the probate estate?

___ Yes [SKIP TO QUESTION 5]

___ No

4. If the estate recovery program reaches beyond the probate estate, what other assets does the state target?

5. Is the scope of property subject to estate recovery clearly understood in practice?

Yes No

If No, please describe the areas of uncertainty: _____

6. In practice, does the program seek recovery against:

Yes No Cash assets that were exempt because they were below the Medicaid asset limit.

Yes No Other personal property owned outright by the beneficiary prior to death.

Yes No Personal or real property which the beneficiary owned jointly prior to death.

Yes No Personal or real property in which the beneficiary had a life estate prior to death.

7. Are you aware of any instances of problems with title conveyance due to estate recovery?

Yes No

If Yes, please describe the problems: _____

SERVICES FOR WHICH RECOVERY IS SOUGHT

8. For Medicaid beneficiaries age 55 or over, please check off all services listed below for which the state currently seeks recovery and note the scope of recovery?

Nursing facility services

All

In part (explain): _____

ICF/MR facility services

All

In part (explain): _____

Home and community based services

All

In part (explain): _____

Hospital services

All

In part (explain): _____

b. Liens on deceased beneficiary's real property obtained through probate court proceedings

Yes No

c. Other Liens:

Yes No

If Yes, please explain: _____

11. When the home of a living Medicaid beneficiary is sold, is a lien on the home enforced at that time?

Yes No

Any explanation: _____

12. Is there a process in place for ensuring immediate removal of a lien on the home when a Medicaid beneficiary returns home?

Yes No

If Yes, please describe: _____

13. Is there an established estate value below which recoveries will not be made?

Yes No

If Yes, describe: _____

14. Is there an established claim level below which the State will not seek recovery?

Yes No

If Yes, describe: _____

NOTICE & HEARING ISSUES

15. Are Medicaid applicants given notice in writing of the estate recovery process at the time of application?

Yes No

16. At what other times are Medicaid beneficiaries and families given notice of estate recovery?

a. Upon admission to nursing home as a Medicaid beneficiary?

___ Yes ___ No

b. For those under age 55, upon determination that they are considered permanently institutionalized?

___ Yes ___ No

c. Upon receipt of non-institutional long-term care services?

___ Yes ___ No

d. Upon placement of a lien?

___ Yes ___ No

e. Upon enforcement of a lien?

___ Yes ___ No

f. Other

___ Yes ___ No If Yes, Please explain: _____

17. In your opinion, are the notices accurate and understandable?

___ Yes ___ No

If No, what are the problems with notice? _____

*** IF POSSIBLE, PLEASE ATTACH EXAMPLES OF PROBLEM NOTICES  ***

PERMANENT INSTITUTIONALIZATION

18. Are you aware of:

a. Any state initial determinations finding that a Medicaid beneficiary is "permanently institutionalized" for purposes of estate recovery?

___ Yes ___ No

b. Any state administrative appeals hearings on the issue of whether a Medicaid beneficiary is "permanently institutionalized" for purposes of estate recovery?

___ Yes ___ No

UNDUE HARDSHIP

19. Has your state established criteria for waiving estate recovery based on undue hardship?

Yes No

If Yes, what are the criteria: _____

20. Does the state provide beneficiaries or their family written notice of an undue hardship exemption to estate recovery?

Yes No

If Yes: a. When and how is notice given?: _____

b. In your opinion, are the notices accurate and understandable?

Yes No

If No, what are its shortcomings? _____

21. If undue hardship is established, does the program:
(Check all that apply)

Waive estate recovery

Defer estate recovery

Negotiate a modified estate recovery

Other action(please explain): _____

IMPACT OF PROGRAM

22. Do estate recovery practices vary by local jurisdiction within the State?

Yes No

If Yes, describe: _____

23. In your opinion, does Medicaid estate recovery effectively deter persons from "Medicaid estate planning," i.e., intentionally sheltering substantial assets for purposes of becoming eligible for Medicaid?

Yes No

24. Please rank order (From 1 to 4) the populations over age 55 from whom recoveries are most frequently made.

Persons who engaged in Medicaid estate planning

Persons who were always "poor"

Persons who spent down their assets on medical care

Other (describe): _____

25. Briefly describe how you believe the estate recovery program affects the elderly poor?

26. If Medicaid is converted to a block grant program by the Congress, do you expect the estate recovery program to change in any of the following ways?
(CHECK ONE):

Expand in scope

Contract in scope

Stay about the same

Other (Please describe): _____

27. Please share any other insights you have on the positive or negative aspects of the Medicaid estate recovery program in your state:

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE!

Your Name: _____

Title: _____

Agency: _____ Phone: _____

Address: _____

IF YOU WOULD LIKE A COPY OF THE REPORT BASED ON THIS SURVEY, PLEASE CHECK THIS BOX. YOU SHOULD EXPECT IT IN EARLY 1996



Please remember to return:

√ ___ This questionnaire(A postage-paid envelope is provided for your convenience.)

√ ___ Copy of any notices or other attachments supplementing your answers

THANK YOU!

surv-adv.fin

APPENDIX C

Undue Hardship Criteria

In the states reporting undue hardship regulations, their criteria fell loosely into six broad, sometimes overlapping categories with multiple variations described below. Some states cast their criteria only in terms of "factors" to be considered in determining hardship, rather than as substantive standards. These are noted as such in the descriptions.

1. The estate consists of an income producing asset (business, including farm or ranch), and recovery would cause loss of livelihood (22 states).

- AR - Asset is the sole asset of survivors; the income is not sufficient to meet their living expenses and also repay debt.
- AZ - Asset is business that has been in operation at least 12 months, provides more than 50% of survivor's livelihood.
- CA - The estate is part of a business.
- CO - The estate is part of a business.
- FL - The property is a residence and the business is located at the property.
- HI - The income produced is below the poverty level (adjusted for family size).
- ID - The income produced is limited.
- KS - (Factor to be considered) Impact of action on business in which decedent owned an interest.
- KY - Asset is sole income producing asset; and survivors are related to decedent within 3rd degree of consanguinity; and asset produces annually not more than \$50,000 for each heir and \$50,000 for each family member of heir.
- ME - (Factor to be considered) Property is income-producing and provides funds for applicant's necessary support and maintenance.
- MN - Assets are necessary part of survivor's occupation in which survivor has worked continuously and exclusively and which is sole source of income.
- MT - (Factor to be considered) Asset is part of a business, and recovery would deprive survivor of sole means of livelihood and survivor has no other means of satisfying Medicaid claim.
- NC - The net income produced from asset is below 75% of poverty level.
- NJ - Recovery will result in survivors becoming eligible for public and/or medical assistance.
- NM - Asset is sole income producing source.
- OH - Asset is part of survivors' business.
- NY - (Factor to be considered) Asset is income-producing business.
- SC - Survivor is parent, child or sibling, and without the income-producing asset, income would fall below 100% of poverty level.
- UT - The income of survivor is limited.
- WA - The income of survivor is limited.
- WI - Asset is part of survivor's or beneficiary's business and recovery would result in loss of livelihood
- WY - Property is beneficiary's home and part of a business.

2. Property is the primary residence of the survivors (12 states)

- AZ - Survivor was in residence at least 12 months prior to beneficiary's death and survivor owns no other residence.
- FL - Survivor was in residence at least 12 months prior to beneficiary's death and survivor owns no other residence.

- CA - Survivor was in residence at least 12 months prior to beneficiary's death; and resident is aged, blind, or disabled; individuals who would have difficulty obtaining financing to repay the state
- HI - Residence is of modest value and occupied by survivor at least three months before beneficiary's admission; and survivor provided care to beneficiary that allowed beneficiary to live at home, does not own any real property other than interest in the home, and has an income not greater than 200% of poverty level.
- MD - Forced sale/transfer would deprive a dependent who lives in a residence; and dependent unable to provide an alternative residence. "Dependent" defined as certain relatives who received more than half their support from the deceased.
- ME - (Factor to be considered) Asset had been primary residence of the survivor, or survivor is a resident and co-owner of property.
- MN - Survivor continuously occupied homestead for at least 120 days prior to beneficiary's death.
- MT - (Factor to be considered) Survivor is aged, blind or disabled relative of decedent who continuously lived in home for one year or more before beneficiary's death, and would have significant difficulty establishing alternative living arrangement, obtaining financing (such as home equity loan) to repay department or arranging other means to repay department.
- NC - Forced sale would displace the survivor, and survivor's income below 75% of poverty and assets are below \$12,000.
- OR - Recovery would cause survivor to become homeless.
- SC - Survivor is parent, child or sibling residing in home at least two years prior to beneficiary's death, does not own other property, and is below poverty level. Exemption limited to house and one acre maximum.
- WA - Recovery would deprive survivor of shelter, and survivor lacks means to provide alternate shelter.

3. *Only asset is homestead of modest value (4 states).*

- FL
- KY - Defined as \$50,000 or less
- HI - (see primary residence criteria above)
- NM

4a. *Without receipt of estate proceeds, the survivor would become eligible for public and/or medical assistance (8 states).*

- CA
- CO
- ID
- MT - (Factor to be considered)
- NJ - The asset is the sole income producing property.
- NM - Or the survivor will be at risk of serious deprivation.
- OR
- WI - Or the survivor is receiving general relief already.

4b. *Allowing the survivor to receive the estate would enable him/her to discontinue eligibility for public and/or medical assistance (4 states).*

- CA
- CO
- MT - (Factor to be considered)
- NM

5. *Recovery would deprive the survivor of necessities of life, e.g., food, shelter, clothing (8 states).*

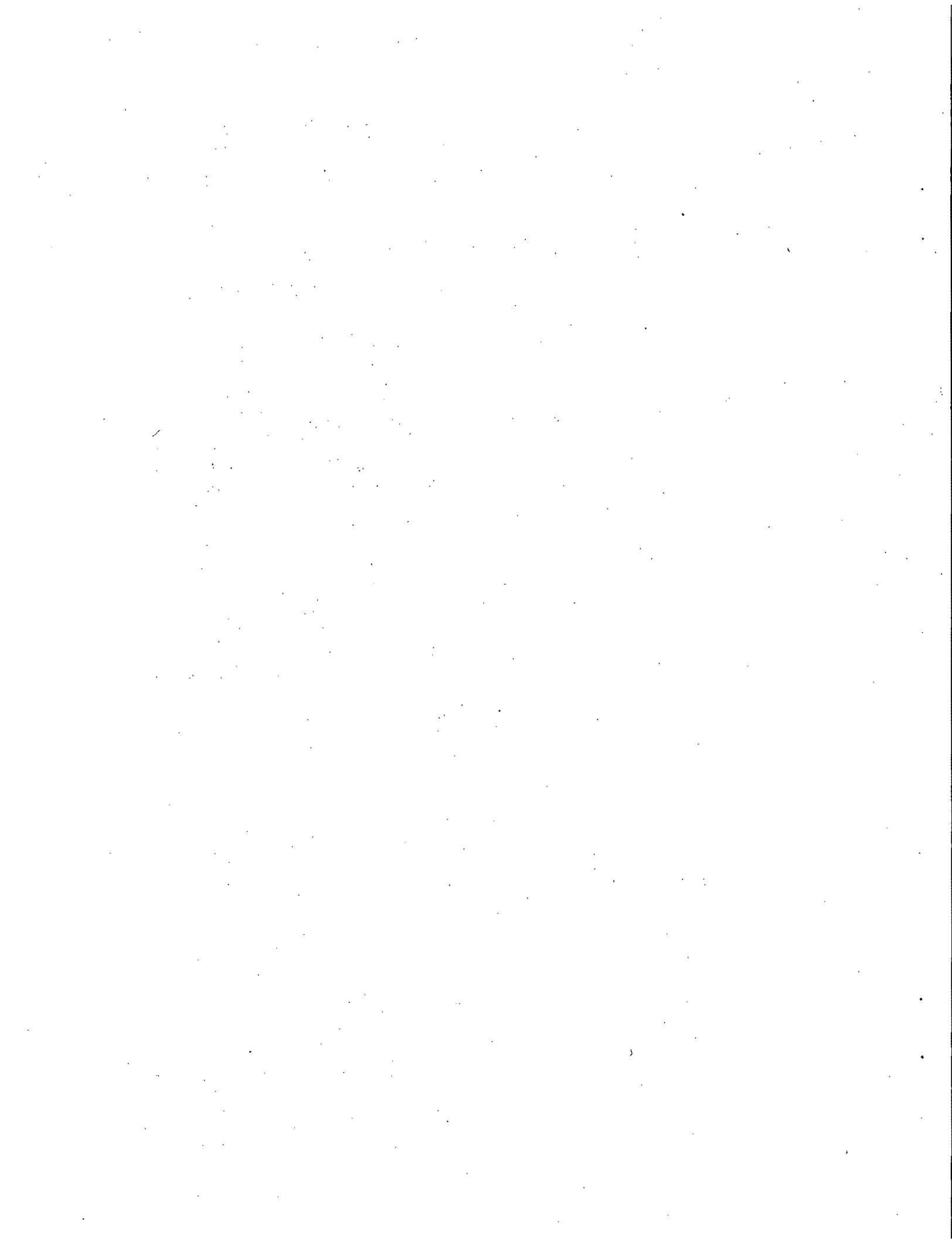
- AZ - (If estate is personal property only) Survivor's income is below poverty level and survivor owns no real property.
- FL
- CA - Or the survivor needs the equity in the property to make it habitable.
- IA - The total household income is less than 200% of poverty level, and total household resources do not exceed \$10,000.
- KS - (Factor to be considered) Impact of recovery on financial circumstances of family.
- MT - (Factor to be considered) Whether property is needed by survivor to acquire necessities of life and whether there are other means to satisfy department's claim.
- WA - Recovery would result in impoverishment of survivors.
- WV - Recovery would jeopardize survival of the family unit or severely disrupt the family's income.

6. *The survivor made substantial personal contributions to the property or to the care of the beneficiary so beneficiary could remain at home (3 States).*

- FL - (Factors to be considered) Consider contributions by survivor to value of the asset or the support/care of decedent; or any outstanding debt with higher priority (as a mortgage) assumed by survivor.
- KS - (Factors to be considered) Actions of family in helping decedent, particularly when such actions helped avoid or reduce medical costs.
- ME - (Factors to be considered) Survivor used personal resources to maintain the property, pay the taxes, etc.; or applicant lived in the property and provided significant care for the deceased beneficiary so beneficiary could remain at home for a long period.

7. *Other Criteria.*

- Survivor had transferred the property to the deceased beneficiary for no consideration (CA).
- Sibling, son, or daughter have been residing in beneficiary's home at least one year and provided full-time care that delayed beneficiary's entry into nursing home (FL).
- Cost involved in sale of property would be greater than value of the property (FL).
- Hardship waiver incorporates state debtor-creditor law homestead exemption that may be asserted by survivor (ND).
- Monetary definition
 - ID - Claim is less than \$500 or total assets are less than \$500.
 - KY - Recovery less than \$5,000.
- Beneficiary received medical assistance as a result of a crime committed against the beneficiary (ID).
- Criteria similar to TEFRA lien rules (survival by spouse, minor or dependent child, sibling and/or caregiver child) (OH, VT).
- (Factors to be considered): Applicant had a contractual relationship with deceased recipient in which residence was held as security or was required to be transferred for value previously received; or applicant relied to detriment on promise by deceased recipient that residence would become theirs at recipient's death (ME).
- Availability of alternative means for satisfying the claim (KS).
- Other "Compelling Circumstances" (AR, FL, NM, NY, KS - factor to be considered: "any other relevant factors").

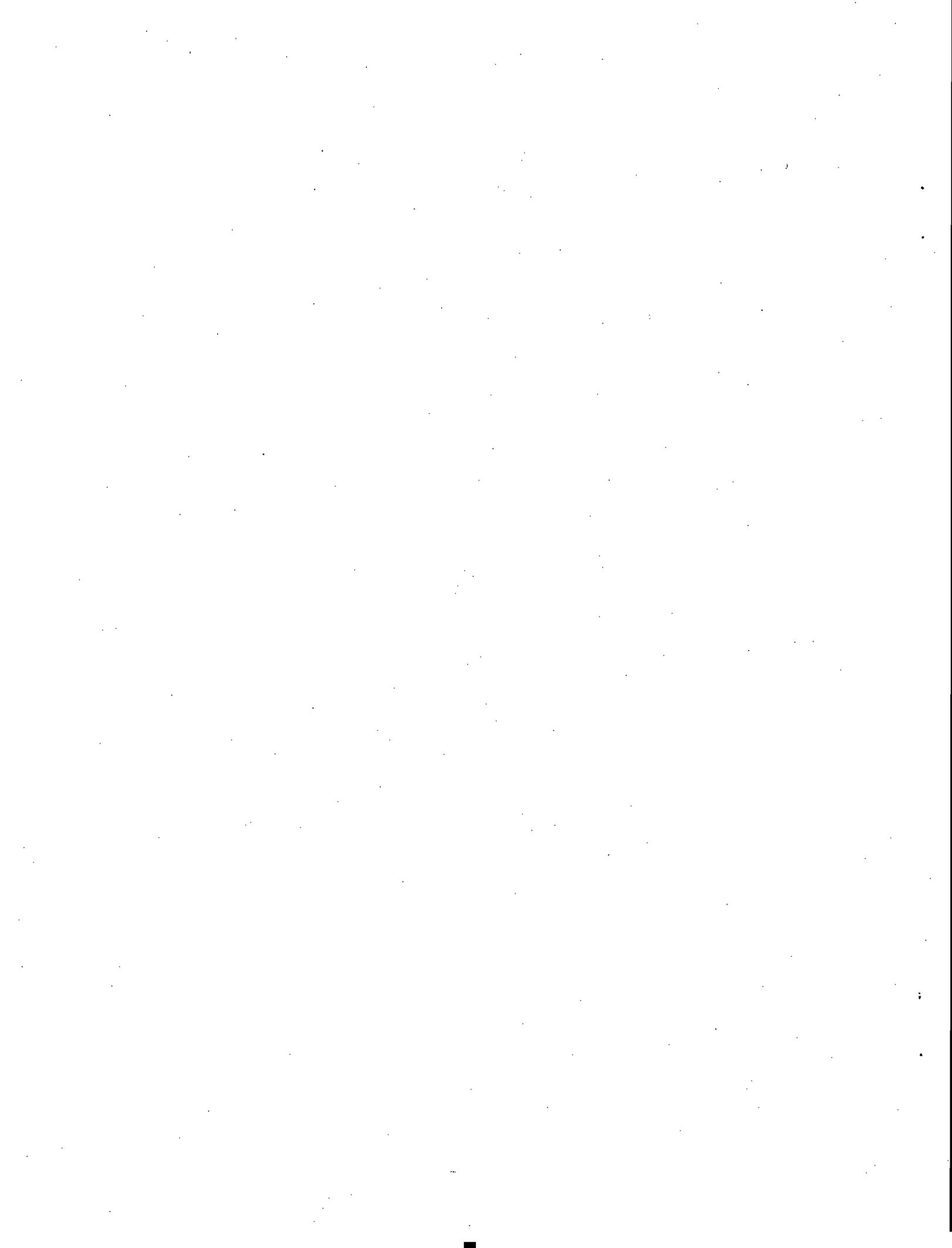


APPENDIX D

Frequency of Hardship Waivers

The survey included a subsample to assess the frequency of undue hardship waivers requested, granted and denied by state agencies. The subsample involved brief telephone interviews with Medicaid officials from eight states. These eight states were selected because they had been operating estate recovery programs since at least 1993, and had established undue hardship criteria in accordance with OBRA. Interview respondents were staff responsible for the estate recovery programs. The interviews show that some states fail to track the number of hardship waivers requested and granted. Thus, the data may be of limited utility, and provides only a "ballpark" estimate of the frequency of hardship waivers. The interviews revealed the following:

- | | |
|------------|--|
| California | The state does not track hardship waivers. However, the respondent's "guestimate" is that out of a caseload of 11 - 12,000 open estate recovery cases, the agency gets "about 20 requests a month." Of these, he estimates that a majority are denied. Of the requests denied, he estimates that "5 - 10% are appealed." |
| Colorado | From July 1994 through June 1995, a total of two waivers were granted and seven denied. From July 1995 through the present, a total of five waivers were granted and two denied. There were no appeals. |
| Maine | Since October 1993, "about 100" waivers have been granted, and seven denied. No appeals. The respondent speculated that the relatively high number could be because the state criteria allow waivers for individuals who paid taxes on or otherwise maintained the property. |
| Maryland | Since the state's hardship criteria have been in effect (about six months), there have been 12 requests for waivers. Ten of these were rejected, and two were granted. There have been no appeals yet. |
| Minnesota | Since the counties are responsible for the estate recovery program, the state does not keep track of hardship waivers. However, the respondent was "not aware of any." Her guess is that "there are not many requests" and she knows of no appeals. |
| Montana | To date, no hardship waivers have been granted. While there have been a couple of verbal inquiries, so far there have been no formal requests. |
| Washington | In approximately the last year, there have been five waivers granted and one denied. No appeals. The agency has also received a couple more verbal requests for information, but these were not pursued. |
| Wisconsin | Since the hardship criteria were on April 1, 1995, there have been 17 requests for hardship waivers, of which eight were granted, two were denied, and seven are pending. No appeals. |



APPENDIX E
Examples of Estate Recovery Notices

Contents

**Nebraska Department of Social Services Brochure
“Medicaid Estate Recovery Program”**

**Iowa Department of Human Services
“Estate Recovery Program” Flyer**

**Idaho Department of Health and Welfare, Division of Medicaid
“Notice of Statutory Claim”**

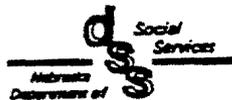
**Minnesota “Notice of Claim for Medical Assistance in Decedent’s Estate”
(Includes Notice of Undue Hardship Waiver)**

**Does
Estate Recovery
affect a
recipient's eligibility
or benefits?**

NO. This program **DOES NOT** affect medicaid eligibility or the exempt property that can be held by a living recipient. The program also **DOES NOT** affect the medical benefits available to a recipient.

**Are there Other
Exemptions if
Estate Recovery would
Cause Hardship?**

YES. The state **WILL NOT** recover from an estate if doing so would cause a hardship for the heirs. If the state takes action to recover medical assistance from an estate, the heirs may ask to have the recovery waived or adjusted based on hardship. The state will consider all requests and will make arrangements when it finds that a true hardship exists.



The Nebraska Department of Social Services is committed to affirmative action/equal employment opportunity and does not discriminate in delivering benefits or services.

DSS-PAM-128 Rev. 8/94 (99034)
(No Previous Version)



 printed on recycled paper

**Medicaid
Estate
Recovery
Program**

**NEBRASKA
DEPARTMENT
OF
SOCIAL
SERVICES**

What is Estate Recovery?

Estate Recovery is a program established by state and federal law.

Under the Estate Recovery Program, the Nebraska Department of Social Services will recover medical care costs, which were paid for by medicaid, from the ESTATES of certain former recipients.

How will Estate Recovery be Accomplished?

The state will file a claim against the estate of certain deceased medical assistance recipients. The estate will include all of the property (personal and real) that is left when a recipient dies.

The estate administrator will use money from the estate, including the sale of property, to pay the state for the costs of medical care provided to the recipient.

Who will be Affected?

Only the estates of nursing home residents or persons who receive medical care after age 55 will be affected.

Only the costs of medical assistance provided after July 16, 1994 will be recovered.

Will any Estates be exempt from Recovery?

YES. The state may recover the costs of medical assistance from an estate only when:

1. Medical services were delivered to a person of any age who lived in a nursing home **OR** to a person over the age of 55 in any living situation.

AND

2. The deceased recipient **IS NOT** survived by a spouse, child under 21, or a dependent who has a disability.

Further, the state **WILL NOT** recover medical assistance costs from the sale of a deceased recipient's home if:

1. There is a brother or sister who lived in the home for at least one year before the recipient went to a nursing home and who has lived there continuously since the date of the nursing home entry.

OR

2. There is a son or daughter who lived in the home for at least two years before the recipient entered a nursing home, whose care allowed the recipient to delay nursing home placement and who has lived in the home continuously since the date of nursing home entry.

Iowa Department of Human Services

ESTATE RECOVERY PROGRAM

WHAT IS ESTATE RECOVERY?

If you have received any Medicaid benefits after July 1, 1994, the Iowa Department of Human Service may file a claim against your estate when you die in order to recover all or part of the benefits paid out.

If you have a spouse or a dependent, blind, or disabled child when you die, Medicaid estate recovery may be delayed.

WHO IS AFFECTED?

Estate recovery affects all Medicaid recipients who are:

- 55 years of age or older, or
- Institutionalized and cannot be reasonably expected to return home.

WHY IS THIS BEING DONE?

Federal law requires states to have an estate recovery program.

The Iowa Legislature has directed the Iowa Department of Human Services to implement the estate recovery program in our state.

Note: The Department of Human Services *will not* put liens on property but *will* make a claim against the estate of persons covered by this policy.





State of Idaho

DEPARTMENT OF HEALTH AND WELFARE
Division of Medicaid

PHILIP E. BATT
Governor
LINDA L. CABALLERO
Director
TRESA NEWMAN
Administrator

Bureau of Medicaid Systems and Operations

Towers Building - 6th
P.O. Box 83720
Boise, ID 83720-0036
(208) 334-5923
Fax (208) 334-5718

November 16, 1995

7~ 8~ 9~
Authorized Representative
10~
11~, 12~ 13~

RE: NOTICE OF STATUTORY CLAIM
Estate of 2~ 1~

Dear 7~ 9~:

The Department of Health and Welfare would like to extend its condolences upon the loss of your loved one. To comply with Federal and State law, the Department of Health and Welfare must seek reimbursement from the estate of 2~ 1~. Recovered funds are utilized to help finance medical services for other people in need.

Since 2~ 1~ received \$6~ in Medicaid benefits, the Department of Health and Welfare hereby gives you notice of its claim against any real property, and/or assets in this estate. You are hereby advised that a lien may be placed against any real property in this estate. If any of the decedent's personal property or real property is improperly sold or distributed, the Department may pursue legal action to satisfy its claim. I understand there may be a bank account or other assets in this estate.

Enclosed is a questionnaire you are asked to complete; please include an accounting for expenditures made since the death of 2~ 1~. Please return this questionnaire and any related documentation within 15 working days. If additional time is needed, please call for an extension.

A Hardship Waiver may be granted if any of the following criteria are documented.

- * If the only asset belonging to the recipient is a family-owned business which is the sole support of other family members;
- * If the Department's claim is less than \$500.00;
- * If the total assets of the entire estate are less than \$500.00, excluding trust accounts or other bank accounts.

Please note that a waiver is not granted because family members expect an inheritance, or will be inconvenienced by the lack of an inheritance. The Department's statutory claim has priority over the decedent's will.

Pg. 2 (con't)

If you believe you fall under the Hardship Waiver criteria, you may submit a written request for a Hardship Waiver. Please send your request accompanied by supporting documentation, to the following address:

Department of Health and Welfare
Estate Recovery Unit
Towers Building - Sixth Floor
P.O. Box 83720
Boise, ID 83720-0036

Once your request has been reviewed a Notice of Decision will be sent informing you of the outcome.

This Notice of Statutory Claim only relates to the property and/or assets of the deceased person. No demand is being made upon you personally for payment. If funds are available, a check should be made payable to **STATE OF IDAHO, ESTATE RECOVERY**. An envelope has been enclosed for your use.

Thank you for your cooperation in this matter. If you have any questions, please contact the Estate Recovery Unit at (208) 334-4955.

Sincerely,

David A. Baker
Medicaid Recovery Officer

Enclosures

(MINNESOTA)

**Notice of claim for Medical Assistance
in Decedent's Estate**

TO: Parties listed in attachment A

FROM: Ms. Susan Smith
Jones County Human Services Department
1318 Central Avenue
Puckettville, Minnesota 55431-5178

RE: Estate of James Jackson
Jones County District Court
Jones County Probate # _____
Jones County Human Services # _____
Claim for Medical Assistance Services

DATE: June 22, 1995

Claim: On _____, 1995, the Jones County Human Services Department filed a claim for \$ _____ with this estate for medical assistance services provided to the decedent and/or the decedent's spouse.

Waiver: If paying this claim will cause you undue hardship, you can apply for a waiver of the claim. If your circumstances do not meet the definition of undue hardship, or if you wouldn't personally benefit from the waiver, the county cannot grant your application.

An undue hardship exists when:

1. Estate could not pay the claim except by selling assets (for this paragraph only assets means real or personal property), subject to the probate proceedings, for which all of the following are true for a period of at least 180 days prior to the date the decedent died and from that date through the date the waiver is finally granted:

- A. The assets are used by the waiver applicant to produce income in his or her trade, profession, or occupation; and
- B. The assets are a necessary part of the waiver applicant's trade, profession, or occupation; and
- C. The trade, profession, or occupation in which the assets are used is the waiver applicant's sole source of income; and
- D. The waiver applicant has worked continuously and exclusively in the trade, profession, or occupation in which the assets are used.

In this exception only the phrase "trade, profession or occupation" includes a working farm the waiver applicant actually operates. It does not include a farm he or she does not actually operate or rents to others.

2. The claim could not be paid except by selling the decedent's real estate subject to the probate proceedings for which all of the following are true:

A. The waiver applicant actually and continuously occupied the real estate as his or her only dwelling place for at least 180 days prior to the date the decedent died and from that date through the date the hardship waiver is finally granted; and

B. The real estate for which the hardship waiver is requested was classified as homestead property for property tax purposes under Minnesota Statutes, Section 273.124, as amended, throughout the entire period referred to in the preceding paragraph.

3. Regardless of anything else to the contrary, if your circumstances are wholly or partially the result of the following actions by the decedent, they can never be an undue hardship:

A. actions which divested or diverted assets in order to avoid recovery of amounts advanced on behalf of the decedent or decedent's spouse for medical assistance from the decedent's estate; or

B. actions which divested or diverted assets with the result or effect that amounts advanced on behalf of the decedent or decedent's spouse are wholly or partially unrecoverable from the decedent's estate.

These actions include, but are not limited to, estate planning, the use of trusts, gifts, and annuities.

How to Apply for a Waiver: To apply for a waiver complete and return the enclosed application to me at the address listed above within 30 days of the date of this notice. We will not accept applications which are not actually received or postmarked within this 30 day period. In these cases, you will lose your right to apply for and receive a waiver of the claim.

The County will send you a written Determination within 30 days after receiving your application. In some cases the county may, at its discretion, extend this time period. The Determination will state whether, to what extent, and on what terms and conditions the county will grant the waiver and its reasons for doing so.

Right to Appeal: If you disagree with the Determination by the county you may appeal. The Determination will include instructions on how to file an appeal.

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