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# MEDICARE AND MEDICAID

## HEARINGS

BEFORE THE

## COMMITTEE ON FINANCE

## UNITED STATES SENATE

NINETY-FIRST CONGRESS

SECOND SESSION

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PART 1

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FEBRUARY 25 AND 26, 1970

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ADMINISTRATION WITNESSES

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Printed for the use of the Committee on Finance

U.S. GOVERNMENT PRINTING OFFICE

42-122 O WASHINGTON : 1970

For sale by the Superintendent of Documents, U.S. Government Printing Office
Washington, D.C. 20402 - Price 75 cents

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# MEDICARE AND MEDICAID

WEDNESDAY, FEBRUARY 25, 1970

U.S. SENATE,
COMMITTEE ON FINANCE,
*Washington, D.C.*

The committee met, pursuant to recess, at 10:15 a.m., in room 2221, New Senate Office Building, Senator Russell B. Long (chairman) presiding.

Present: Senators Long, Anderson, Gore, Hartke, Ribicoff, Harris, Byrd, Jr., of Virginia, Williams of Delaware, Bennett, Miller, and Hansen.

The CHAIRMAN. This hearing will come to order.

Today the Committee on Finance begins the fourth phase of an extensive series of hearings on the medicare and medicaid programs. The first phase was marked by hearings in 1966, at which the reimbursement formula for paying hospitals and doctors was criticized as being too generous. The second phase involved another hearing, in July, 1969, during which the committee raised serious questions about medicare's role in financing teaching hospitals by providing extraordinary allowances for supervisory physicians. The failure of these programs to furnish information to the tax collector of large payments to doctors was also explored.

The third phase of this work came earlier this month when the committee published a report prepared by the staff, identifying areas in which the operation of the medicare and medicaid programs might be improved and made more efficient. The study began more than a year ago when the committee formally instructed the staff to inquire into the operation of the programs.

In this fourth phase of our hearing, the committee will hear a response to the staff report by the administrators of the program. At a later hearing, providers of services, such as hospitals, nursing homes, and physicians will be heard. In addition, the committee will want to hear from the insurance companies who serve as intermediaries and carriers under the program, and also from the medical schools.

The staff report is a litany of shortcomings in the medicare and medicaid programs. It describes many important areas of apparent laxity in supervision. It shows the failings of carriers and intermediaries in enforcing the regulations and instructions and in auditing the claims for payment submitted to them as agents of the Federal Government. It highlights abuses by some practitioners, hospitals and nursing home proprietors. It points to instances where the reimbursement formulas appear to go beyond the intent of Congress.

Above all, it makes the first concrete suggestions which have yet been assembled for broad constructive changes in the administration of the program, or where necessary, in the statute itself, to make medicare and medicaid more efficient and more responsive to the needs of the people they serve.

It is not the purpose of these hearings to attack the medicare program or the medicaid program. Rather, we want to attack the problems of those programs. They are good programs and have brought benefits to millions of people who otherwise would have been deprived of adequate medical care. I know the committee is approaching this work with an attitude of making these good programs better. Last year, our top priority was tax reform. This year, it is medicare reform.

The staff report observes that part A of medicare, which pays for hospitals bills, will suffer a shortfall of income, as compared to outgo of $131 billion over the next 25 years. And I am advised that estimates currently being made by the Department will show that the deficit is substantially greater than that. Medicaid is in an equally poor financial condition.

The major suggestion coming out of the Department of Health, Education, and Welfare for dealing with this unbelievable cost overrun is to increase medicare taxes by $136 billion over the next 25 years. All of these new tax revenues are needed to pay for the level of benefits the program provides today. Not a single new benefit could be provided with all that money. We could not use a dime of those new taxes to cover the disabled under medicare or to provide for payment of prescribed drugs or to cover costly dental bills. Congressional options to do good for the people rapidly disappear as more and more of the Nation's taxing capacity is preempted to pay for the ever-rising cost of health care. This is not fair to the elderly; it is not fair to the poor; it is not fair to the disabled; and it is not fair to the taxpayer.

Let me illustrate the high price paid by medicare. Prof. Max Shain of the University of Michigan was an adviser to the Michigan Insurance Department on new contracts to be written under medicare in that State. The Michigan Blue Shield plan—medicare's agent—filed a rate contract for medicare which, according to Professor Shain, was based on physician's fees that were 10 percent higher than Blue Shield paid for its highest income subscribers. When Professor Shain pointed out what he believed to be a clear violation of the law, he reported he was told by Blue Shield:

> Well it's true that most of our elderly members have very low incomes, but you just don't understand the new situation. The subscriber for these old people is now the U.S. Government, Uncle Sam, you know, and he has a very high income, in the billions. The social security people have already approved this interpretation.

I do not believe the Committee on Finance will vote $136 billion of new medicare taxes without first trying to build some cost-reducing safeguards into the medicare program and trying to get the vigorous, hard-nosed supervision and administration that a $9 billion health program demands. It is clear after 3½ years of experience that the reimbursement formula for hospitals and method of paying doctors under medicare are more generous than they need have been. In retrospect, it appears that under the original reimbursement rules too high a price was paid to doctors and hospitals, possibly because of appre-

hension that they would boycott the program unless their demands were met.

May I say that some of the conversations that I have had with doctors has indicated that many of them felt, in view of the fact that they were against the program to begin with, that they might as well charge all the traffic would bear when they were asked to participate in it.

Let me include at this point in the record our committee press release announcing these hearings. I believe Senator Hansen has a few words to say.

(The press release follows:)

MEDICARE-MEDICAID HEARINGS ANNOUNCED BY FINANCE COMMITTEE

Senator Russell B. Long (D., La.), Chairman of the Committee on Finance, announced today that on Wednesday and Thursday, February 25 and 26, 1970, administrators of the Medicare and Medicaid programs led by Undersecretary John G. Veneman will testify in public hearings with respect to the various problems and recommendations described in the Finance Committee staff report entitled: "Medicare and Medicaid: Problems, Issues, and Alternatives," which was published by the Committee on February 9.

Senator Long indicated that, subsequent to the February hearing, additional hearing dates would be scheduled at which time the Committee would begin to receive testimony from the interested public. The Committee's objectives, according to the Chairman, are to explore changes in the law and in the operation of Medicare and Medicaid which could make these programs more responsive and efficient in meeting the needs of the people for whom they were designed.

Observing that the Medicare program is suffering from an actuarial deficit (over a 25-year period) of $131 billion, he said the Committee should not blindly approve the administration's request for $136 billion in new Medicare taxes merely to pay for cost overruns, without first trying to cut the excesses out of the program. He said further that "Congress has the responsibility and opportunity to make a good program better."

Senator HANSEN. Mr. Chairman, when the Congress enacted the Medicare program, some Members questioned the wisdom of this act and expressed their opposition to the legislation. However, Congress passed the Medicare program and it was signed into law by the President of the United States. A promise was made to the American people.

Because this promise was made, the citizens of the country expect it to be fulfilled. I was most disturbed when I read the report of the staff of this Committee stating the problems, issues and alternatives facing the Congress with regard to the administration of the Medicare and Medicaid program.

Our citizens do not expect to receive something for nothing. They make contributions to the Medicare and Medicaid program through State and local taxes as well as monthly premiums. Still our citizens are finding it difficult to obtain the services they need and meet the requirements of government red tape. A solution must be found.

Mr. Chairman, I wish to congratulate you and the distinguished Senator from Delaware for the leadership you have taken to point out these problems and to seek solutions. Everything should be done to insure that the programs are efficiently administered to provide the services promised by this legislation.

The CHAIRMAN. Thank you. Now, let me recognize the distinguished Under Secretary of the Department of Health, Education, and Welfare, the Honorable John G. Veneman.

May I say, Mr. Veneman, before you say it, I am the first to agree that you did not initiate this program. You did not put it into effect. You found it this way.

Mr. VENEMAN. Thank you, Mr. Chairman. That takes care of my first page.

The CHAIRMAN. But if something is wrong, if something is costing too much, it ought to be corrected no matter how it got that way and we want to work with you in that endeavor.

Would you start by identifying your assistants who are with you here?

**STATEMENT OF HON. JOHN G. VENEMAN, UNDER SECRETARY, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE; ACCOMPANIED BY LEWIS BUTLER, ASSISTANT SECRETARY FOR PLANNING AND EVALUATION; JOHN D. TWINAME, ADMINISTRATOR, SOCIAL AND REHABILITATION SERVICE; ROBERT BALL, COMMISSIONER OF SOCIAL SECURITY; ARTHUR HESS, DEPUTY COMMISSIONER OF SOCIAL SECURITY; HAROLD NEWMAN, COMMISSIONER, MEDICAL SERVICES ADMINISTRATION; AND ROBERT MYERS, CHIEF ACTUARY, SOCIAL SECURITY ADMINISTRATION**

Mr. VENEMAN. Thank you very much, Mr. Chairman. I am pleased to have this opportunity to return to the committee and discuss a subject that is paramount in the minds of not only the committee, but the country.

The CHAIRMAN. I overlooked one item I would like to take care of. Senator Anderson had a brief statement he wanted to make about this matter and I believe Senator Williams might also want to say something. Both have been very much interested in this program. And they are as concerned as I am, and I am sure Senator Ribicoff and others, that medicare be properly administered.

Senator ANDERSON. Mr. Chairman, medicare has proven to be a most important element contributing to the security of our aged citizens. It has permitted them to enjoy their twilight years in dignity and with less fear that illness will drain their financial resources. Medical care has been available to them, not as charity but as a right. The acceptance of the program more than justifies the efforts of those of us who had an active role in bringing it about.

Medicaid, by removing the stigma of the charity hospital concept, has provided the poor and the medically indigent with health care which was unavailable to them in the past.

These programs are only 3½ years old. They are still in their shakedown phase. That there are problems in them, as is evidenced by the hearings before this committee last July and by the recently released staff report, should not be surprising. In attempting to correct these problems—and we must—we should not so concentrate on what is wrong that we overlook what is right. At the outset of these hearings, Mr. Chairman, I should like to reaffirm my belief of many years that medical insurance for the aged, which I worked so hard to bring about, and good medical care for the poor, are socially necessary programs.

As we examine the deficiencies in these programs, I am aware that the major problem is not one of individuals but rather one of the system itself. I do not mean to suggest that those persons suspected of

fraud, abuse, and incompetency should be overlooked. But I think our principal emphasis should be on such questions as:

Are the present reimbursement methods and formulas adequate for programs of this scope?

Can payment on the basis of "usual, customary, and prevailing" be justified or continued?

Are the methods of providing medical services as efficient as we should have a right to expect?

With hospital costs increasing at three times the rate of general prices and with physicians' fees increasing at twice the rate, I am concerned that, in making it possible for the elderly and the poor to receive good medical care, we may be pricing many of the younger and working population out of the health care market. I am disturbed that our reimbursement system and formulas have rewarded the inefficient and have led to an uncontrolled multiplication of costly facilities. I am concerned that the concept of "usual, customary, and prevailing" has provided a floor rather than a ceiling and that every year since these programs began the "usual" has become the unusual and the "prevailing" has not prevailed. The system as presently operating hopes for voluntary restraint on costs and, as the record shows, this is an unrealistic hope.

As we proceed with these hearings, Mr. Chairman, I am confident that we will search for new approaches—both legislative and administrative—to improve what is good in these programs and to correct those things which need correction.

I am confident that, because of our 3½ years' experience, we can develop improved methods of paying for these necessary services which will be fair to the hospitals, physicians, and other providers of services as well as to the taxpayers and beneficiaries. I am confident that the American genius which put a man on the moon in less than 10 years can develop innovations in the Nation's health care system which will utilize our presently overworked human and physical medical resources in a more efficient and economical manner. It is because of this confidence and because I know that the concept of medicare no longer is on trial that I look forward to these hearings, knowing that out of the interplay of ideas from the committee, administration, medical professions, and public will come the practical answers we all need.

The CHAIRMAN. Thank you very much. Would you now proceed to identify your able assistants and to explain the problems as you see them, Mr. Secretary.

Mr. VENEMAN. Thank you very much, Mr. Chairman. I believe the committee was informed that I have another commitment to fill this morning, so I will have to leave. I have with me my Assistant Secretary for Planning and Evaluation, Lewis Butler, who has been working rather extensively in long-range programing and planning in the health field. Mr. Butler will be available to respond to questions when I have to go to my next commitment.

Next to me to my left is John Twiname, who will begin Monday as the new Administrator of Social and Rehabilitative Services, replacing Miss Mary Switzer, who has long been associated with this committee and is known to most of you.

To my right is Commissioner Ball, Commissioner of Social Security. To his right is Mr. Art Hess, the Deputy Commissioner, and I would like to introduce one other in the back of the room, a gentleman who came aboard this week, Mr. Howard Newman, who is the new Commissioner of the Medical Services Administration in the Sociacial and Rehabilitative Services. Mr. Newman, of course, has replaced Dr. Land, who was his predecessor.

We also, to comply with the request of the committee staff, have asked as many persons as possible who were involved in the program in 1965, who participated in the development, to be in attendance. I think most of those are in the audience, including, of course, Mr. Tom Tierney and Bob Myers and others with the Social Security Administration. So, they will be available for questioning.

What I would like to do, Mr. Chairman, is just comment briefly upon some of the recommendations that we have made and then ask Mr. Ball to describe some of the pertinent aspects of medicare and its administration, what the Social Security Administration has been doing to improve the program, and then ask Mr. Twiname to make a statement on the steps that have been taken during the past months to improve the administration of the medicaid program, the title 19 program.

I think we all recognize that we have reached a rather critical stage of development in our health care system in that the organization and delivery of health care in the United States has not kept pace with the advances in medical science and technology and with the rising needs, demands and expectations of our society for health services. We have made tremendous strides in the search for more definitive medical procedures, but we have not yet succeeded in evolving an efficient and economical system for the delivery of useable knowledge to those who can benefit from its application.

As a consequence medical care costs have been rising sharply and have become a significant matter of urgent public concern. Programs to reduce the financial barriers to hospital and medical care, such as medicare and medicaid, have helped millions of people in this country, as Senator Anderson pointed out, but they have also put further strains on the existing structural defects in our health care system. We will need to take steps way beyond the scope of medicare and medicaid to solve the problems of shortages of health personnel, problems of inefficient organization of the delivery of health care and problems of maldistribution of health facilities, and some of the problems of meeting consumer needs for preventive and comprehensive care.

As I pointed out, the two programs were built on the existing arrangements, existing structure for organizing, for delivering, for paying for health care that prevailed at the time the programs went into effect. Therefore, apart from certain safeguards which were built into medicare, such as utilization review and the provision of payments for certain alternatives to high cost institutional care, the net effect was to conform to the circumstances and the practices of the existing health system.

In its methods of payments, for example, medicare was limited to reimbursing facilities and physicians for their services on the same basis as generally was already in use. Neither the reasonable cost nor the reasonable charge criteria estblished in the law have provided opportunity for any major cost-control efforts.

Now, I believe the time has come to make some fundamental changes in the law which governs both medicaid and medicare reinbursement. We have talked a lot about incentive systems and I believe the time has come that we need an incentive system of institutional reimbursement. We also need changes in the law that will help control the increases in the amount that the medicare program will recognize in the charges of the individual practitioners.

In the cases of hospitals and other providers of services institutional providers, the reimbursement is now based upon reasonable cost which is determined retroactively. This is true not only for Government programs but for the majority of Blue Cross plans. Hospitals consequently do not have a strong economic reason for trying to improve the efficiency of their operation. As their costs are reduced, they receive less money and as their costs rise, as long as they are within the scope of payable charges and are in line, they can be sure of having a large part of them paid by the third-party payers.

I think the time has come that we should move in the direction of determining reimbursement prospectively instead of retroactively. With the rates set in advance the provider would be challenged to stay within the limits of the known reimbursement to be received and the provider would share in savings that come from economies that are achieved through effective management.

Thus, the economic incentives for efficiency and economy in the rendition of services would for the first time be introduced in the program's methods of payment. In this way we would harness the ingenuity of thousands of managers and policymakers in our health institutions to the objectives not only of quality care but of effective and efficient management. There are several ways that this could be done. For example, we can approach the prospective arrangement through the development of budgets for institutional providers which would be preapproved by budgetary or charge review committees.

These committees would have equal representation from institutional providers, the third-party payers, and from the public, including medicare and State medicaid representatives, and there would be a review committee that would be responsible for certain geographic areas. Such committees would have the authority to approve either the budgets of the institutions or the charge schedules that they may develop.

A system of prereview of charge schedules somewhat along the line that I have described has been in effect in the State of Indiana for a number of years and the concept of preapproval of institutional budgets is now under study in the State of New Jersey.

Secondly, the establishment of target rates could be based upon known patient costs for a past period and projected costs for the future period limited to corresponding increases in appropriate cost indices. Currently, New York State and New York City are utilizing this general approach on a demonstration basis.

Thirdly, you could have actual negotiation, with various classes of hospitals of comparable size and scope of service in the same geographic areas. While no specific programs of this type are currently underway to any major extent we believe that some experiments that have been started in Connecticut and California may provide a basis for this approach. The establishment of committees of the kind sug-

gested in example 1 would be needed to assure fair representation of private and public interests.

Experience under the broadened experimentation authority we have requested as well as participation by hospitals and Blue Cross plans in a number of alternative approaches in the private sector would be available to assist in the development of meaningful options. We note, too, that your staff has indicated in its report that they are working toward a proposal for incentive reimbursement and we would be pleased to work with them in attaining this objective.

Whichever of these approaches or combinations that we might ultimately utilize as providing an effective way of going into a prospective rate, the public visibility given to the process and the published results would be in itself preferable to the present system under which the amount paid for any given service may not be known until a considerable time has elapsed after the actual delivery of the service.

The program commitments in both the title 18 and title 19 programs would be much more predictable and furthermore, these programs would no longer have only a passive response to costs incurred unilaterally by providers but would have a positive role in actually influencing in advance the amounts which would be made available for institutional health care. Institutional managers would be given a strong basis for resistance to pressures for constantly increasing expenditures and would have an economic incentive to improve their institutional operations.

I do not want to suggest in any way that this would be a simple task and it is going to take a great deal of time to come up with a satisfactory approach for prospective reimbursement. But I believe that the benefits that can be obtained more than merit the efforts to move as rapidly as possible in the direction of an incentive formula based upon prospective rate determination.

We also are suggesting that the law should be changed so as to limit further the rate at which increases in physicians fees would be recognized by medicare. The basic difficulty at the present time is that despite the improvements which have been made in applying reasonable charge guidelines, the best that can be done under the present law is to introduce a lag in the recognition of fee increases. Under the present law the amount the physicians charge is the controlling factor in determining program liability under the supplemental medical insurance program and the reasonable charge is derived from the individual physician's customary charge so long as it does not exceed the prevailing charge in his particular locality and the level of fees recognized under comparable circumstances by the contracting carrier in its own business.

The prevailing charge in turn is derived from what physicians in a locality customarily charge. Customary and prevailing charges under the program and the fees recognized by the carriers under comparable circumstances in their own business reflect in the long run and after a suitable lag in recognition of fee increases whatever the physicians choose to charge the public generally in a market where the growing demand is pressing increasingly on the limited supply of health personnel.

The reliance on Blue Shield schedules as the limiting factor in medicare reimbursement as suggested for an interim period by the staff report would not seem to many of us to have long range viability. Tying the payments under a program as large as medicare to the Blue Shield schedules would have the effect of exerting a major upward pressure on those schedules. Previous comments sent to the committee have noted additional problems in such an approach.

For example, the varied impact such a limitation on medicare payments would have in different parts of the country, the special purpose nature of many Blue Shield schedules that make them inappropriate for use under the medicare program and the likelihood that when such schedules lag substantially behind the usual and customary fees being charges, the costs are in fact shifted to the patient. In this respect, the patients that we are covering under medicare have to be recognized as those that generally have few resources for paying additional medical costs over and above what is reimbursed under medicare.

We believe that it is necessary also to move in the direction of an approach to reasonable charge reimbursement that ties recognition of the fee increases to some index. Under such an approach allowable charges recognized for medicare would next year be generally limited to either presently recognized charges or to a new prevailing level set at the 75th percentile of the 1969 average customary charges for a given service in an area.

In the future the prevailing charge fee would move upward under this plan only in proportion to increases in an index which is made up of pertinent portions of wage and price indices. Under such an approach, recognition of fee increases would continue but only in relation to those things that have a bearing on the physician's cost of doing business.

I think, Mr. Chairman, that you would recognize this proposal as essentially what we put into effect under the title 19 program last year.

Improvements in method of payment for covered services such as I have been discussing attack the problem of rising health care expenses from only one angle—the value attributed to each unit of service. Equally important, of course, is the question of the volume of service that is rendered and the medical necessity of such services. We have taken and are taking as you know, a variety of administrative steps to improve the surveilance of utilization under the medicare and medicaid programs and we have proposed a number of legislative changes that we believe can contribute toward effective utilization practices under the program. The proposed health cost effective amendments would modify the utilization review procedures to provide for a payment cutoff where unnecessary hospitalization is discovered in the course of a sample review of hospital or extended care admissions. It would authorize with the concurrence of professional members of a review team, the program's refusal to make further payments to an individual who has grossly abused the program, authority we do not have now, and it would authorize experiments for the use of areawide or communitywide utilization review and medical review mechanisms.

While a shift toward prospective reimbursement for providers of

services offers promise of stimulating more effective management by hospitals and other institutions, it is also important that any future payment approach have built into it a rational posture toward capital expenditures, one that supports other governmental and voluntary efforts to plan for orderly distribution of facilities.

Accordingly, the proposed health cost effectiveness amendments include a proposal that would authorize withholding of reimbursement of interest on loans and on depreciation, for capital expenditures under medicare, and under the medicaid program where the providers have made major expenditures that are inconsistent with the recommendations of appropriate health-planning bodies.

A similar provision was included by the Senate in the 1967 amendments but was eliminated in the conference committee.

We are also proposing for the medicaid program modifications in the rate of Federal participation with incentives for the use of outpatient service and disincentives for the use of long-term institutional care. This proposal will place limitations on the length of stay for which there will be full Federal participation.

No one can deny that medicare and medicaid have moved a long way in a short time toward achieving their goals and improving the availability of medical care services for the elderly and the low income people of this Nation. We have more than 20 million people who are eligible for benefits under medicare and more than 12 million who would be receiving medicaid benefits next year.

At the time of the enactment of these programs and during the early parts of their implementation the Nation assumed that by removing the financial barriers to the receipt of good health care services, the problems of health care for the aged and poor would be largely solved. In the 4 years that have passed since these programs were started we have learned rather dramatically that the ability to finance does not necessarily guarantee the availability, the adequacy or the reasonable cost of care and that the health care system has severe problems in the supply and distribution of facilities that exist, problems in manpower and services and in the organization and delivery of these services; and that the payment and benefit structures both public and private place barriers against efficiency, economy, and productivity. The difficulties that medicare and medicaid face in large measure are problems of the health care system as a whole.

Although the Federal, State, and local governments now purchase about 37 percent of all the personal health care, and more than half the hospital care services, the health care system itself is basically private, composed of a variety of autonomous individual and institutional providers. Thus, it is very important to recognize that many of the solutions to the problem will be found only in changes within the private health industry.

The Federal Government clearly needs to safeguard the public interest in administering the public programs. While the public programs of medicaid and medicare have pointed up fundamental issues that have been prevalent in our medical economy as a whole, they should not bear the full brunt of responsibility for required changes. We are going to need the joint efforts of legislative and executive branches of government and the private sector to move toward a solution of these fundamental difficulties.

We have been working on the problems of the organization and delivery of health services and have requested budget increases for fiscal 1971 to increase research and demonstrations in this area. Innovations in new systems that are developed through the programs of the National Center for Health Services Research and Development, through OEO and comprehensive health planning project grants, may provide more efficient and more economical services to medicare and medicaid beneficiaries. But the ability of medicare and medicaid to respond through their reimbursement policies to these developments not only influences the services received by the beneficiaries but will also affect the continued existence and the further adoption of these new institutions for the benefit of the Nation at large.

We are, therefore, reviewing our policies on reimbursement to better meet the needs of potentially efficient but non-traditional methods of providing service. In medicaid we have been working with the States to have the new outpatient comprehensive care centers recognized as eligible providers of service.

Our ability to increase the supply of medical manpower and to bring rationality to the development and distribution of the facilities and services depends on extensions and improvements in the health manpower, regional, medical, comprehensive health planing, and the Hill-Burton programs. What we can accomplish in these fields will affect the costs, the availability and the quality of services under these programs. We have already sent up recommendations for revisions in most of these other health programs that encourage the development of ambulatory care programs and that will assure greater coordination between the comprehensive health planning and regional medical programs. We have requested additional funds for research and development in cost-effective improvements in health care delivery.

Since both the private sector and the private purchasers have a major impact on the health care industry, we need to consider in partnership with the private sector the ways in which their policies may stimulate these improvements. We need to encourage that sector to take action to remove some of the impediments to change. For example, private employers and consumers need to evaluate their health insurance policies so as to provide incentives to the use of lower cost alternative modes of core, and I think that private insurers need also to look at their policies on reimbursement and their payment methods since these may seriously influence utilization of care, costs, and the distribution of services.

It is this kind of organizational "put together" that will make the difference not only to the cost but in the organization and the delivery of better health care, not just to the recipients under title 18 and title 19 but to all citizens. We in the Department are giving the highest priority to the exercise of the discretion and the leverage that we have in the various programs to enhance and make more rational the organization and delivery of medical care.

In looking at the broad array of problems and the possible solutions we welcome the concern that has been expressed and the help afforded to us by this commite not only over the particular programs over which you have jurisdiction but also in connection with the

many other legislative measures that are planned to make coordinated progress in the health field.

Mr. Chairman, I wish to express my appreciation for being with you again and I would like at this time to ask Mr. Ball to carry on and provide you with some additional information on the actual administration of the medicare program as we know it today.

The CHAIRMAN. May I just ask you one or two questions? I believe you have an 11 o'clock meeting representing the Secretary of HEW with regard to your appropriation.

Under the hospital plan's present financing, including the 1967 tax increase, what is the latest estimate of the deficit between estimated income and costs in terms of dollars and as a percent of payroll for the next 5 years.

Mr. VENEMAN. This is under the hospital insurance side, Mr. Chairman?

The CHAIRMAN. Yes.

Mr. VENEMAN. Mr. Chairman, I think I am going to have to turn that question over to Mr. Bob Myers, the Actuary for the Social Security Administration.

Mr. MYERS. Mr. Chairman, as you know, we have——

Mr. VENEMAN. I have not seen these figures, Mr. Chairman.

The CHAIRMAN. If that is the case, then, I will just reserve that question—just keep your seat, Mr. Myers. I will ask that question along with some other questions later on.

Let me just get down to a general question that I think involves this problem and I believe you touched on it in your statement.

Do you recognize that if we are going to keep the costs of this program anywhere near what the estimate was in the beginning—and I think that started out as a solid and honest estimate above what the costs for similar services were at the time allowing for an increase—is not someone going to have to sit in there for the Government, taking the view that he is representing the taxpayers who are paying for all this and the old people who are having to put up their tax money along with others to try to get them as much as can be purchased for their money? Just as when we let a contract, we try to see to it that we have as many competitors qualified to do the job bidding for it and then see to it that we take the low bid and that the low bidder delivers on the contract and does everything he is supposed to do and that we do not pay him more than we ought to for that kind of work?

Mr. VENEMAN. I think that we probably touched on two areas of this in the testimony. The two new things that were pointed out, of course, were the prospective payment where you would figure out what your charges are going to be. In other words, we would be fixing the rate of payments in advance. Secondly, I think the limitation, of course, on the fees charged for services provided by physicians and others would be a step in this direction.

The CHAIRMAN. It seems to me from the point of view of getting the taxpayers value received and saving them from at least part of more than $100 billion of increased taxes and spending, somebody is going to have to be the rough, tough guy here. Somebody has got to be the mean guy from the point of view of the doctor, the nursing homes, the drug companies, the hospitals—all these groups. Somebody

has got to be the tough guy to say that this is all we are going to pay.

Mr. VENEMAN. Mr. Chairman, I think we have got two problems. One is the problem of payment. You know, we are looking into a lot of things and I think the prospective payment thing is one, and I think ultimately we are going to have to take a look at prepaid insurance coverage but that is only one side of the coin. I think the other side of the coin that we have to recognize is we have got a poor delivery system. We tried to take a medicare, and medicaid program and superimpose it on a delivery system that was inadequate to handle it. So, as long as the Government is paying 37 percent of all personal health costs as I recall, and about half of the total expenditures for hospital care, we had better start using our leverage.

I think we are both saying the same thing. We just have to figure out how. To try to reduce the cost through increased efficiency and better utilization without trying to change something more fundamental in the system, I think is desirable but it is not the total answer.

The CHAIRMAN. Well, by rights it would seem to me that you fellows over there in the executive branch are in a lot better position to bear down on these things and insist and demand that you get everything you are paying for and get a good buy for your money. We fellows have to run for office. You have had that experience yourself, Mr. Veneman, and the best way is to try to work it out so we fellows running for office do not have to run around telling all these doctors we think they are charging too much—that the fees are outrageous and unreasonable. Somebody else ought to tell them that.

You came here after having been a candidate for office. Bob Ball has been around here and he has not had to run for office since I came to the Senate.

It seems to me there ought to be somebody around here who says, "Look, this is too much money."

Mr. VENEMAN. I am most sympathetic. [Laughter.]

The CHAIRMAN. Well, one of the first things I learned when I came to Congress was that you ought to try to work it if you can in such a way that you do not have to tell the drugstore and drug manufacturers and doctors and the hospitals they are charging too much money. You do not have to tell them no. Somebody else will tell them no and usually he should be the fellow who is not running for office.

Mr. VENEMAN. You know, as a matter of fact, what we are suggesting, in part, Mr. Chairman, is that the person that ought to tell him is his peer and if we can get good utilization review—and I think this has been one of the weaknesses—then the doctor will tell the doctors are charging too much, or this service is unnecessary. This can be very helpful.

The CHAIRMAN. Yes, but if you try to do it that way I am afraid you are going to run into the situation where the druggist is going to tell the doctor, "Look, old friend, now, you quit finding fault with me, otherwise I am going to find fault with you because there are some things you are doing I do not approve of," and half the time you will find the fellow at the drugstore is the brother of the doctor, so that——

Mr. VENEMAN. But there are good procedures——

The CHAIRMAN. They are relatives.

Mr. VENEMAN. There are good means of utilization review. I think we have had some good programs. One of them is the San Joaquin

Foundation program which is essentially a monitoring system being used by several public and private third parties and which has reduced the cost of title 19 in one particular region in California.

There are methods of doing this. You always run that risk when you have peer review of having too many friends associated on the review board but I think that this can be overcome.

Mr. Ball has a comment.

Mr. BALL. I was just making the point to the Secretary, Mr. Chairman, that in addition to the peer review, I think we all agree that you must have a tough claims review process and you will be interested, I am sure, to know that right at the present time 30 percent of all part B claims involving physician bills are being reduced in at least one of the services shown on the claim. It is an increasingly controlled approach and I think the suggestion that the Secretary has made in his testimony which would introduce into the institutional reimbursement a real incentive factor where the manager of the individual hospital or the policymaker can keep some of the money for the institution if he gets under a target rate, may have the potential of increasing their cooperation in providing more efficient and economical administration. Straight cost reimbursement does not do it because now if they are more economical and efficient, we just reduce the reimbursement.

The CHAIRMAN. Well, it seems to me that you are buying a tremendous amount of medical services and you are buying so much of it that you ought to have people in your shop—after all, you have all the consultants and advisers you want available to you—who are in a position to advise you about what you ought to have to pay.

You are buying something in quantity. You ought to be in a position to know what it should cost and to say, "all right, here is what we are willing to pay" and I think in doing that that it ought to be on a basis with the doctor sitting on one side of the table, for example, or the nursing home on one side of the table looking after their interests and it ought to be anticipated that they are after more than they are now making and somebody ought to be sitting on the Government side looking strictly after the Government's point of view and say we are not going to pay one penny more than we think is necessary.

Mr. VENEMAN. Mr. Chairman, I think we have one additional problem. I think we both recognize in this whole field of payment for services and facilities, there is a real difference between the medicare and medicaid programs because, as you know, while they are both buying in the same market, one of the problems that we have is our lack of ability to fully control the State programs.

We have got 50 medicaid programs going on in the country. Since we are paying half the cost we ought to be able to get some leverage there, too. I think we are going to have to take a stronger stand on what is incorporated in the State plans as they implement these programs so that they are consistent with what we are attempting to do from this level.

The CHAIRMAN. Well, I think if you go back and read some of my old speeches prior to the time I voted for medicare—back in the time when I thought we might find some better way to do all this—I predicted that the cost of medicare was going to be far beyond anything anybody estimated and I pointed out some of the reasons. I think every one of those prophecies has come to pass.

Mr. VENEMAN. I think out of fairness we ought to recognize a few things. The program is going through a transition; you have got a new source of revenue, resources, to pay for health services that was not there before. Therefore, a lot of facilities, a lot of providers of services were able to be reimbursed better. A lot of them moved in with new construction, new equipment. The results are some one-time outputs. And I think that we have seen, and I think Mr. Ball can probably give you the specifics on the percentage increase, but we have seen somewhat of a flattening out of cost increases in some parts of the medical service price index.

The CHAIRMAN. I regret to say that this staff report pretty well documents the statement that they all had one thing in common. They all had ambitious plans for increasing their revenues.

Mr. VENEMAN. Mr. Chairman, with your permission, I do have——

Senator RIBICOFF. Before he goes, I want to make a point of procedure. I read in the paper yesterday where Bob Myers, for whom I have the greatest respect, talks about the men in HEW who make policy. Now, basically, when Mr. Veneman goes we are going to listen to people who are the bureaucrats of the Department—who do not make policy.

Now, when is Mr. Veneman coming back so we can ask some policy questions?

Mr. VENEMAN. That is the reason I asked Assistant Secretary Butler to be present. Mr. Butler is the Assistant Secretary for Planning and Evaluation. He has been focusing in on the entire health field and he is here to speak from the policy standpoint for the administration. I will attempt to be back this afternoon.

Senator RIBICOFF. I might say this is a matter of such grave importance that, in all due respect, I think we should be up at the Secretary level to answer policy questions.

The CHAIRMAN. Can you be back tomorrow?

Mr. VENEMAN. I certainly will, Senator. I may be able to be back this afternoon if you are meeting.

The CHAIRMAN. I am not sure we can. We have a revenue bill on the floor today. It does not involve anything like this, only about $600 million a year, but it is still money and we have the responsibility of managing it on the Senate floor today.

Mr. VENEMAN. If that is the case, I will be in Ways and Means.

Senator WILLIAMS. I would suggest we excuse him now and if he can be back tomorrow morning we can resume our questioning.

Senator BYRD. May I make a comment at that point? It seems to me that Secretary Finch should come before this committee. I have not seen him since the day he came in and asked to be confirmed.

[Laughter.]

Mr. VENEMAN. Senator, may I only express that Secretary Finch this morning had to cancel out all of his appointments because of the appropriations bill but I am sure that upon invitation he will be most pleased to appear before this committee. He has enjoyed every moment here.

The CHAIRMAN. Well, he has not heard as much about school problems here as he has elsewhere and that is more controversial than what you are testifying on at this moment, Secretary Veneman. We will excuse you now and hope that you will review the record and will be

prepared to discuss what transpires here when you return tomorrow. Thank you.

Mr. VENEMAN. Thanks.

The CHAIRMAN. Mr. Twiname has a statement, I believe. We will go ahead and let Mr. Twiname present his statement and then we will proceed from there.

Mr. TWINAME. Mr. Chairman, I would like to——

Senator RIBICOFF. With all due respect, Mr. Chairman, the problem—Mr. Twiname, how long have you been with HEW?

Mr. TWINAME. Ten months, Senator.

Senator RIBICOFF. The job you are just taking—you are taking it over on Monday.

Mr. TWINAME. Yes, sir.

Senator RIBICOFF. You see, the problem we have, Mr. Chairman, we have big policy matters to decide. Yet HEW is supposedly represented by people without the experience and background to make policy. I think we have got some basic decisions to decide here, Mr. Chairman. Mr. Twiname is assuming his post on Monday. Mary Switzer is getting out and he is taking her place. Now, you have a man who has not been in the policymaking position coming here today on a job he is going to assume on Monday and I think we are wasting an awful lot of time in not getting down to the basic problems that face this whole problem of health in America. I think it is presuming on the committee's time and our time to be making decisions on this level with nine Senators here present to try to decide some basic questions.

The CHAIRMAN. Well, I would say that as far as the present brass is concerned, we are a lot better represented than they are, Senator Ribicoff. But, the oldtimers who were here and who were in the Department at the time these policies were formulated and these decisions were made are, for the most part, here. As soon as a statement by the, you might say, newcomers who have been appointed by President Nixon have been disposed of, we will then hear from these fellows who gave us the estimates to begin with, and why and what has happened since that time. They are available to us.

For example, you know Commissioner Ball. He has been here, I think, as long as you and I have, and I believe Bob Myers was your actuary when you were Secretary of HEW.

Senator RIBICOFF. I have the highest respect for all of them, but I am aware of the fact that these are permanent employees under civil service and, basically, they have to follow orders and they make their decisions and take actions depending upon what comes down from the White House or the Secretary. They have to comply accordingly, which is proper in this type of government. But what we are dealing with here is basic policy.

Now, Bob Ball or Bob Myers do not make policy. They are there to assist the Secretary and give them technical advice. They are available to the committee, to assist the committee and give them technical advice. But neither Bob Ball nor Bob Myers has the authorization from the White House or the Secretary to make basic decisions and I think this is a problem that we have to face. I think it is presuming upon the time of the U.S. Senate to expect basic policy decisions—about $125 billion and $130 billion—by the bureaucracy of the Department and not by the men who run the Department.

Senator HARTKE. Mr. Chairman——

The CHAIRMAN. Everything you say is correct but I do think that——

Mr. BUTLER. May I respond?

The CHAIRMAN (continuing). We will get a lot of information we want, Senator Ribicoff, and we had better go ahead the way we are going and we will try to get Secretary Finch and Under Secretary Veneman back here as soon as we can. Meanwhile, I think we can find out a lot about what we want to know.

Senator HARTKE. I would like to join the Senator from Connecticut in this expression of concern about policy. I do believe if you read through the statements that are here you constantly run into the "I am new in the position there." Yet, we know there have been some charges made as to what the social security scheme is, and whether it is being implemented in the fashion it should be. The fact of the matter is if the reports that are made are in any way true then there is a big conflict going on.

I think it makes it very difficult to find out—first, we will have to ascertain where each one of these individuals are presently located in the scheme of this conflict that is evidently underlying part of the difficulty down at the Administration. I would hope that the plea of the Senator from Connecticut to proceed with the policy decisions first would be heeded. I really think it is not only a waste of time but I think it may be counterproductive to start down with the details first without an understanding what the broad policy decisions are at the present time.

The CHAIRMAN. Well, you are not going to find anybody who knows any more about this business than Bob Ball over there and if you are talking about what the estimates were and why, I think Mr. Myers over there is the best man on that. We can do one of two things.

I would like to have Secretary Finch here and Under Secretary Veneman, to hear everything that is said but the people who know more about it than they do are here and I would hope that we can go ahead and find out what we can today and then move ahead tomorrow.

To be fair to them, we are looking into the cost of those programs now but we do not have a bill here. We are talking about a study our staff made and we want to know why medicare is going to cost twice as much as it was supposed to and what might be done to save the taxpayers a great deal of money and to get a better run for the taxpayers' dollar. Meanwhile, Under Secretary Veneman has to go over, I believe, to the House Appropriations Committee. After all, there is not going to be any HEW program if they do not have enough money to keep it going. So, they have a problem on both sides.

Now, I will abide by the will——

Senator HARTKE. Mr. Chairman, let me——

The CHAIRMAN. I think we are going about it as best we can. I would assume they are, too.

Senator HARTKE. I do not think there is any question that the staff report is an excellent report and it does point out the impending bankruptcy of the medicare programs. Now, this would not necessarily be a difficult proposition if there had not been a charge of sabotage but there is a charge of sabotage now in the open, of the program. And as long as that charge is out in the open, I think it is a rather peculiar way to start out by starting out with the same review by the same people that gave us the facts and figures before.

The staff report is here. Their previous actions are here and now this policy charge is made. It is out in the open. It is not made by the Senate but made inside of the administration, social security.

The CHAIRMAN. I am not aware of all that. I must admit I am not the most avid newspaper reader. Sometimes things are very inaccurate that you read in the press. We are simply trying to find out the facts based upon what our own people told us. I do not see any alternative but to go ahead with this hearing.

Senator WILLIAMS. I would like to point out if we had not entered into this colloquy the testimony would have been delivered and we could have been questioning these gentlemen who are here. Later, if we want to get Mr. Wilbur Cohen and some of the others back that would be fine, but, we have got a group here and I suggest we let the witnesses testify and then we do our testifying a little later.

The CHAIRMAN. Why do we not go ahead and hear this statement. Will you please proceed, sir?

Mr. TWINAME. Thank you, Mr. Chairman.

On behalf of the Social and Rehabilitation Service, I welcome this committee's continuing interest in health care and in the problems surrounding the delivery of health services to the poor. I would like to speak about the medicaid program briefly.

As I said, I am John Twiname, to be Administrator of Social and Rehabilitative Service, and this is Mr. Howard Newman now beside me at the table, who has assumed the responsibility for the medicaid program this week.

We believe that the publication of the February 9 staff report of the committee will deepen public awareness and stimulate public discussion that are of immediate importance. And we welcome it and take it as constructive for the medicaid program.

Medicaid, born at the same time as medicare, but no twin, was enacted because the Congress believed that access to good health is a right rather than a privilege and that medical care of high quality must be available to all regardless of their ability to pay. I am pleased to be able to report that the principle of access to health care has been extended to every State but two, and the medicaid program is virtually nationwide. In recent months, some 2½ million people in 10 States have been added to the eligibility rolls and we anticipate that more than 12 million low-income people will receive medical care with medicaid's help this year.

We all know that medicaid has been a difficult program, even a cumbersome one to administer. Partly because of the legislation, partly because of the nature and administration of the welfare program it supplements, partly because it is a Federal-State program, medicaid operates not as one but as 52 distinct and separate programs. Each program is different in design, in people covered, and in services offered. We know that medicaid is an expensive program. Like every public or private program that has delivered or paid for medical care in the last several years, it is more expensive than anyone could have anticipated. It has suffered from some excessive utilization and to a much lesser extent from outright fraud. It has not always been administered efficiently, effectively, or imaginatively. There is one thing the program has not suffered from, however, and that is praise. Little praise has come from legislators and administrators, or from provid-

ers who are paid for their services, or, for that matter, from the people medicaid cares for—that is, until States threaten to retrench and reduce fees, services, or eligibility.

For that reason, before discussing once again the problems we are having with this new program, let me spend a minute in its praise—medicaid is, in its own way, bringing Congress' intent to life by bringing health care to many millions of people.

First, medicaid has more than doubled the number of people who receive federally aided medical assistance—5.4 million people received assistance in 1965. Over 12 million will receive aid this year.

Second, medicaid is doing for children now what the Kerr-Mills program attempted to do for the aged. It is bringing health care to those whose families have enough money for their daily needs but not enough for special medical needs. From 1965 to 1969 the number of children who received federally supported medical assistance rose from 1.5 million to 4.2 million and 1.7 million of the children in the latter group were not in welfare families.

Third, numbers alone do not tell the story. We are beginning to learn about the program's effectiveness from objective studies made by disinterested scholars. Preliminary data we have now from a study conducted by the Columbia University School of Public Health indicate that public assistance recipients who are eligible for medicaid are getting more health care than other low-income people who are not eligible. This is a basic question that has really been raised—are we getting anything for our money that we would not have gotten if medicaid had not been put into effect? The results seem to indicate that people are getting medical care in a substantial form that they would not have otherwise.

There is no doubt in my mind that the program is helping sick poor people get medical care. But there is also no doubt in my mind that we can and we must improve the program.

With your permission, I will submit for the record a document entitled "Medicaid's Initiatives Since January 1969," which describes 38 initiatives this administration has taken to contain costs, improve management, and increase effectiveness. Most of these actions have been taken since the last hearings of this committee. In a sense I would like to submit it as a response to the last hearings that you held, Mr. Chairman, and on the other hand, in covering these initiatives, I think we also describe the problems in the program and these initiatives are only beginning attacks on those problems.

In my statement I have listed A through L, headings which I will not now read but would like to highlight as we go through this additional document called "Medicaid Initiatives." * I can highlight what I feel would be some of the more interesting points for you.

The A section I have already covered. Medicaid is now a virtually nationwide program with 48 States and four jurisdictions in the program.

Section B is the reactivation of the Medical Assistance Advisory Council which is now working and attempting to integrate its efforts with the medicaid task force that was appointed by the Secretary.

The CHAIRMAN. Why do you not just get down to your statement? There is no point in just reading that A through L.

*The material referred to appears at the conclusion of Mr. Twiname's prepared statement, p. 24.

Mr. TWINAME. All right. The third section that we have in that paper is entitled "Improved Standards for Services." The issuance of regulation——

The CHAIRMAN. This will be included in the record. That will save time and let us get on to where you talk about what your thoughts are.

Mr. TWINAME (continuing). Good; they are cross-referenced as you see and in connection with section C, I spoke about these new regulations. One area in which there has been a great public concern is nursing home care. The National Advisory Council on Nursing Home Administration has developed several important documents to help the States implement the 1967 amendment that require the licensing of nursing home administrators by July 1, 1970. Regulations to implement the amendment will be published in the Federal Register this week. A model licensing law was sent to the States in January of this year, 1970.

And third, rules and regulations with appropriate guidelines to be used by State licensing boards were issued in November.

The council has also identified the knowledge and experience needed by a nursing home administrator and has outlined educational offerings for incumbent administrators who do not qualify for licensure.

Fifth, standards for payments for skilled nursing care have been developed and published.

I will pass the other initiatives and speak about the encouragement of new methods for delivering health care. Medicaid has been encouraging these new methods. In 16 jurisdictions, 35 OEO health centers bill medicaid for the care they give medicaid patients, an arrangement the Medical Services Administration advocates.

Secondly, the Medical Services Administration also monitors plans for model cities programs and encourages inclusion of health-related activities and we have been working on that, especially this year.

Thirdly, we are considering proposals that will use appropriated funds to develop new and innovative health care delivery systems in geographic areas that are now poorly served by traditional health services.

We have also been encouraging new ways to pay for health care. Mr. Veneman spoke to that in his testimony. Prepaying medical costs, using a per capita premium as a basis for estimating them, may soon be recognized as the payment method of choice. Particularly if the provider group assumes the financial risks, this is an especially attractive arrangement for State agencies. A few States have instituted pilot plans of this kind and others are very interested.

Cost control has been the object of a whole series of published regulations. I cover that in this separate document. One requires States to establish procedures for utilization review for every item of services provided. Others impose ceilings on payments States may make for institutional services, for drugs, and for services of physicians, dentists and other practitioners. Another involves the Federal Government with the States in the prosecution of fraud which was requested by this committee in the last hearings.

One regulation being developed will require States to file with the Internal Revenue Service reports of aggregate payments made to

providers identified by name, address, social security or employer identification number.

The legislative proposals required by the President's 1971 budget soon to be forwarded to the Congress, would reduce Federal contributions to the medicaid program at the same time it redirects utilization of health services from long-term institutional care to ambulatory care, including preventive health services. The proposal calls for increased Federal contributions to the cost of selected outpatient services and decreased Federal contributions to the cost of long-term institutional care. Since Federal contributions to services that account for 68 percent of the medicaid dollar would be reduced, we expect to save a significant amount of Federal matching funds.

Last July the Secretary of our Department appointed a Task Force on Medicaid and Related Programs and asked the group to look into both immediate and long-range problems. This is covered in a separate section in the supplementary paper, section I.

In November that task force reported to the Secretary and made many recommendations related to medicaid effectiveness, management, and eligibility. These are being studied, worked on now, and some of these recommendations are being immediately implemented, including one that suggested a reorganization of the Medical Services Administration.

I am happy to say that we have just appointed a new Commissioner for medicaid. Mr. Newman here, who is an administrator, hospital administrator, with expertise in the provision of health care for the poor.

We have designed a new structure for the Medical Services Administration and a substantial number of new positions have been allocated. Plans have been approved to increase its staff in Washington and the regional offices.

An extraordinary recruiting effort has been initiated and a new organization will soon be in operation.

States also are continuing to take steps to improve their program management procedures. To help them develop comparable reporting systems, we have developed systems specifications for their claims payment processes and for their surveillance and utilization review functions. What we have done here is work with the medicaid task force to contract with a firm that has put in some of the more sophisticated utilization and surveillance reporting systems in States. We have now a document—a basic plan for States—which we are going to try to implement in every State beginning with demonstrations in three States of the use of this format for computer handling of the claims payment process so that we can have a utilization review program.

I have before me, and will go over with you whenever you are interested, some example printouts that show how we have disciplined a doctor and a nursing home and a pharmacy as a result of State implementation of this program. This illustrates how we can get a handle on this information and then work through the State agency with a review group to bring discipline into the program.

At the same time we have been working with another contractor to develop a format for reporting the information to the Federal agency, to us here. This document, that is also available to you, is the result of a contract that has just been completed to find out what information

is needed at our level—at the Federal level—from the States, so that here in the Department we can exercise management control.

I would, at your invitation, be happy to demonstrate how we work with providers—doctors and pharmacies or nursing homes—in the example that I have brought with me.

In conclusion, let me say, as Senator Ribicoff has pointed out, we are new. I am new as Administrator of Social Rehabilitation Service. Mr. Newman has just taken over as Commissioner of Medicaid. But together we are dedicated to extending these administrative initiatives that are submitted here for the record and we will welcome working with the committee to expand our efforts in bringing the costs under control and extending better quality health care for the poor. I will be happy to try to answer any questions that you have on this statement or the program.

(Mr. Twiname's prepared statement, with attachment referred to on p. 19, follows:)

STATEMENT BY JOHN D. TWINAME, DEPUTY ADMINISTRATOR, SOCIAL AND REHABILITATION SERVICE, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

On behalf of the Social and Rehabilitation Service, I welcome this Committee's continuing interest in health care and in the problems surrounding the delivery of health services to the poor. I trust that the publication of the February 9 staff report of the Committee will deepen public awareness and stimulate public discussion of questions that are of immediate importance.

Medicaid, born at the same time as Medicare, but no twin, was enacted because the Congress believed that access to good health is a right rather than a privilege and that medical care of high quality must be available to all regardless of their ability to pay. I am pleased to be able to report that the principle of access to health care has been extended to every State but two, and the Medicaid program is virtually nationwide. In recent months, some two and a half million people in ten States have been added to the eligibility rolls and we anticipate that more than 12 million low-income people will receive medical care with Medicaid's help this year.

We all know that Medicaid has been a difficult program, even a cumbersome one to administer. Partly because of the legislation, partly because of the nature and administration of the welfare program it supplements, partly because it is a Federal-State program, Medicaid operates not as one but as 52 distinct and separate programs. Each program is different in design, in people covered, and in services offered. We know that Medicaid is an expensive program. Like every public or private program that has delivered or paid for medical care in the last several years, it is more expensive than anyone could have anticipated. It has suffered from some excessive utilization and to a much lesser extent from outright fraud. It has not always been administered efficiently, effectively, or imaginatively. There is one thing the program has not suffered from and that is praise. Little praise has come from legislators and administrators, or from provides who are paid for their services, or, for that matter, from the people Medicaid cares for—until States threaten to retrench and reduce fees, services, or eligibility.

For that reason, before discussing once again the problems we are having with this imperfect child, let me spend a minute in its praise—Medicaid is, in its own way, bringing Congress' intent to life by bringing health care to many millions of people.

First, Medicaid has more than doubled the number of people who receive Federally-aided medical assistance—5.4 million people received assistance in 1965. Over 12 million will receive aid this year.

Second, Medicaid is doing for children what the Kerr-Mills program attempted to do for the aged. It is bringing health care to those whose families have enough money for their daily needs but not enough for special medical needs. From 1965 to 1969 the number of children who received federally supported medical assistance rose from 1.5 million to 4.2 million and 1.7 million of the children in the latter group were not in welfare families.

Third, numbers alone do not tell the story. We are beginning to learn about the program's effectiveness from objective studies made by disinterested scholars. Preliminary data from a study conducted by the Columbia University School of Public Health indicate that public assistance recipients who are eligible for Medicaid are getting more health care than other low-income people who are not eligible.

There is no doubt in my mind that the program is helping sick poor people get medical care. But there is also no doubt in my mind that we can and must improve the program.

With your permission, I will submit for the record a document entitled "Medicaid's Initiatives since January 1969," which describes 38 initiatives this Administration has taken to contain costs, improve management, and increase effectiveness. Most of these actions have been taken since the last hearings of this Committee. The initiatives fall into 12 subject areas as follows:

A. Medicaid now Virtually a Nationwide Program.
B. Reactivation of the Medical Assistance Advisory Council.
C. Improved Standards for Service.
D. Development of Provider and Consumer Understanding.
E. Employment of Medicaid Consumers in Subprofessional Roles.
F. Encouragement of New Methods of Delivering Health Care.
G. Encouragement of New Ways to Pay for Health Care.
H. Cost Control Through Issuance of Regulations.
I. Efforts of the Secretary's Task Force on Medicaid.
J. Strengthened Leadership and Staff.
K. Program Review and Evaluation Projects.
L. Development of Program Management Procedures.

I should now like to highlight some of the initiatives that will have significant effect on the program's development in a manner consistent with the Committee's interest in improved management and reduced cost.

NEW INITIATIVES

Issuance of regulations and other activities have improved standards for services, thus establishing safeguards for consumers (Refer to Medicaid Initiatives in 1969, Section C). One area in which there has been great public concern is nursing home care. The National Advisory Council on Nursing Home Administration has developed several important documents to help States implement the 1967 Amendment that requires States to license nursing home administrators by July 1, 1970. Other regulations will be published in the *Federal Register* this week. A Model Licensing law was sent to the States in January 1969; rules and guidelines for State Licensing Boards were issued in November. The Council has also identified the knowledge and experience needed by a nursing home administrator and has outlined educational offerings for incumbent administrators who do not qualify for licensure.

Standards for payment for skilled nursing care have also been published as interim policy—regulations have been developed and are being cleared.

Medicaid has been encouraging new methods of delivering health care and expects to expand this activity. (Section F) In 16 jurisdictions, 35 Office of Economic Opportunity health centers bill Medicaid for the care they give Medicaid patients, an arrangement the Medical Services Administration advocates.

MSA also monitors plans for Model Cities programs and encourages inclusion of health-related activities.

We are considering proposals that will use appropriated funds to develop new and innovative health care delivery systems in geographic areas that are now poorly served by traditional health services.

We have also been encouraging new ways to pay for health care. (Section G) Prepaying medical costs, using a per capita premium as a basis for estimating them, may soon be recognized as the payment method of choice. Particularly if the provider group assumes the financial risk, this is an especially attractive arrangement for State agencies. A few States have instituted pilot plans of this kind and others are interested.

Cost control has been the objective of a whole series of published regulations. (Section H) One requires States to establish procedures for utilization review for every item of services provided. Others impose ceilings on payments States may make for institutional services, for drugs, and for services of physicians, dentists, and other practitioners. Another involves the Federal Government with

the States in the prosecution of fraud. One regulation being developed will require States to file with the Internal Revenue Service reports of aggregate payments made to providers identified by name, address, and social security or employer identification number.

The legislative proposals required by the President's FY 1971 budget (p. 471 Appendix) and soon to be forwarded to the Congress would reduce Federal contributions to the Medicaid program at the same time it redirects utilization of health services from long-term institutional care to ambulatory care, including preventive health services. The proposal calls for increased Federal contributions to the cost of selected outpatient services and decreased Federal contributions to the cost of long-term institutional care. Since Federal contributions to services that account for 68 percent of the Medicaid dollar would be reduced, we expect to save a significant amount of Federal matching funds.

Last July, the Secretary of HEW appointed a Task Force on Medicaid and Related Programs and asked the group to look into both immediate and long-range problems. (Section I) By November, the Task Force reported to the Secretary and made many recommendations relating to Medicaid's effectiveness, management, and eligibility. Some of these recommendations are being immediately implemented, including one that suggested a reorganization of the Medical Services Administration.

I am happy to say that we have just acquired the services of a new Commissioner for Medicaid, an able hospital administrator with expertise in the provision of health care to the poor, Howard N. Newman from Philadelphia. We have designed a new structure for MSA and a substantial number of new positions have been approved to increase its staff in Washington and the regional offices. An extraordinary recruiting effort has been initiated and the new organization will soon be in operation. (Section J)

States continue to take steps to improve their program management procedures. (Section K) To help them develop comparable reporting systems, we have developed systems specifications for their claims payment processes and for their surveillance and utilization review functions. We have also ascertained our own reporting and information needs for a management information system and have coordinated both systems so that we can test the effectiveness of an integrated management information plan that can be used at the State and Federal levels.

As you know Mr. Newman and I are relatively new in our management responsibility for this program. He assumed his position as Commissioner last week. I will become Administrator of the Social and Rehabilitation Service next week. Together, we are dedicated to extending these initiatives and implementing the kind of management controls that will better insure quality health care for the poor on a more cost effective basis.

We will be happy to try an answer any questions that you may have about the Medicaid program.

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## Medicaid Initiatives Since January 1969

### A. MEDICAID NOW VIRTUALLY A NATIONWIDE PROGRAM

Medicaid is in effect in all but two States (Arizona and Alaska) which do not have programs because of special problems involving their Indian and Eskimo populations. Ten States began operations since January 1969, bringing the total to 48 States and 4 jurisdictions. In fiscal year 1969, Medicaid paid for care for 11.3 million people.

### B. REACTIVATION OF MEDICAL ASSISTANCE ADVISORY COUNCIL

1. After a period of inactivity, vacancies in the MAAC were filled, its mission reestablished, and a new chairman, Donald C. Smith, M.D., Professor of Maternal and Child Health at the University of Michigan, appointed.

2. The Council is now engaged in a profound and continuing review of the Medicaid program, its policies, plans, accomplishments, and the prognosis for its future. The Council is working closely with the Department's Medicaid Task Force and will follow through on its recommendations when the term of the Task Force is over.

C. IMPROVED STANDARDS FOR SERVICES

1. The National Advisory Council on Nursing Home Administration has developed several important documents to help States implement the 1967 Amendment that requires the licensing of nursing home administrators by July 1, 1970. Regulations to implement the Amendment will be published in the *Federal Register* this week.

2. After public hearings held in various parts of the country, a Model Licensing Law was prepared and sent to the States in January 1969.

3. In November 1969, recommended rules and regulations with appropriate guidelines to be used by State Nursing Home Administrator Licensing Boards were issued.

4. At the same time, the Council issued a report identifying the knowledge anad experience needed by a nursing home administrator, methods of determining their qualifications, and criteria for a "waiver" program, and describing educational programs for "waivered" nursing home administrators.

5. Standards for payment for skilled nursing care have been developed and published. (Interim policy published June 24, 1969. Final policy being cleared.)

6. The amount, duration, and scope of medical assistance offered by States in complying with the Medicaid program has been redefined. (August 30, 1969.) Policy regulations defining "early and periodic screening and diagnosis of individuals under 21" and standards for reimbursement for care in rehabilitative institutions are now being cleared.

D. DEVELOPMENT OF PROVIDER AND CONSUMER UNDERSTANDING

1. Understanding what the Medicaid program can and cannot do underlies proper and efficient use of the program by providers and consumers alike. Such understanding has been cultivated by publication of charts, flyers, and pamphlets and notably by a popular pamphlet "Medicare-Medicaid, Which is Which?"

2. To encourage States to benefit from the growing administrative expertise in the Medicaid community, a communications network will be established to link Washington, the Regions, and the States.

E. EMPLOYMENT OF MEDICAID CONSUMERS IN SUBPROFESSIONAL ROLES

The employment of Medicaid patients as health aides and interpreters of the program to their peers is essential to fullest and most efficient use of the program. Programs for the most effective use of this group will be developed in conformity with the mandate of the 1967 Amendments.

F. ENCOURAGEMENT OF NEW METHODS OF DELIVERING HEALTH CARE

1. In 16 jurisdictions, 35 OEO health centers bill Medicaid for the care they give Medicaid patients. These reimbursement arrangements implement a 1968 agreement between the Department of Health, Education, and Welfare and the Office of Economic Opportunity. MSA constantly encourages such arrangements.

2. MSA monitors plans for Model Cities programs and encourages inclusion of health-related activities. Such activities are now being funded in some areas, largely as a result of MSA's interest.

3. We are considering proposals that will use appropriated funds to develop new and innovative health care delivery systems in geographic areas that are now poorly served by traditional health services.

G. ENCOURAGEMENT OF NEW WAYS TO PAY FOR HEALTH CARE

Prepaying medical costs, using a per capita premium as a basis for estimating them, may soon be recognized as the payment method of choice. Particularly if the provider group assumes the financial risks in case expenses exceed premiums, this is a particularly attractive arrangement for State agencies.

A few State Medicaid agencies have instituted pilot plans of this kind. They contract to purchase from a provider group some or all of the services for which Medicaid patients are eligible by paying a fixed, prepaid, per capita, premium. Although few States are involved in schemes like this now, enough interest has been shown by other States to indicate that it is an idea whose time may be close.

H. COST CONTROL THROUGH ISSUANCES OF REGULATIONS

Several regulations already issued or in preparation directly affect program cost.

1. Regulation 40-9 requires States to establish procedures for utilization review for each item of service provided.

2. (a) Regulation 40-4 requires States to reimburse hospitals for inpatient services on a "reasonable cost" basis using title -VIII's reimbursement formula. (January 25, 1969)

The same regulation imposed "ceilings" on payments States may make for services other than inpatient hospital services: *For drugs*, ceiling is either cost of acquisition plus fixed fee or the price paid by the general public. *For institutional services other than inpatient hospital care*, ceiling is "reasonable cost" as applied for title XVIII.

(b) *For physicians, dentists and other practitioners, Regulation 40-4(C-1)*, ceiling is payment under structure in effect on January 1, 1969, or the "reasonable charge" allowed by title XVIII-B of the Act at that time, whichever is less. Increases in reimbursement after July 1, 1970, will depend on existence of utilization review program and will be limited to increase in cost of living index (July 1, 1969).

3. Regulation 40-14 involves the Federal Government along with the States in the prosecution of fraud (January 1970).

4. Regulation 40-13 requires providers of services to keep records of services rendered and to furnish information about claims for payment to the State on request. (September 20, 1969)

5. Regulation 40-10 provides for a level of less expensive care in the form of institutional services in Intermediate Care Facilities under titles I, X, XIV or XVI. (June 24, 1969)

6. A regulation to require States to file with the Internal Revenue Service reports of aggregate payments made to providers identified by name, address, and social security or employer identification number is being cleared.

7. A regulation to require States to evaluate patients' need for care before admission to nursing homes and mental institutions and reevaluate it thereafter is being cleared.

I. EFFORTS OF THE SECRETARY'S TASK FORCE ON MEDICAID

1. In July 1969, the Secretary of HEW appointed a Task Force on Medicaid and related Programs and asked the groups to look into both immediate and long-range problems.

2. The Department of HEW detailed 30 professional experts to assist the 27-man committee and by November the group made many recommendations relating to Medicaid's effectiveness, management, and eligibility in a report to the Secretary.

3. Some recommendations that require only administrative action are being implemented immediately, while legislative proposals are being developed where necessary to implement others. A recommended change in the internal structure of the Medical Services Administration is now being cleared and will soon be put into effect.

J. STRENGTHENED LEADERSHIP AND STAFF

1. A new commissioner of the Medical Services Administration, selected for his administrative experience with health programs for the poor, took office this month. For many years, Mr. Howard Newman was responsible for the organization and supervision of hospital-based health delivery systems for low-income people. He also served with the Bureau of the Budget as a White House Fellow.

2. We have designed a new structure for the Medical Services Administration and a substantial number of new positions have been approved to increase its staff in Washington and the regional offices.

3. An extraordinary recruiting effort has been initiated to fill the new positions with people experienced in health services and management. The new organization will soon be approved and in operation.

4. The Assistant Secretary for Health and Scientific Affairs has reserved a position on his staff for a Deputy Assistant Secretary who will coordinate Medicaid and Medicare policy with policy and activities in the Department's other health programs.

K. PROGRAM REVIEW AND EVALUATION PROJECTS (PREP)

1. On-site evaluations in 11 States called attention to program deficiencies and started a correctional process.
2. In the seven States that spend the major share of Medicaid funds, mini-prep reports identified problems in claims-payment procedures.

L. DEVELOPMENT OF PROGRAM MANAGEMENT-PROCEDURES

1. MSA staff consultation with States on drug utilization and control techniques has decreased expenditures for prescription drugs in some States. Consultation on other subjects has enabled States to operate more efficiently in problem areas.
2. The second Annual Conference of State Medical Assistance Directors and State Medical Consultants in May 1969 gave 71 persons from 37 States and 3 jurisdictions opportunities to discuss technicalities of utilization review and reimbursement problems.
3. Program management is now included in the curriculum of seminars held annually for State and Federal Medicaid personnel.
4. Many States are developing expertise in setting up a variety of good management procedures such as establishment of norms and parameters for utilization review work, reliable budgeting procedures, explicit contractual arrangements with fiscal agents, and effective legislative arrangements.
5. To help States develop comparable reporting systems, the Department developed systems specifications for States' claims payment processes and for their surveillance and utilization review functions. Standardizing and upgrading this activity at the State level will help use resources more effectively, provide care of higher quality, improve management, and reduce costs. A draft of specifications for such a system is now available.
6. Federal reporting requirements and information needs for a Medicaid management information system have been ascertained. The system that has been designed is now being coordinated with the system for State surveillance and utilization review to produce an integrated management information plan that can be used at the State and Federal levels.

The CHAIRMAN. Thank you very much. Now, I think I will ask that every member be limited to about 5 minutes on the first round of questions. Then we can ask more questions—have a second round if Senators want to.

I would like to ask this question. I have asked it before. Under the hospital plan's present financing, including the 1967 tax increase, what is the latest estimate of the deficit between estimated income and costs in terms of dollars and as a percent of payroll? Both ways.

Mr. MYERS. Mr. Chairman, as you have just indicated, I have just completed, a week or two ago, making final detailed cost estimates under new assumptions. Last fall a preliminary estimate was developed using very approximate and short-cut methods. When approximation methods are used, you hope that the errors one way will cancel out the errors the other way, but unfortunately, in this case the errors were all additive, so that the costs were shown to be considerably higher in what I call the final estimates than in the preliminary ones last fall.

Now, to get to your specific question, I would first like to discuss the costs as a percentage of payroll and then I will give you the costs in terms of dollars for the 25-year period over which we make the actuarial evaluation.

The CHAIRMAN. Do you have it for 5, 10, and 25 years, all three ways?

Mr. MYERS. Yes. I have figures that I can give you on that basis for those periods in terms of dollars.

Now, before getting into this, though, I would like to mention one thing. As you will recall, in the past, the cost estimates have always been made under the assumption that the maximum taxable earnings base, which is $7,800 in present law, would remain at $7,800 in all future years. As to the new estimates, I have made two alternative estimates. One with that same assumption, and the other under the assumption that the earnings base would rise in the future to reflect changes in the general earnings level. The latter situation has been the experience in the past 20 years—namely, that the Congress has kept the earnings base up to date with changed earnings. Therefore, it seems to me that the latter is a reasonable assumption, but I think that both assumptions should be looked at.

Under the assumption that the earnings base remains at $7,800 over the next 25 years, despite the fact that it is assumed that the general wage level of persons covered under social security will increase at a very considerable rate, actually rising by 180 percent over the 25-year period, the estimated level-cost of the benefits and the administrative expenses is 2.76 percent of taxable payroll.

Now, as against this, the level—equivalent of the graded contribution schedule in the law—which as you know, rises from the present 1.2 percent for the employer and employee combined to 1.8 percent in 1987—is 1.52 percent of taxable payroll. Thus there is an actuarial lack of balance or deficite of 1.24 percent of taxable payroll.

Now, if you look at this in the second way—assuming that the taxable earnings base rises in the future more or less in the same manner as the general wage level of the covered population—then the estimated level-cost of the benefit payments and administrative expenses is 2.01 percent of taxable payroll. The level-equivalent of the contributions is about the same as it was previously—namely, 1.56 percent of taxable payroll—so that there is an actuarial deficit of 0.48 percent of taxable payroll.

Now, to put it perhaps in more simple language, what this actuarial deficit means is that, according to these estimates, if it is desired to have the system adequately financed over the 25-year period, the contribution rates would have to be increased by this amount—namely, for example, in the second alternative, by roughly half a percent of payroll in every future year. At least, that would be one way of doing it. There could, of course, be other combinations but that is one possible way, and it is what in essence I mean when I say there is an actuarial deficit.

Now, turning to the dollar figures, let us look first at the 25-year period, and then I will give you figures for the 5- and 10-year periods measuring from 1970 on. Over the 25-year period from 1970 to 1994, the total outgo for benefit payments and administrative expenses is estimated at $479 billion, rounding it to the nearest billion dollars. Now, the total amount of contributions under the assumption that the earnings base will remain at $7,800 in the next 25 years, even though wages will rise greatly, is $263 billion, so that there is a difference of $216 billion as the excess of outgo over income according to the present contribution schedule.

Now, if it is assumed that the earnings base keeps up to date, and again that the present tax schedule is maintained, then the total con-

tributions would be $384 billion, leaving an excess of outgo over income of $94 billion.

The CHAIRMAN. Well, now, the rest of that, Mr. Myers, I suggest be provided for the record so we can get on with this.

Now, are you aware of the fact that Congress said back in 1965 that this program was to be estimated on a conservative basis and that you should not anticipate an increase in the wage base to finance this program? In other words, at that time we were talking about a base of $6,600. That is here in our 1965 committee report. We felt any increase in the wage base ought to be used for additional benefits or an increase in the cash benefits rather than for this purpose. Are you aware of that?

Mr. MYERS. Mr. Chairman, I am quite aware that that is, of course, a correct statement of the history of the cost estimates—namely, that it was assumed, as a margin of safety, the earnings base would be assumed to be level. But I think that there were different interpretations placed on what this meant.

For instance, in the reports of the board of trustees it was stated, I believe, that if the experience turned out as estimated, and if the earnings base did in actuality rise, then the scheduled increases in the contribution rates would not be required.

Mr. MYERS. Commissioner Ball tells me that statement is also in the committee report. I believe that it is.

The CHAIRMAN. As I understand it, at the time we anticipated that if wages went up we might be able to cut the taxes. That is my impression.

Mr. MYERS. That is correct.

The CHAIRMAN. This is what I want to know. You have consistently underestimated the cost of the hospital insurance program. We have repeatedly expressed our admiration for you as a man who came up with honest estimates based on the facts and the assumptions available to him from which to project those estimates.

Why have those estimates been consistently below the actual experience?

Mr. MYERS. Thank you, Mr. Chairman. You are quite correct that the estimates have been consistently low. When the estimates were made in 1965, it is true that both this committee and the House Ways and Means Committee gave approval, or perhaps you might say gave instructions, to use assumptions that would be on the conservative side and yet it has turned out that the experience has been much worse.

The CHAIRMAN. Let us understand this. At the time of medicare's enactment we made assumptions that were on the conservative side. We anticipated an increase in demand. My impression was that you were looking at prevailing costs for services and estimating beyond that. That is what we meant when we said conservative. We were trying to be on the safe side.

Mr. MYERS. That is correct, Mr. Chairman. What went wrong with the estimates as against the experience was really two major factors, and there are a number of minor ones. The major factors are these.

First, the extent of hospital utilization has been about 25 percent higher than in the original estimates. But I believe that an even more important factor has been the way that hospital costs have risen in

the past, which was far more I believe, than anybody anticipated back in 1965. At least, part of that was due to the general inflation in prices that we have had since 1965, but by no means all. And in the new estimates I have made assumptions as to future increases in hospital costs that are much more conservative than in the past. Previously, I thought that the large excess of hospital costs over the general wage level would diminish in a few years. In these new estimates, I have assumed that such increases in hospital costs would last for quite a long time, and at least I hope that these estimates will prove much more realistic than the previous ones.

The CHAIRMAN. Right. Now, for the record, I want you to fill in what the 5- and 10-year estimates are and I want to- —

Mr. MYERS. Yes, sir.*

The CHAIRMAN (continuing). I want to get from Mr. Ball an answer to a question I was going to ask Mr. Veneman. How do you expect to get arm's-length public interest policymaking in administration when the advisory groups are often heavily weighted with people who are representing providers who would benefit from higher payments for these services?

Mr. BALL. There is no bargaining, Mr. Chairman, by advisory groups. Advisory groups are brought in for their special advice in a given technical area and the Health Insurance Benefits Advisory Council which has, as you know, the broad responsibility under the law to review regulations of the Secretary before he finally issues them and to give general advice has on it, people from the backgrounds not only of providers and physicians but of senior citizens and labor and consumer representatives.

The CHAIRMAN. Senator Anderson?

Senator ANDERSON. I have a health insurance card here. How many other people have a card of that nature?

Mr. BALL. About 20 million, Senator Anderson.

Senator ANDERSON. And their premium payments are 20 million times $4 for me and $4 for the Government right now?

Mr. BALL. At the moment on the part B, the voluntary part, it is somewhat short of 20 million. The card is held also by people with hospital insurance only but there are over 19 million who have the voluntary insurance and they are currently paying $4, to be matched by the Government; but beginning July 1st it will be $5.30 each.

Senator ANDERSON. That is premium income?

Mr. BALL. Yes, sir.

Senator ANDERSON. Have you estimated premium outgo?

Mr. BALL. Yes, sir. Mr. Myers estimated both for the next fiscal year.

Senator ANDERSON. We have got 25 years in advance costs for part A; I cannot wait that many years. I probably will not live that many years.

Mr. BALL. Senator, the two parts of the program are handled entirely differently in the estimates. The hospital insurance program that the chairman was questioning Mr. Myers about is done over a 25-year period because for one reason, it is on a prepayment basis. All the covered workers in the country make contributions just as they do for social security. It is a payroll deduction. But the voluntary plan is just on a year-by-year basis. The premium is settled in December

*See p. 33.

for the following fiscal year and then the Secretary is required the next December to review that and promulgate if necessary, a new premium for the next year. So that goes on a year-by-year basis.

Senator ANDERSON. This is the largest insurance business in the country, is it not?

Mr. BALL. Yes, indeed.

Senator ANDERSON. It was very large to start off with.

Mr. BALL. Yes, indeed.

Senator ANDERSON. Did you start off by estimating how many people would buy coverage and then estimate how many would claim benefits?

Mr. BALL. Yes, Mr. Chairman. We expected in the voluntary—I mean, Senator Anderson—in the voluntary part of the program we did not really expect quite as high a rate of participation. We actually got in the first sign up the very remarkable response of 92 percent of all the older people in the country. We had thought it was more likely to be around 85 percent. But, of course, the income increases with the liability so it made no significant difference to have more people.

Senator ANDERSON. I am only hopeful that some day we will start to estimate premium income and premium outgo and try to see if we are going to balance the books.

Mr. BALL. Well, that is the objective. Would you want to comment on that, Bob?

Mr. MYERS. Senator Anderson, in the voluntary supplementary medical insurance plan that you are talking about, the income has largely balanced the outgo, the only problem having been in this present fiscal year when the premium rate was frozen at $4 per month when it should have been around $4.40, $4.50, or $4.60. Over the years, this program has really had much less of a financial problem than the hospital insurance program. Our estimates for the supplementary medical insurance program have each year been within about 7 percent of the experience. Unfortunately, it was always 7 percent too high so that the trust fund did not build up to quite the proper level on a pay-as-you-go basis, but the trust fund now has a balance of about $200 million. By next June 30, it will be around $60 to $100 million. Then, the new premium rate goes into effect and that will once again hopefully set it back on its financial feet completely.

Senator ANDERSON. How much deficit will there be this year?

Mr. MYERS. You mean, how much will the Government contribution be?

Senator ANDERSON. Deficit.

Mr. MYERS. The deficit, if measured on an incurred basis as is customary in insurance programs, will be something in the order of $300 million, so that the cash balance of the fund has been drawn way down.

Senator ANDERSON. $300 million. Has the rate increased?

Mr. MYERS. There was this deficit of $300 million because the premium rate was not increased. I had recommended to former Secretary Cohen, in December 1968, that the premium rate should go up from $4 to $4.40, but he——

Senator ANDERSON. Would that have balanced the books?

Mr. MYERS. It would have come much closer. We probably would have needed $4.50 or $4.60.

Senator ANDERSON. Would it have balanced the books—balanced the accounts, do you think?

Mr. MYERS. No. There still would have been a small deficit, but not nearly as large as the one that has occurred.

Senator ANDERSON. Should you not try to balance the books?

Mr. MYERS. Yes, sir. That is what we try to do when I make the estimates, and I think that the $5.30 that is promulgated for the next premium period will be sufficient to do so.

Senator ANDERSON. And done year by year.

Mr. MYERS. This is done year by year but as Commissioner Ball said, we just make the estimates 1 year in advance so that the promulgation can be made.

Senator ANDERSON. You have long-term figures that are disturbing. I think probably you ought to calculate costs year by year. The insurance companies do it year by year.

Mr. MYERS. Well, with the hospital insurance program being financed by a payroll tax, the estimates necessarily are made——

Senator ANDERSON. I am not worried about that one. Medicare started the biggest insurance business in the world. When it started it estimated what premiums would be and what costs would be incurred. When you found you were not going to have enough money to pay the costs, you should raise the rates. Every private insurance company does that and needs to do it.

Mr. MYERS. Yes, Senator. That is what we are trying to do, and now that we have several years of experience to build on, I think that the estimates can be made much more reliably than back in 1965, when there was no program like this in existence.

Senator ANDERSON. I hope so. That is all I am trying to do.

Mr. MYERS. I certainly hope so, too, Senator.

The CHAIRMAN. Senator Williams?

Senator WILLIAMS. In line with the same questions, Mr. Myers, you recommended a rate of $5.30 for fiscal 1971 and that has jumped from $4. I understand you made an interim recommendation about a year ago, did you not, for an increase to around $4.50?

Mr. MYERS. Senator Williams, in December 1968, I recommended to former Secretary Cohen that the premium rate should go up from $4 to $4.40.

Senator WILLIAMS. Why was that not carried out?

Mr. MYERS. Well, according to the law, the Secretary makes the promulgation, and he need not necessarily follow the advice of the actuary. So, Secretary Cohen decided to keep the rate at $4, because I suppose he believed that this could be accomplished by holding down physician-fee increases and so forth.

Senator WILLIAMS. Do you really believe that is the reason?

Mr. MYERS. No.

Senator WILLIAMS. No. Thank you.

[Laughter.]

Senator WILLIAMS. Neither do I.

Now, to get back to the part A program. You have given an estimate of a $216 billion deficiency for 25 years. Now, will you go down the line and give us 5-, 10-, 15-, and 20-year deficits in dollars.

Mr. MYERS. I can give you 5- and 10-year figures now.

Senator WILLIAMS. All right.

Mr. MYERS. For 5 years, it is $9.4 billion, and for 10 years, it is $36 billion.

Senator WILLIAMS. You do not have 15 and 20?

Mr. MYERS. I would have to compute them. I have not summarized them here. I will do that for the record along with what Senator Long asked.

(Information requested follows:)

COMPARISON OF ESTIMATED CONTRIBUTION INCOME AND TOTAL OUTGO FOR HOSPITAL INSURANCE SYSTEM FOR SELECTED PERIODS

ASSUMING THAT EARNINGS BASE REMAINS AT $7,800

[In billions of dollars]

| Calendar-year period | Contribution income | Total outgo | Excess of outgo over income |
|---|---|---|---|
| 1970-74 | 28.4 | 37.8 | 9.4 |
| 1970-79 | 66.7 | 102.9 | 36.2 |
| 1970-84 | 119.1 | 193.7 | 74.6 |
| 1970-89 | 184.1 | 316.1 | 132.0 |
| 1970-94 | 262.7 | 478.5 | 215.8 |
| ASSUMING THAT EARNINGS BASE IS ADJUSTED FROM TIME TO TIME TO KEEP UP TO DATE WITH GENERAL EARNINGS LEVELS | | | |
| 1970-74 | 30.6 | 37.8 | 7.2 |
| 1970-79 | 77.2 | 102.9 | 25.7 |
| 1970-84 | 148.2 | 193.7 | 45.5 |
| 1970-89 | 248.3 | 316.1 | 67.8 |
| 1970-94 | 384.2 | 478.5 | 94.3 |

Note: Total outgo data relate only to outgo for insured persons.

FEBRUARY 25, 1970.

MEMORANDUM

From: Robert J. Myers, Chief Actuary, Social Security Administration.

Subject: Comparison of Contribution Income and Total Outgo for Hospital Insurance System for Various Future Periods.

This memorandum is in response to a request at the Hearings before the Senate Committee on Finance to provide information, for various future periods, as to the contribution income and the total outgo under the Hospital Insurance system under the provisions of present law, with respect to insured persons.

Such a comparison is shown in the attached table on two different bases—(1) under the assumption that the present $7,800 maximum taxable earnings base remains constant at this figure over the next 25 years, despite the fact that earnings are assumed to rise significantly—by about 180% over the 25-year period, and (2) under the assumption that the earnings base is adjusted from time to time in the future so that it keeps up-to-date with the general earnings level and thus maintains the same relative position that the $7,800 base did in 1968.

It should be noted that the figures are not discounted (at interest) to the present time, which is the proper actuarial approach when considering income and outgo figures over a period of future years.

ROBERT J. MYERS.

Senator WILLIAMS. Now, the 25-year deficit of $216 billion is your most recent, we will say, latter part of February estimate; is that correct?

Mr. MYERS. Yes, Senator.

Senator WILLIAMS. Now, what was your estimate in December 1969, about 3 months ago?

Mr. MYERS. That estimate was as I recall, about $127 billion.

Senator WILLIAMS. And then in 1965 when this program was first initiated as I recall it, your estimate was that it was on an actuarially sound basis at that time, was it not?

Mr. MYERS. That is correct.

Senator WILLIAMS. And then in 1967 there was a deficiency projected and we raised the taxes 25 percent and again it was on an actuarially sound basis; is that correct?

Mr. MYERS. According to my estimate at the time; yes, sir.

Senator WILLIAMS. With this growing actuarial deficit which changes periodically, almost every 30 days, is that as a result of some of the sabotage in the Department to which you referred in your recent speech?

Mr. MYERS. No, sir. The changes in these estimates are due to changes based on two things. First, the developing experience, so that we have a sound base to build on. In other words, we knew later what the current experience was, whereas back in 1965, of course, it was a new program.

The second reason is that there is this very substantial increase that I have made in the new assumptions as to future trends in hospital costs. These are much less what you might say optimistic, or else you might say they are more conservative than previously, because they assume that the annual increases in hospital costs will continue at a relatively high rate for the next 10 years or so.

Senator WILLIAMS. Well, what disturbs me is not only the errors we are finding in these projected estimates upon which we felt we had a right to rely, but also that your deficit estimate in December was around $127 billion and today it is $216 billion. That is an increase in about 60 days of $89 billion—a very high percentage increase. It is a substantial increase.

Now, during this same period this committee has indicated, and the Department itself has indicated, that they are going to adopt more strict steps toward administering this program which will reduce its costs. That is the only development I know of which has taken place in the last 60 days. And yet we are told that these changes apparently are going to cost us $89 billion more than was projected in December. I am going to be very frank with you, Mr. Myers; it is getting confused and I am wondering about these estimates. How many people do you have in your staff of actuaries?

Mr. MYERS. I have on my staff approximately 20 actuaries, of whom you might say five or six are fully qualified actuaries and the others are in the process of qualifying.

Senator WILLIAMS. You do have five or six who are fully qualified?

Mr. MYERS. Yes, sir.

Senator WILLIAMS. And those five or six concur in these errors that are changing 30 to 40 percent every month.

Mr. MYERS. Senator, first of all, I think the reason for these changes is not because of the changes in the operating experience, but as I tried to bring out previously, the estimate made last fall was a preliminary one. It did not go into all the details of the estimating procedure the way this one does, and unfortunately, some of the approximations that were made last fall were not precise, and all the variations in them, or the errors in them, all moved in the same direction.

The figures I am giving you today are based on very detailed cost estimates, and they are not just approximations.

Now, to answer your question specifically, not all my staff of actuaries work on the medicare cost estimates, but rather there are just three of us. I think that the staff member who particularly works on this subject believes that, if anything, these estimates are still too low. I do not think so myself.

Senator WILLIAMS. Has any group been appointed to review the estimates of your actuarial department?

Mr. BUTLER. Mr. Chairman, may I comment about that? Lewis Butler, Assistant Secretary for Planning.

Such a group has been appointed, Mr. Chairman. In fairness to Mr. Myers, I think the committee would understand the extreme difficulty of making these estimates in times of increasing utilization and galloping inflation in medical costs.

We have appointed such a group and I think it might be helpful to the committee to know who is serving on the review of both the assumptions and the dollars developed from those assumptions, the actuarial estimates. This group is appointed by the Secretary. Morton Miller, vice president and actuary for Equitable Life; Seymour Fenichel, consulting actuary for Blue Cross; Dr. Herbert Klarman of the Downstate Medical School, a New York economist; Dr. Robert Eilers, Wharton School of Business, University of Pennsylvania; Dr. Paul Densen, the director of the Harvard Center for Community Health and Medical Care; Dr. C. Worth Bateman, an economist with the Urban Institute.

That group will be reviewing the estimates for both the medicaid title 19 and the medicare programs and we will hope to report to the committee at a later time what develops from their deliberations.

Senator WILLIAMS. Are members of this group actuaries themselves?

Mr. BUTLER. There are two actuaries in the group and four economists. The economists to look at the assumptions.

Senator WILLIAMS. I wonder if it would not be well for us to have a report or estimate made by a group of independent actuaries similar to what any insurance company would do, to project this cost.

Mr. BUTLER. That is what the plan is, Senator. May I comment on another point you raised about the $4 part B premium. I think it is important that we understand the sequence of events on that premium.

Senator WILLIAMS. I think we understand them, to be frank with you, but you may explain them.

Mr. BUTLER. When the premium was not raised from $4, the steps taken to control costs in medicare were not sufficient to make that premium adequate which meant that a year later, in order to keep the program actuarially sound, even assuming passage of our additional cost control procedures, the premium had to jump from $4 to $5.30. That $5.30 is a—it is a conservative estimate with a contingency for differences that may arise in the future. But we thought it was important that the country have the direct and fairest possible estimate that we could make of a premium that was actuarially sound.

Senator WILLIAMS. Well, my time is up. I just have one more question for Mr. Myers here.

I was very much interested in your recent speech, Mr. Myers, and I am going to quote from the paper here:

**The chief actuary of the Social Security Administration charges that Democratic holdovers and career employees are sabotaging the Nixon Administration's moderate policies and substituting their own expansionist policies.**

Then it goes on to state that—

**Wilbur Cohen, the HEW Secretary under former President Lyndon B. Johnson, might just as well be the Secretary as far as any change in attitude is concerned.**

You go on down and list these—keep repeating these charges. Would you tell us more about those who are sabotaging this program and identify them for this committee so that we can bring them down here and find out a little bit about what their policies are. I think our committee should look into this because if there is sabotage going on in this multibillion dollar program we certainly want to know it. I am sure that as one who has been in office for a number of years working with these men, you can easily identify them. I know you well enough and have enough respect and confidence in you to believe that you would not have made that as an idle statement. So will you now identify those individuals?

Mr. MYERS. Senator Williams, of course you realize that the remarks that were credited to me there I made in my personal capacity, if I can be disassociated from my official capacity.

Senator WILLIAMS. You can identify them in your personal capacity rather than in your official capacity. That is perfectly all right.

Mr. MYERS. Also, Senator Williams, I am sure that in your long and distinguished career you have occasionally been misquoted by newspapers or misinterpreted. I think there is at least some misinterpretation there. The speech I gave, which I would be glad to supply to you personally or for the record, does not anywhere involve any such strong language as "sabotage." That was the newspaper headline writer or the newspaper writer. But rather, this paper expressed my views as to the various possible courses that social security might take in the future and as to the people who believed in one course or another.

Senator WILLIAMS. Well, you still have not identified those who are sabotaging this program or those who are making it hard to administer.

The CHAIRMAN. Why do you not explain just what you had in mind. I understand how editors have only so much space to fit the headline in and they have to find some words to fit the space. Unfortunately, people do not read beyond the headlines many times.

Would you mind explaining just what you did have in mind, Mr. Myers?

Mr. MYERS. Yes, Mr. Chairman. As I indicated, I did not use the word "sabotage" anywhere, and I did not intend to imply that anywhere. But what I did in this article was to discuss what I considered to be the two general philosophies of where the social security program should go and what it should be.

One approach which I termed the moderate approach says that the social security program should continue to carry out the same general role that it is doing today; that the benefit level should be changed only to reflect changes in economic conditions; and the benefit level should not be expanded so that it would do away with private insurance and private pension plans and private savings.

Senator WILLIAMS. And you will furnish us this afternoon a copy of that statement? Will you have it for me?

Mr. MYERS. Yes, sir.

Senator WILLIAMS. And you will be back here tomorrow?

Mr. MYERS. Yes, sir.

Senator WILLIAMS. I will withhold further questions.

(Mr. Myers' prepared text referred to follows. A similar article from the March 1970 issue of Nation's Business appears at page 148. Testimony continues on page 44.)

[From the Pension and Welfare News]

THE FUTURE OF SOCIAL SECURITY—IS IT IN CONFLICT WITH PRIVATE PENSION PLANS?

(by Robert J. Myers, FSA *)

The future development and role of the social security program, and its concomitant effect on the private pension system of the country, depend on many factors and elements. This paper will discuss several of these matters, namely:

Scope of paper:

(1) The interrelationship of social security and private economic security plans.
(2) The expansionist philosophy of social security.
(3) The moderate philosophy of social security.
(4) The concept of poverty.
(5) The effect of the consolidated budget on social security.
(6) Income-tax integration rules for private pension plans and similar other requirements.
(7) The influence of social security staff on the development of the program.

INTERRELATIONSHIP OF SOCIAL SECURITY AND PRIVATE ECONOMIC SECURITY PLANS

The basic question may well be raised as to whether the social security program and private economic security plans—private pension plans and individual insurance and savings—should be competitive and in conflict, or whether they should complement each other.

For many years, the viewpoint has been widely expressed that social security should provide a basic floor of protection upon which private economic security measures can, should, and will build. In other words, under this concept, social security and private economic-security efforts are complementary and are by no means in conflict. Lately, however, in certain quarters, an effort is being made to rewrite history so as to "prove" that the floor-of-protection concept never really existed, except possibly in the minds of those who were basically opposed to the social security program.

There are some, whom I term "the expansionists," who believe that the Government should provide full economic protection for virtually the entire population when an earnings loss occurs. Specifically, they feel that the Government's responsibility for retired persons goes way beyond providing them a level of benefits upon which the vast majority can subsist, but beyond which they can build further economic security by their own efforts. The expansionists feel that the Government should provide a level of income replacement that is virtually as high as income before retirement. And they would use the social security program as a tool to do so.

There is a very important philosophical question here. Is this properly and desirably the function of government? Or is it sufficient—and actually better—for the Government to establish a social insurance system which will provide a floor of protection upon which people can build either individually or jointly with their employers? In other words, is it desirably the Government's function to take complete care of all the citizens? If so, then one might well ask how far this should be extended into the private lives of people of all ages, whether working at adequate wages or not.

*The views expressed here are those of the author and are not necessarily those of the Social Security Administration.

## THE EXPANSIONIST PHILOSOPHY OF SOCIAL SECURITY

Let us now turn to how the expansionists would achieve their goals in the area of cash benefits under social security. I shall not deal in this paper with their goals in the medical care field, other than to state the obvious, but most significant point that, in the long run, they seek to have all medical care provided directly by the Federal Government, financed either from general revenues or payroll taxes. The irreversible steps in this direction would be taken by extending the coverage of the Medicare program first to all beneficiaries and then to all covered workers and their dependents.

The specific blueprint of the expansionists for "improvement" of the Old-Age, Survivors, and Disability program (OASDI) is first to increase the maximum taxable earnings base from the present $7,800 per year to at least $15,000 currently, and then to keep it up to date with changes in the earnings level. The reason for this is that then the vast majority of workers would have their full earnings covered by the program and, therefore, could have full economic security provided by it.

### *Next step*

The next expansionist step would be to increase drastically the general benefit level so that, even for workers earning up to the maximum taxable base, the benefits would provide virtually full replacement of the take-home pay before retirement. To achieve this end would require approximately a doubling of the present benefit level.

Now how do the expansionists propose to find the money to finance such changes? One simple, and apparently fiscally painless way, is to introduce a sizable Government contribution or subsidy to the system. Some expansionists suggest that this Government subsidy should average about one-third to one-half of the total cost of the program—i.e., it would equal anywhere from 50 percent to 100 percent of the combined employer and worker contributions.

To put such a matching basis into effect immediately would be extremely difficult because of the large sums needed from the General Fund of the Treasury. For example, if the Government subsidy were to represent one-third of the cost of a program that would be expanded in line with the aims of the expansionists, it would be in the order of $15,000,000,000 a year currently for OASDI alone, and much more in later years. Accordingly, the expansionists propose the approach of gradualism—or, in other words, the "camel's nose in the tent" process—by having the Government contribution be 5 percent in the first year, 10 percent in the second year, etc.

Still another source of financing the expansionist aims is to tap the employers for a heavier proportion of the cost. For example, the expansionists have proposed that there should be no taxable earnings base for employer contributions (or, in other words, the employer should contribute on his entire payroll). They have also suggested that the employer should contribute at twice the rate applicable to the employee (instead of equal sharing, as has always been the case).

### *Disability*

The goals of the expansionists are not limited solely to the level of OASDI benefits. They also want to expand the disability benefits, so that they would no longer be on a "permanent and total" basis. Rather, they would include coverage for all types of disability—temporary disability, long-term occupational disability, etc.

If the foregoing goals of the expansionists as to levels of OASDI benefits were achieved, the consequences must be clear to everyone. Not only would there be the direct effect of eliminating most private-sector efforts in the economic-security field, but also a most significant effect on our national economy would occur. Private savings of all types, including pension plans and deferred profit-sharing plans, would be greatly reduced. This, in turn, would result in a shortage of investment funds for private industry to expand its economic-productivity activities. Accordingly, private industry would have to turn more and more to the Government for such funds. This would mean increasing governmental regulation, control, and even ownership of productive activities.

## THE MODERATE PHILOSOPHY OF SOCIAL SECURITY

The moderates have a strong belief in the continuing desirability of social security as a floor of protection and, similarly, in the significant continuing ef-

forts of the private sector in providing economic security. The moderates believe that the social security system should be kept up to date with changes in economic conditions and that any weaknesses or deficiencies which show up should be remedied.

Specifically, the position of the moderates is that the benefit level should be kept up to date with changes in the cost of living, whether this be done on an *ad hoc* basis or by automatic-adjustment provisions. Similarly, they recognize that benefits should be reasonably related to recent earnings before retirement, disability, or death, when past economic conditions have produced significantly rising general earnings levels. Such recognition of past earnings trends can be accomplished through a final-pay approach in computing benefits. Virtually the same effect can also be obtained by adjusting the factors in the benefit formula (as has been done in the *ad hoc* OASDI benefit increases in the past two decades).

The moderates also support periodic adjustments in the maximum taxable earnings base and in the amount of earnings permitted for full receipt of benefits under the retirement, or earnings, test. Such adjustments should be made on the basis of changes in the general earnings level and can be accomplished either on an *ad hoc* basis or by automatic adjustments.

Since 1950, the *ad hoc* procedure has produced quite satisfactory results in connection with changes in the earnings base. The $3,600 base first effective in 1951 covered 81.1 percent of the total earnings in covered employment, while the $7,800 base effective in 1968 covered 83.6 percent. This proportion for the first effective year of the three intervening changes was about 80 percent in each instance, so that the $7,800 base in 1968 might be said to have gone a little too high. Finally, it may be noted that the $9,000 earnings base, effective for 1972, that has recently been proposed by President Nixon will cover an estimated 81 percent of total earnings in covered employment, and thus is in line with the bases actually adopted since 1950.

*General revenues*

The moderates are strongly opposed to the injection of general revenues into the OASDI system. They argue that this will seriously weaken cost controls of the program. Changes in the program might be voted without regard to the cost considerations—on the grounds that "the necessary financing can always be easily obtained from general revenues." On the other hand, under the present self-supporting contributory basis, the costs of any benefit changes are fully recognized; they are met by direct, visible financing charges applicable to workers and employers.

One problem which may occur is that, for budgetary or political reasons, the Government subsidy may not be paid in the amount required or at the time specified. Several times in the past, government contributions to OASDI were legislated, but were not actually made, or were delayed for long periods. For example, appropriations for the cost of benefits arising from "gratuitous" military-service wage credits (for periods before 1957) have either not been made at all or have intentionally been made in an amount lower than the required actuarial determinations. Then, too, general-revenue appropriations authorized for the Medicare program have frequently been delayed considerably beyond when they were due (although generally an appropriate interest adjustment was provided).

It is not inconceivable that reliance on Government subsidies for financing a major portion of the cost of OASDI could lead to partial repudiation of the benefit obligations.

Another difficulty which may arise is the pressure that would be generated to impose a means test on the beneficiaries. Then, those who have substantial other income would not be paid benefits—on the grounds that people with large incomes should not receive payments partially financed from general revenues.

Those who oppose a Government subsidy to OASDI do not necessarily oppose benefit changes involving substantially increased costs. They believe, however, that such costs should be openly and completely recognized through direct financing provisions.

## THE CONCEPT OF POVERTY

Nowadays, widespread discussion of the subject of poverty occurs—how to eliminate it, how changes in existing programs will reduce the number of persons in poverty, etc. Offhand, to hear this discussion, one would believe that poverty can be scientifically measured, just as can the relationship between the circum-

ference of a circle and its radius, or the distance from the earth to the moon at any particular time, or even the cost of a pension plan.

Actually, such is not the case because the concept of poverty that is so widely used currently is derived from a mechanistic approach. Specifically, this approach proclaims that poverty is present if the individual or family has less annual income than a certain prescribed dollar amount. At times, such amount is varied according to the size of the family—and, at times, according to geographical location. Quite illogically, many of those who use the data seem to believe that, if an individual is just below the so-called poverty amount, then he is indeed in very dire condition, whereas once his income has reached this level, he is in quite different status.

*Defining poverty*

Poverty, like sin, is opposed by every person of good will. The problem, however, is to define poverty adequately and not merely to set up meaningless mechanistic standards that have no basis in fact. A clear distinction should be made between "poverty" and "destitution" or "want." Many persons who are under the poverty line, as mechanistically defined currently, are not really in need by any objective standard and, in fact, might be considered affluent according to the living standards of some countries.

Social security was established to prevent want and destitution, and was not intended to deal with this new measure of poorness called "poverty." However, it is quite clear that the social security program has, over the past three decades been the most important governmental program in combatting both destitution and poverty arising from the economic risks of death, disability, and retirement. Those who believe in a complete expansion of the social security system, so that it would virtually take care of the entire economic-security needs of a country, frequently use the poverty concept to support their aims. For example, when poverty is defined in a mechanistic style at a very high level, arguments can be presented for a significant increase in the general level of social security benefits.

*Realistic standards*

Those with a moderate philosophy insofar as the role of the social security program is concerned are by no means unconcerned about the problems of poverty and human needs. They believe that the facts of poverty should be demonstrated by objective, realistic standards, and not merely by mechanistic approaches.

## THE EFFECT OF THE CONSOLIDATED BUDGET ON SOCIAL SECURITY

A new element has recently arisen that may have an important effect on the future development of the social security program—namely, the consolidated or unified budget. Until recently, the budget of the United States Government involved only direct governmental operations and did not include the operations of the social security trust funds and other similar funds, such as those of the Railroad Retirement and Civil Service Retirement systems. Recently, the budget approach was changed, so that the operations of these various trust funds are included within the budget, which is now on a so-called consolidated basis.

Accordingly, any excess of income over outgo for the social security trust funds (including the two Medicare trust funds) tends to produce a budget surplus and vice versa. In actual practice, it was for this reason that in the fiscal year that ended on June 30, 1969, a budget surplus of about $3,000,000,000 was reported. The social security trust funds showed an excess of income over outgo for this fiscal year amounting to about $4,000,000,000. Thus, under the former budgeting approach, without including the social security trust funds, there would instead have been a budget deficit of about $1,000,000,000.

*Budget "surplus"*

In the current fiscal year, ending June 30, 1970, a budget surplus of about $3,500,000,000 was forecast by President Johnson in his budget prepared in January 1969. The corresponding excess of income over outgo for the social security trust funds was about $7,000,000,000. Thus, under the former budgeting approach, there would have been a deficit of about $3,500,000,000. As a result, because of the significant effect of the social security program on the federal budget, there are now strong incentives to use it as a budgetary and economic tool.

As a result, there may well be pressures to make changes in the social security system—either in the budget area or in the tax area—primarily to affect the short-range picture and without any real emphasis on the long-range results. I need hardly tell this audience about the dangers of making changes in long range benefit programs solely with a view of the financial impact in the first year or two.

At the present time, and in the next few years, under both present law and, to a lesser extent, under proposals currently being considered by Congress, the trust funds will show sizable annual excesses of income over outgo[1]. Under present economic conditions, when inflation is present, the economic planners are glad to have this excess of income over outgo under the social security program.

Their views might change greatly and rapidly if economic conditions shift and inflation no longer seems the danger, but rather the so-called fiscal drag of the excess of social security income over outgo is "the enemy" (as it was so wrongly considered to be as recently as in 1965). Under these circumstances the economic planners would press strongly for reduction of the social security contribution rates (and would, in fact, like to have Congress delegate to the Executive Branch the power to do so).

In my opinion, it is not necessary for the social security system to build up large balances in the trust funds. Instead, a good rule of thumb would seem to be to have a balance of about one year's outgo. This should be accomplished by setting proper contribution rates for the future according to the best estimates possible. Then, however, the rates should not be spasmodically varied to react to either actual or speculative changes in economic conditions. Among other reasons for maintaining scheduled contribution rates for a social insurance system is the psychological point that people reasonably expect a certain degree of stability in premium and contribution rates for all types of insurance plans.

## INCOME TAX INTEGRATION RULES FOR PRIVATE PENSION PLANS AND SIMILAR OTHER REQUIREMENTS

Particularly in appearing before this audience, I would hardly wish to expound at length on what should be the proper income-tax integration rules for private pension plans. However, since this subject is interrelated with the level of social security benefits and since the effect of the integration rules can encourage or stifle the growth of private pension plans, a brief discussion is desirable.

Certainly, very restrictive integration rules—such as those that were originally announced by the Internal Revenue Service—could have a serious, stifling effect on the growth of private pension plans, or even on the maintenance of the present high level of activity in this area. The same could also be said for many types of control that could be exerted on private pension plans—such as compulsory vesting—in the guise of requirements for qualification for income-tax purposes.

### *Integration*

Integration rules have been derived to effectuate the Congressional mandate that pension plans should not be discriminatory in favor of high-paid individuals, after taking into account the combination of benefits under such plans and social security benefits. Nobody can argue that this is not a wise and proper requirement. Putting it into effect, however, is easier said than done if a precise procedure is desired.

I am convinced that no completely precise procedure is possible. I believe that the approach that was taken for many years—which might be termed the 37½ percent method—was reasonably satisfactory and, with all the related intricate network of allowances for various types of plans, had worked out quite well over the years. I saw no justification or necessity for changing this approach, especially since there had never been demonstrated any instances where discrimination in favor of high-paid persons had occurred thereunder.

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[1] Interestingly enough, many of the budgetary and economic-planning experts refer to such an excess of income over outgo as a "surplus", not understanding that an insurance or pension program can have such success in the early years of operation and yet be greatly underfinanced.

*First reaction*

The initial IRS approach, which would have reduced the integration basis by more than one-third, brought down a tremendous storm of adverse criticisms and complaints on the IRS. It was quite clearly and correctly pointed out that any apparently scientific mathematical computations in this area were of questionable value and significance and that actually they generally seemed to be made in order to arrive at a particular result.

As a result of this storm of criticisms, IRS produced a revised basis—which might be termed the 30 percent method, a reduction of about 20 percent. In my opinion, there is considerable question as to why even this restriction is necessary or desirable in order to prevent discrimination occurring in favor of high-paid individuals.

*Believes expansion desired*

One might well ask why IRS took the action of restricting or deliberalizing the integration rules. In my opinion, this was done—and the technical computations justifying the action were made solely to support such action—primarily and fundamentally to restrict the growth and development of private pension plans. In turn, this would leave more of a vacuum that could only be filled by expansion of the social security program—a result that was not viewed with any concern or dismay by the government officials involved.

*President's Committee*

I believe that the same situation is also true—and perhaps to an even greater extent—with regard to the recommendations of the President's Committee on Corporate Pension Funds and Other Private Retirement and Welfare Programs that was established by the Johnson Administration, and especially by the Inter-Agency Staff Committee that was established to study ways to implement the proposals of the President's Committee. The representatives on the Inter-Agency Staff Committee from the several governmental departments consisted of persons who had relatively little knowledge of the specific operations and structure of private pension plans, but who had strong beliefs in the direction that the Government should be the predominant provider of economic security for the nonworking population. This was certainly a clear instance of the fable about having the fox guard the hen coop.

THE INFLUENCE OF SOCIAL SECURITY STAFF ON THE DEVELOPMENT OF THE PROGRAM

By no means least important in determining the future course of the social security program is the influence exercised by top-level staff in the Social Security Administration.

The administrative operations of the program have a well-deserved nationwide reputation for efficient, impartial, and honest functioning. This is due to a devoted and capable group of civil servants, from the top administrative officials down to the lowest grade clerks. Such successful functioning is necessary, regardless of the future role of the program, but this does not mean that the system must expand at the expense of private-sector activities in the economic-security area.

*Philosophy and duty*

However, when it comes to the research, program evaluation, public relations, and program planning functions, the situation can be quite different. Even though the staff so engaged may be completely sincere, as well as capable, they cannot be expected to present as strong a case against proposals which are contrary to their basic philosophical beliefs as they could in favor of proposals of an opposite nature.

Over the years, most of the Social Security Administration staff engaged in program planning and policy development have had the philosophy—carried out with almost a religious zeal—that what counts above all else is the expansion of the social security program. To some of them, to believe otherwise amounts virtually to being opposed to the program—and even really in favor of its repeal. Thus, such persons have not necessarily tended to be political as between Democrats and Republicans, but rather they have favored and helped those who want to expand the social security program the most.

In fact, one might say that some social security staff members are dedicated to an expansion of the social security program so that it takes over virtually

all economic security needs. This is in sharp contrast with the moderate approach, which believes that there should be a reasonable sharing of the economic security field between the public and private sectors, with the financing being on a sound basis and completely visible to all, so that the financial burdens involved are readily apparent.

One might perhaps excuse this expansionist approach of many social security planning officials on the grounds that it is only natural for people to advocate and work strongly for the growth of the activity in which they are engaged. There is, however, a difference in this respect as between workers in the private and public sectors. The civil servant has an equal responsibility to both those who are beneficiaries and those who bear the cost of the benefits. Equal publicity should be—but usually is not—given to those who will pay the increased taxes, as against those who will receive the higher benefits.

*Supporting conclusions*

Many social security researchers, as I have observed over the years, have the view that the purpose of research in the social sciences is to gather data to substantiate a predetermined conclusion, so as to attain a desired social goal. As a result, according to this belief, valuable research time, effort, and money should be devoted solely to proving the desired point and should not be "wasted" by searching for all the facts. This is in sharp contrast with Ruskin's wise saying, "The work of science is to substitute facts for appearances and demonstrations for impressions." In many instances, such biased research cannot be blamed solely on the researchers themselves, but rather to a considerable extent on the policy officals and others who direct their work along those lines.

Civil Service is, in general, a very desirable personnel policy, so as to have efficient and impartial administration in governmental operations. Certainly, in the management and purely technical areas such as accounting and drafting legislation (and, even, preparing actuarial cost estimates), the social and economical philosophy of the individual will have no effect on the results of his work.

In the policy planning field, however, the top policy officials should have staff members working for them who are fully sympathetic to their views and approaches. Too much Civil Service and too little flexibility in filling top personnel posts can easily hamstring any Administration in a particular area. For example, if the high-ranking Civil Service techanical employee is of the same conviction as a public advocate of the "out" party, how can it be expected that he will produce a vigorous, air-tight rebuttal for his political superior to an attack on Administration proposals by such an advocate?

## CONCLUSION

In summary then, one may well raise the question "How much economic security should be provided through the Government?" Should social security provide only a basic floor of protection, upon which individuals and, in part, their employees should build, with public assistance for the small minority whose basic needs are still not provided for—as the moderates believe?

Why should Government supply complete economic security to the aged, the disabled, and the survivors of deceased workers so as to replace virtually the full wage loss—as some expansionists advocate? If so, what are the implications in other areas such as medical care for the total population and even the ownership and management of industry and commerce?

If all should be guaranteed, or provided, the highest possible medical care by the Government, how about guarantees or provisions so that none shall have incomes substantially below the average, or that none shall have diets that are not the highest nutritional quality, regardless of whether they could afford to—and would wish to—do otherwise?

There is a basic, important question here for America to decide. There is a choice to be made, and the citizens should be given all the facts on both sides, so that they can make a wise decision.

As a postscript, I might add that the social security proposals made recently by President Nixon, and now under consideration by Congress, fully meets the criteria of the moderate philosophy. At the hearings of the House Ways and Means Committee, several proposals were put forth that were definitely along expanionist lines.

The CHAIRMAN. Senator Gore?

Senator GORE. Mr. Secretary, what would have been the differences in cost of medicare and medicaid over the past year and what would be the anticipated difference in the next decade, if such estimates are available, if the Blue Shield schedule of fees had been paid instead of the escalated fees?

Mr. BUTLER. Senator Gore, we do not have those estimates at this time. We would be happy to make an attempt to develop them for you. As you understand, the Blue Shield schedule of fees does not represent full payment for the cost of services rendered in many, many locations. But we would be happy to develop those figures.

Senator GORE. Let me ask for your comment on a statement handed me by the committee staff made by Blue Shield officials to this committee in 1965:

> Even in indemnity plan areas the Blue Shield schedules generally reflect the prevailing charges in the community, and that including service benefit plans, an increasing percentage of claims are satisfied in full by the Blue Shield payments.

Were you familiar with that testimony?

Mr. BUTLER. I was not personally familiar with it, Senator. I might ask Mr. Ball to respond to your question about the Blue Shield schedule.

Mr. BALL. Senator Gore, I would like to make two points. One is, if I could go back to the first point that was under discussion, just to say that it is very difficult to estimate what the situation would have been if Blue Shield schedules had been followed, because with a program as large as medicare tied to those schedules, I think it is almost inevitable that they would quickly have been revised upward. There was nothing to prevent them from just raising those schedules.

Senator GORE. I am making an assumption that the settlement for services was made on the basis of Blue Shield fees.

Mr. BALL. Yes. That estimates can be made. I just want to emphasize that that is not, in my opinion, what would have happened if the program had been tied to it.

Now Senator, on your second point, although that is the way——

Senator GORE. Before you come to the second one, this business of escalation of fees as a result of added load creates a demand. Let me ask you what you think might happen if the Congress passed a program that doubled the demand for lawyers.

Mr. BALL. I would expect an increase in lawyers' fees. I think the increase in demand against a stable supply of practitioners is the main reason for the fact that physicians' fees are increasing somewhat faster than the general level of ways and that medicare and medicaid share some of the blame for the increased demand. But the point I was concerned about in your question is that I do not believe that you would have stopped that by saying do not allow medicare to pay any more than Blue Shield fees because Blue Shield itself is a voluntary organization quite responsive to physicians and I believe that under the circumstances where their fees were governing medicare, they would have raised those fees. That was my only point.

Senator GORE. Well, let us examine this. Do you think that in this hypothetical case I put, to which you answer that the level of legal fees would have been advanced, do you think that this would result in an improved quality of legal service?

Mr. BALL. It might have have resulted in more people getting legal service, Senator. I do not think it would improve the quality, but under medicare, for example——

Senator GORE. Well, let us stay with the lawyers just a little bit.

Mr. BALL. Under the lawyers I think if you had a plan like that, more people would get service but there would be no reason to think that it would be better quality.

Senator GORE. Now, let us say that it resulted in a doubling of the number of legal fees. Then you say it would result in an escalation of the amount of legal fees.

Now, with respect to the legal profession, you would have a doubling of the fees and an escalation in the amount of those fees, so you would have something more than twice the legal income, something more than twice the income for the legal profession, would you not?

Mr. BALL. Senator, I am not able to say that it would double. I merely would concur in the idea that it would increase.

Senator GORE. Well, I was assuming that we superimpose upon a private profession a Government program that doubles the demand for legal advice and service. That was my assumption, not yours.

Mr. BALL. And I would think they would increase.

Mr. BUTLER. Senator, may I comment? If I can go to the principle that you have enunciated, Senator, I think we are in complete agreement.

Senator GORE. It is not a principle. It is a hypothesis.

Mr. BUTLER. The principle that if you increase the demand, something happens to prices unless you do something about the supply.

Senator GORE. That is exactly what I was coming to.

Mr. BUTLER. Of course, this is exactly what happened in this program. It was conceived without any consideration as to what would be done with the supply side. No arrangements were made in the medicaid or medicare program to increase manpower or anything else demanded on the supply side and certainly part of the results of that, not entirely but a great part of it, of course, was the escalation in costs and that was a fundamental defect, in our opinion, in the programs.

Now, the question is how to control the cost and——

Senator GORE. There are two sides to that. One, how to control the cost, and another, how to increase the availability of medical services.

Mr. BUTLER. That is correct. And how to within the programs reorganize the forms and delivery of services in such a way that they are delivered on a more efficient and less costly basis.

Now, I think the essential point made in the Senate Finance Committee report about the need to control providers' fees is one that we agree with completely. And then the question is, how?

As Mr. Veneman outlined this morning, that we do not believe that tying to the Blue Shield schedules is the best way to do it. Tying them to a percentile as we have outlined as we did in the medicaid program in the long run is going to be a more effective mechanism.

Senator GORE. Well, of course, one way to have prevented this problem was to continue the unavailability of medical service to millions of our people. We could solve this problem now, I suppose, so far as the finances are concerned, by terminating that availability. No one suggests that. Not even the most ardent Republican I have heard lately suggests that, though most of them resisted the program violently when it was installed.

Senator BENNETT. And were not they right in terms of the way the situation has operated? And is it not interesting that the Republicans are now back in power with the responsibility of clearing up the mess that the Democrats created when they were running this program?

You brought up the political angle, Senator, and I am glad to reply to you.

Senator GORE. I had not intended to be partisan at all. [Laughter.]

Senator BENNETT. No. Neither did I. [Laughter.]

Senator GORE. Now that we have a bipartisan understanding may I proceed? [Laughter.]

It is a fact, as Senator Bennett has said, that the Democrats created this financial problem by making medical service available to needy people. That is a weakness of Democrats. We look after people. And one of the strong points of the Republicans, they want to look after that dollar, raising the interest rates every time the moon comes up.

Mr. BALL. Senator, could I just for the record——

Senator GORE. Now, are you bipartisan or what?

Senator BENNETT. Let me say to Senator Gore that I have the next turn at questioning.

Senator GORE. Really, I wanted to come——

Senator BENNETT. I have the last word.

Mr. BUTLER. As a partisan may I respond?

Senator GORE. Yes, indeed.

Mr. BUTLER. I would say this. Obviously, we are all completely in favor of medical service to the aged and the poor that these programs have provided. The only question is could better or more expanded services have been provided for less money and in a manner that would not have driven up prices for the other consumers in the country. This really was not done when the programs were initiated and what we are attempting to do now is to develop systems whereby through incentives, risk on the providers, and other techniques we can control those costs and at the same time provide the services to the aged and the poor and make it possible for those who pay out-of-pocket for the services to get them at a reasonable cost, which is increasingly difficult for them.

Senator GORE. Well, just as a matter of history, when I was trying to bring about enactment of the medicare bill, and was the author of the first one to pass either House of Congress, there was very little support on this committee on either side and none at all from the other side. Now, concurrently I was trying in my own way to increase the number of doctors and nurses in training, make available the opportunity for such training to boys and girls who were unable to pay for it.

Now, please outline what the administration plan is now for increasing the supply or the availability of medical training.

Mr. BUTLER. Well, maybe I can describe quickly, Senator, what was done in the 1970 budget and is being continued in the 1971 budget. We initiated a physician augmentation program which would make available to the medical schools of the country places for an additional 1,000 medical students. They now have a total of between about 8,000 and 9,000 graduates a year. The intent is to add an additional 1,000 medical students immediately to those classes by making available $10,000 per student to each medical school that would so expand.

Senator GORE. Mr. Secretary, $10,000 will not be a drop in the bucket compared to the need.

Mr. BUTLER. Well, let me—I think we can agree with you, Senator. There is no question about it.

Senator GORE. Thank you, Mr. Chairman.

Mr. BUTLER. But the problem is the capacity of the institutions to respond and we are not at all sure that even this year the institutions can respond to the money that is being made available to them to expand at the rate they need to and now we are working with them in the hope that through the creation of community medical schools, use of existing hospitals, to be turned into teaching hospitals, the use of existing basic science facilities and things of that kind, to in some places double and even triple the output of State medical schools within, that is, the intake, within the next 5 years. The institutions need to arrange themselves to be able to do this and it is a very difficult job for them.

Senator GORE. Well, my time is up and I will not question you along that line. I think a great deal can be done with present facilities. For instance, there can be night classes. You can use the facilities twice a day instead of once a day. There are a great many opportunities, if the Government has the will and the determination, to provide the funds and the incentives for the youth.

Thank you, Mr. Chairman.

Mr. BUTLER. I think we are in complete agreement.

Mr. BALL. In the interest of the accuracy of the record, can I just say I would not want to leave Senator Gore's and my discussion of the lawyer situation stand as if it were an analogy for what actually happened to physician fees. The situation in 1969——

Senator GORE. I was not drawing an analogy. I was taking a hypothetical case.

Mr. BALL. I may have interpreted it wrong. What I want to say is physicians' fees actually rose about 6 or 7 percent but medicare has recognized only a 3-percent increase in physician fees for the year 1969. That is all the increase in the liability of the program. As I said earlier, 30 percent of the claims involving physicians' bills are being reduced currently by the carriers. Also on the statement that was read into the record from the Blue Shield people who testified before the committee, they have since reconsidered that position and have issued a new statement that makes clear that a great many of the Blue Shield schedules that are in existence do not reflect current charges by physicians. That is in a release on Thursday, February 12, called "Blue Shield Comments on Medicare Report by Senate Staff," which I will be glad to submit it for the record.

(The release referred to follows:)

BLUE SHIELD COMMENTS ON MEDICARE REPORT BY SENATE STAFF

CHICAGO.—A spokesman for the National Association of Blue Shield Plans (NABSP) expressed disappointment today over the data in the Report of the Staff to the Senate Finance Committee on the problems of Medicare and Medicaid.

Speaking for NABSP—the coordinating office for 72 U.S. Blue Shield Plans which serve more than 76 million Americans—Ned F. Parish, NABSP Executive Vice President, said in Chicago:

"We were called on by government in 1966 to assist in the administration of the Medicare program, which was designed in a manner contrary to the suggestions we had made based on 25 years of experience.

"Now, we are faced with a report which states that Blue Shield Plans paid more to physicians for taking care of Medicare patients than for patients covered by Blue Shield private programs.

"The report takes Blue Shield fee schedules—some developed more than 15 years ago—and compares them to Medicare payments in 1968. Obviously these fee schedules, some of which were designed for partial payment to physicians, do not meet current physician charges.

"Medicare administration calls for payment to the physician on the basis of the usual, prevailing and reasonable charge. In comparing this with Blue Shield programs based on the same payment principle, there was no significant difference in the amounts allowed to physicians."

Parish said he had testified before the House Ways and Means Committee on November 10, 1969, and had submitted a study entitled, "Physician Fees: A Comparison of Government and Non-Government Carrier Payments," which was prepared by Edward S. Mills, Ph.D., and Theodore F. Lake, M.B.A., of the NABSP staff.

This study showed that "no statistically significant difference existed between the charge levels allowed by Blue Shield carrier plans for Medicare and for their private enrollment, when the comparable customary, prevailing and reasonable charge method of payment was used."

Parish said findings of this Blue Shield study were disritbuted to the news media and government agencies, "and we have not received any comments critical of our approach to the data, and our interpretation of it."

The Blue Shield executive reported that Mills and Lake had analyzed Chart 1 of the staff report and had found the following:

> The Senate staff report indicates an average Medicare payment by Alabama Blue Shield for an inguinal hernia is $193 compared to the Blue Shield maximum payment for private business of $75. The $75 figure is from the Alabama Plan's lowest level contract—last revised in 1956—which was never intended as a paid-in-full schedule.
>
> For a cholecystectomy (gall bladder) operation, the Senate staff report lists an Alabama Blue Shield maximum of $100—again from the lowest level fee schedule—compared to the average Medicare payment of $303. NABSP computation of the Alabama data indicates an average Medicare payment of $289 and a private business average payment of $286.
>
> In Michigan and Minnesota, the average Blue Shield figure for a prostate operation was higher than the average Medicare payment. In Michigan, the Blue Shield allowance was $398 and for Medicare, $389. In Minnesota, the private subscriber fee was $384, but only $348 for the average Medicare patient.

The Colorado Blue Shield Plan has also taken issue with Chart 1, which shows that the average Medicare cataract operation in Colorado costs $348 as compared to "Blue Shield maximum payment" of $250. The Colorado Plan pointed out that the $348 represented a cataract operation in 1968, compared to a Blue Shield schedule of $250 for this operation in 1953.

The Senate Staff report resulted in the following sensational headline in the ROCKY MOUNTAIN NEWS on February 8: "One Colorado Doctor Reaps $326,262 From Medicare." The story indicated that another Colorado physician had earned some $150,000 from Medicare.

John J. Vance, Executive Vice President of Colorado Blue Shield, said the $326,262 payment was actually made to staff physicians at Colorado General Hospital for hundreds of procedures, X-ray, and laboratory charges by many staff physicians in the teaching institution.

As for the $150,000 payment, this was made to the Denver General Hospital, again for services performed by a number of physicians.

Parish concluded: "It is unfortunate that because of the complexity of the subject a report of this sort is open to such misinterpretations. We are giving our full attention to the report and will make additional comments where warranted.

"We are concerned about rising health care costs and are taking measures to contain them. But in the inflationary economy which we have experienced, it is unrealistic to compare physician charges today with fee schedules developed 10 to 15 years ago for programs which were vastly different from Medicare."

The CHAIRMAN. Let me suggest this. We are to meet in joint session to hear the President of France address the Congress in about 7 minutes. So far, I regret to say, that even under the time limitation I have imposed we have had only opportunity for four members to interrogate this panel of witnesses. I would suggest that we come back tomorrow morning and start where we left off. But I think Senator Bennett wanted to ask some questions—to get in on this—and from the partisan point of view he is certainly entitled to because we have heard from three Democrats and only one Republican. Senator Bennett is recognized.

Senator BENNETT. Tomorrow morning.

The CHAIRMAN. Now, if you want to question for 5 minutes.

Senator BENNETT. No. I think time is awasting. I do not want to sit in the back row in the House during the joint session.

The CHAIRMAN. See you tomorrow.

(Whereupon, at 12:10 p.m., the hearing was recessed, to reconvene at 10 a.m., Thursday, February 26, 1970.)

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# MEDICARE AND MEDICAID

THURSDAY, FEBRUARY 26, 1970

U.S. SENATE,
COMMITTEE ON FINANCE,
*Washington, D.C.*

The committee met, pursuant to recess, at 10 a.m., in room 2221, New Senate Office Building, the Honorable Russell B. Long (chairman) presiding.

Present: Senators Long, Anderson, Gore, Hartke, Ribicoff, Byrd of Virginia, Williams of Delaware, Curtis, Bennett, Miller, Jordan of Idaho, and Hansen.

The CHAIRMAN. The hearing will come to order.

During the hearing yesterday, I made the statement that the medicare program was suffering from $131 billion of cost overruns for the next 25-year period. Before the hearing was over, the committee learned that new estimates place the cost overrun at $216 billion—that is an $85 billion increase in the deficit in a single month. It is utterly inconceivable to this Senator how one program can be operated with such a lack of cost consciousness as to permit this situation to arise.

I pointed out yesterday that someone is going to have to be the rough, tough guy—the mean guy from the point of view of the doctor, the nursing home operator, the drug company and the hospital operator—and tell those people that this is all we are going to pay for this program. We just cannot continue to pay their ever-increasing demands. I stated for the record in 1965 before this program was enacted that it would cost more than the estimates that were then being made. But I had no idea that in the short span of 5 years, we would be looking at a deficit in this single program that would exceed the deficit in the national debt accumulated over the first 156 years of this Nation's existence.

This medicare program is completely out of hand, and it appears that no one but the Senate Finance Committee is doing anything about it. I believe the committee is acting courageously and in the best public interest in trying to get some order into this program and to fix some limit on the amounts that will be paid under this program. But, no matter how courageously we act here, we cannot stop the drain on the program without the complete cooperation of the administrators of the program.

I fear the attitude I was expressing yesterday was misinterpreted in the press. It is our duty in Congress to muster the courage necessary to cut the cost of this program, even if it means a defeat at the polls for every one of us. And if I have my way, we are going to

put a limit on medicare payments that will cut that $216 billion cost overrun by more than one-half.

But I say again, the people of America are entitled to expect that the program will be run by administrators who will keep a firm grasp of the purse strings of the program, and rid the program of the grab-bag attitude that apparently has characterized its operation up to this point.

This is the thrust of the position I stated yesterday. If it was misconstrued by the press or by anyone else, this statement should reassert my position and the courageous position I believe the Committee on Finance is taking in terms that cannot be misconstrued.

The Chair now recognizes Senator Bennett.

Senator BENNETT. I am delaying an executive session in another committee, and I am going to try to stay to the 5-minute limit. That being the case, I have eight questions I would like to ask. I realize that the Secretary is not going to be able to answer them fully today, but I would like to enter them into the record. I have copies for him, and would like to go as far as I can. We can have the answers placed into the record.

(The questions, with answers supplied, follow:)

(1) *Have you attempted to discover and identify all the problems you inherited in Medicare and Medicaid?*

From th time this Administration took office, we have been examining the Medicare and Medicaid programs to identify weaknesses, and we have taken a variety of actions to deal with the problems we have identified. We have done this as part of the careful examination of all Departmental programs that a new Administration might be expected to undertake. In addition, we have taken special steps to obtain a thorough and systematic independent review of all aspects of the Medicaid program through the appointment of a "Task Force on Medicaid and Related Programs," and we have recently appointed an expert consultant group to take a fresh and independent look at the cost estimating process for both Medicare and Medicaid.

(2) *Do you have a list or catalog? Can you furnish it to us so we can compare it with the findings of our staff?*

On the whole, we feel that the Committee staff has identified much the same problems that we have found; in fact, people at various levels within the Department worked closely with the Committee staff and furnished much of the information from which the staff developed its findings.

The Department has not only identified but has already acted to remedy many of the problems discussed in the staff report. Many of the actions are mentioned in a document outlining the Department's comments on the recommendations of the Committee staff, which has been submitted to the Committee. We have also submitted, for inclusion in the hearings record, a listing of administrative actions to improve Medicare operations, and a listing of Medicaid initiatives, taken since January 1969.

Some of the deficiencies we have identified have given rise to the specific proposals of the Health Cost Effectiveness Amendments and the other proposals made by the Administration. The purpose of these proposals is to improve various aspects of the operation of the Medicare, Medicaid, and maternal and child health programs.

(3) *Have you analyzed the causes of these problems?*

We believe that the most serious of the problems in Medicare and Medicaid reflect underlying weaknesses in the Nation's health care system. To solve them, as I said in my prepared testimony before the Committee, we will need to take steps far beyond the scope of Medicare and Medicaid—to deal with problems of shortages of health personnel, problems of inefficient organization of the delivery of health care, and problems of maldistribution of health facilities.

To attack these broader problems within Medicare to the extent this is possible, we are suggesting, in addition to the Health Cost Effectiveness Amendments, fundamental changes in the law: an incentive system of institutional reimbursement, an approach to reasonable-charge reimbursement that ties recognition of

fee increases to changes in certain wage and price indices, and modification of Medicare's payment mechanism to support and help to encourage additional development of health maintenance organizations that provide comprehensive health services on the basis of a fixed annual charge.

(4) *Did your analysis reveal specific weaknesses within the Social Security System which you can pinpoint as to Department, Section and persons responsible?*

As noted above, our analysis has indicated underlying weaknesses in the Nation's health care system and in some of the legislative foundations of the Medicare and Medicaid programs, but in our opinion the professional, technical, and administrative staff involved in administering the two programs have conscientiously and effectively fulfilled their responsibilities.

(5) *Do you plan to develop a comprehensive plan to eliminate each and all of those weaknesses or will the approach be piecemeal?*

As indicated above, we have a series of proposed amendments designed to eliminate or at least substantially reduce the weaknesses in the Nation's health care system and in the Medicare and Medicaid programs. These legislative proposals include the Health Cost Effectiveness Amendments and proposals for an incentive system of institutional reimbursement, for reasonable charge reimbursement that would tie recognition of fee increases to changes in certain indices, and for stimulating the growth of health maintenance organizations.

(6) *We have been told that there are two conflicting concepts within the system roughly defined as the moderate and the expansionist. With which group is the Administration more nearly aligned?*

We believe that the use of the terms "moderate" and "expansionist" in an effort to characterize approaches to the problem of assuring economic security in the United States is misleading. As I have indicated, this Administration is committed to the objective of constructing an overall system that will assure economic security in a way that is consistent with our political and economic institutions. There are, no doubt, differences among responsible persons as to the pace of change and the order of priorities but we believe that this objective is shared by all members of the Department.

(7) *What steps are you taking to prevent frustration and sabotage from within your own staff?*

We have not found any instances of "sabotage" of Administration policies; nor have we encountered any efforts on the part of staff within the Department to frustrate or impede the development or implementation of Administration positions and programs. On the contrary, staff work at all levels within the Department has been conducted responsibly and has been responsive to the policies laid down by the Administration.

(8) *If necessary to produce effective administration, would you consider separating the administration of Medicare and Medicaid from their present administration and putting them together in a new setting?*

We believe it would not be administratively sound or desirable to remove the administration of the Medicare and Medicaid programs from their present settings. We believe that the fundamental problems inherent in these programs derive primarily from the difficulties of the health care system and not from internal administrative deficiencies. Efforts are being made to overcome any administrative difficulties within the current organizational arrangements.

A number of favorable conditions, many of them implementing recommendations of the Medicaid task force, have recently served to strengthen the Medicaid organization. Dynamic leadership has been accomplished through the appointment of the Commissioner, through increases in the Federal staff, and through expanded support from the new Administration. Strong ties are being developed with the Department's operating health programs as well as with other health-involved Federal agencies.

These efforts, along with the implementation of the Health Cost Effectiveness Proposals will do much to improve the Medicaid and Medicare programs as well as to overcome some of the deficiencies presented by the Nation's health care delivery system.

Furthermore, it would be unfortunate to separate the Medicare system from the Social Security Administration in view of the very close relationship which exists in eligibility requirements, record collecton, and processing of the Medicare

claims and benefits and the Social Security cash benefits. The current organizational arrangements make effective use of the large computerized central record keeping operation of the Social Security Administration and of the more than 800 local SSA offices throughout the country.

Senator BENNETT. Now, I would like to go to the first question, Mr. Secretary, have you attempted to discover and identify all the problems you inherited in medicare and medicaid?

**STATEMENT OF HON. JOHN G. VENEMAN, UNDER SECRETARY, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE; ACCOMPANIED BY ROBERT BALL, COMMISSIONER, SOCIAL SECURITY; HOWARD NEWMAN, COMMISSIONER, MEDICAL SERVICES ADMINISTRATION; ARTHUR E. HESS, DEPUTY COMMISSIONER OF SOCIAL SECURITY; JOHN D. TWINAME, ADMINISTRATOR, SOCIAL AND REHABILITATION SERVICE; ROBERT J. MYERS, CHIEF ACTUARY, SOCIAL SECURITY ADMINISTRATION; HENRY SPIEGELBLATT, DIRECTOR, PROGRAM MANAGEMENT DIVISION, SOCIAL AND REHABILITATION SERVICE, MEDICAL SERVICES ADMINISTRATION; MRS. RUTH HANFT; IRWIN WOLKSTEIN; AND THOMAS M. TIERNEY, DIRECTOR, BUREAU OF HEALTH INSURANCE—Resumed**

Mr. VENEMAN. One of the immediate things we did was to appoint a task force who came up with some recommendations.

Senator BENNETT. I recognize that there are two men in your Department. One of them has been in office for 1 week; and the other doesn't come in until next Monday.

Mr. VENEMAN. While these men have been coming aboard, we have been working on these problems.

Senator BENNETT. It is very interesting to this Senator that Mr. Ball testified that with the changes they had already made, he believed that the $4.40 projected rate would be too high.

Mr. VENEMAN. I will let him speak for himself. We were left with the $4 rate which should have been $4.40—even more—last year. That rate was promulgated against the advice of the actuary.

Senator BENNETT. On page 66 of the July 1969 hearing, Mr. Ball stated: "With the kind of cost controls that are now in effect, it is my personal position that $4.40 will be too high for the coming fiscal year," and yet we have had to go to $5.30.

Mr. BALL. I think the comparison is wrong. The sum of $5.30 is the rate for the next fiscal year: Mr. Myers testified that the rate probably should be $4.50 or $4.60 for this year. My reasoning was based on—for whatever interest—that the $4.40 was the correct estimate for the current period, based upon the assumption of the kind of policies in effect in the past. We instituted very strict cost control policies as soon as that $4 rate was promulgated again. We cut the fee increases down to only 3 percent for 1969. Therefore, if the $4.40 rate had been correct before, I assumed it would be too high after the new policies were adopted. The problem was that the $4.40 turned out to be too low a rate under any circumstances.

Senator BENNETT. You said the coming fiscal year.

Mr. BALL. This was on July 2; I meant the fiscal year we have just started; the one we are in.

Senator BENNETT. I admit that.

Mr. BALL. One period had just ended and $4.40 was the rate the actuaries had recommended for the next period.

Mr. VENEMAN. I have not, since being with the Department last January, heard anyone in the Department suggest that the $4 rate was adequate; $4.40 would have been closer to the proper rate.

Mr. MYERS. I would put it a little differently. When the question was brought up, I thought it should be $4.40. The likelihood would then be to have increased utilization when fee controls are put in.

Senator BENNETT. How far should the $4.40 rate bring us during the fiscal year?

Mr. MYERS. We are still in that year, but it would appear that when we get to the end of the year, we will find out that the proper rate should have been more than $4.40. On an actual cash basis, the outgo during the first half of the year was at the rate of $4.40, and the outgo rises during the year.

Mr. VENEMAN. Had that rate been at $4.40 or $4.60, we would not have had to go to $5.30 this year.

Senator BENNETT. I bring the point up because it seems to me that there is complacency in the feeling that all was well. Have you had time to finish with that list or catalog? In our staff study, we have identified quite a few problems. Have you had any similar study or paragraph analysis made?

Mr. VENEMAN. Perhaps being somewhat cynical, the problem is greed. We have the providers who are providing medical services becoming greedy. We have to devise a system, which is not an easy system to devise, to change the payment and delivery of health services so that every time someone provides a service, they are not going to be paid their full charge regardless of cost.

Senator BENNETT. I am interested in the problems you discovered within the Department. You have taken over an on-going program that has obviously not worked. Is the fault entirely outside the administration? Have you discovered instances of that?

Mr. VENEMAN. I don't think we can isolate the problems with the community or in the recipients. I think that our Department and your staff can verify, if necessary, that we have worked together in trying to identify these problems. We have moved administratively and will continue to move in this direction.

Senator BENNETT. Are you saying, in effect, that the problems identified in the staff report are essentially the main problems? You have not identified any other serious ones?

Mr. VENEMAN. I think for the most part the staff has done a good job of identifying the predominant problems. Once again, I think if we are going to make major changes, we are going to have to—the next changes are going to have to be some rather significant changes in the entire health system of this country.

Senator BENNETT. Thank you.

I have used my time and I have to go to the other committee.

Senator HARTKE. Mr. Secretary, yesterday there was talk about who gave birth to the medicare baby. There is no question that Democrats did give birth to a new child here. But I don't think there is any reason to abandon the child just because it cries sometime in the middle

of the night. I think anyone who is familiar with the history of this program knows that medicaid came as a sort of twin. It was not in the original concept at all when the House Ways and Means Committee reported that bill.

It came more or less as a program which had not been well studied nor was there exact understanding of how the legislation would work. There have been some errors in judgment in the determination of cost. I think there is some outright fraud, as you have indicated, which is now on the way to being corrected, is it not?

Mr. VENEMAN. I think the fraud has been overstated as one of the main problems. I think there is always a real element of it there, but that is not the real serious problem.

Senator HARTKE. The unreasonableness of fees, however, which is not outright illegal, in the hospitals and in the medical field, are what you are addressing yourself to?

Mr. VENEMAN. Yes.

Senator HARTKE. I understand you have also taken some steps toward eliminating this activity. Is that correct?

Mr. VENEMAN. That is correct.

Senator HARTKE. By and large, I want to congratulate you—maybe this sounds funny coming from a Democrat, but I want to congratulate you on what you have been doing along that line. You are well on the way. I don't think the past administration did anything but what they thought was right and you are using the same standard.

I think one thing we should not lose sight of in this situation is that many old people for the first time in their lives are receiving health care which they had never anticipated and which they could not afford except for this program. Isn't that true?

Mr. VENEMAN. That is true. But I think we have to distinguish between the two programs. The medicare program is the one that applies nationally. When we start discussing the problems of medicaid, which as you indicate is a stepchild of the bill, we have to recognize that we are really talking about 52 different programs.

Senator HARTKE. I understand that. That is not necessarily the most efficient way to run that shop, is it?

Mr. VENEMAN. It is not the most effective way from the standpoint of having different State laws, different State regulations, different State plans apply. Because we are really at the mercy of the amount of coverage that they give.

Senator HARTKE. And to that extent, it does not provide the best health care for the most people, nor does it provide the ease of operation or efficiency or incentive that you could otherwise use.

Mr. VENEMAN. It is not a question of whether or not it provides the best. It is a question of whether in some States, it may be more than adequate, in some States may be less than adequate.

Senator HARTKE. Do you not need legislation to put in this incentive plan you talk about?

Mr. VENEMAN. It will require legislation.

Senator HARTKE. In other words, as I understand what you are providing here to hospital units, you are establishing an overall operation, is that right, an overall figure which they can shoot for, and if

they can get below that, they can share in some of the benefits. Isn't that basically right?

Mr. VENEMAN. What we are suggesting is that—I think in the testimony yesterday we suggested that you have a committee composed of persons from the facilities, from the community, from the Federal Government, and you would establish a predetermined rate.

Senator HARTKE. That is right. In other words, you have a carrot-and-stick operation that you are providing. If they go over that rate, they are not going to have to do as they have in the past.

Mr. VENEMAN. Once it is established, they would only get the rate.

Senator HARTKE. That is the "stick" end of it. On the other side, they do have an incentive to move to the other side.

Mr. VENEMAN. If they move for efficiency, they are going to get the same rate, but the margin is going to be to their benefit.

Of course, we are going to have to build in very specifically some elements of quality. They cannot reduce the quality of care and still expect to get the same rate.

Senator HARTKE. I just hope that this necessary investigation and changes in the program do not permit those critics who are against these programs to use this as an excuse to either cut down the amount of care or the amount of assistance that we are going to provide for those people who are entitled to them.

Mr. VENEMAN. I think another thing historically that we have to bring into focus is that the Government was in effect providing health care for the low-income, the aged and low-income persons before 1965. And the States were participating. What we had originally was the Kerr-Mills, the MAA program. We also had the PAC or public assistance medical care. These were superseded by title XVIII and title XIX and we did extend coverage. The whole purpose of the 1965 act was to provide "mainstream medical care" for all the people of this country. The objective was great, and I think during the transition, we are bound to have problems. Now it is up to us, regardless of party or who is in power, to iron out the problems and try to make an effective program to meet those objectives.

Senator HARTKE. I agree. I don't think it makes much difference to say which administration is at fault. I think Secretary Cohen was trying to hold the price down, and did initiate some programs to hold prices down. The suggestion to hold prices down that he rejected, was after the election of 1968 and therefore political considerations were not a factor in his decisions.

I might point out there is in the report of the staff a criticism of the program data material which is available to those who are making actuarial prognostications. But as far as they are concerned, they had no real background to base most of their facts on, isn't that true? There was no history here of this type of program in the United States.

What I am saying is there have been abuses, there has been fraud, unreasonable charges, there have been some deficiencies in administration, some mistakes in actuarial predictions. But all of those things really are not nearly as important in the long run as the fact that the good flowing from this program has been massive; extensive health care to a lot of people who needed it. Now you have some housecleaning to do; isn't that right?

Mr. VENEMAN. We have to do a lot of housecleaning.

Senator HARTKE. I urge you to really reexamine the HEW bill in the light of previous testimony, because it was testified here that you needed additional medical facilities, and not cutbacks. The vetoed HEW bill contained additional funds over the President's request for additional hospital spaces.

Mr. VENEMAN. You are talking about the Hill-Burton program, Senator?

Senator HARTKE. Right.

Mr. VENEMAN. I think what has been pointed out as we look at the history of the Hill-Burton program is that for the most part, the acute bed availability in this country is about 90 percent filled. Now, what we have suggested and what the administration suggested in the Hill-Burton legislation is that we attempt to put the emphasis on outpatient care facilities, lower cost facilities. You know, there is no suggestion that we really cut down on the total beds that are going to be available. The question is what kind of facilities are going to be available.

Senator HARTKE. But in addition to medical facilities the vetoed HEW bill contained additional funds for the construction of health, education, and research facilities, for health manpower research support, for the health manpower assistance program, for the trainee and the direct loan program, and for the scholarship program to really increase the amount of additional health facilities and training that could be used. Lack of those facilties and people is one of the shortcomings and one of the things adding to the problems and costs of medicare.

I want to congratulate you for what you have done in this program, but I think on one hand, you are really denying yourself an opportunty to make this program effective by looking at it singularly, without looking into the totality of what is needed in the whole area of medicine.

Mr. VENEMAN. I do not think we have done that, Senator. We have looked at the total picture and I think we have recognized the problems. Of course, and I think it was in my testimony yesterday, the big problem is the delivery systems. We recognize the problems of shortage of manpower. But the answer may or may not be just a total increase in the budget. You are suggesting that that will all of a sudden bring thousands more doctors.

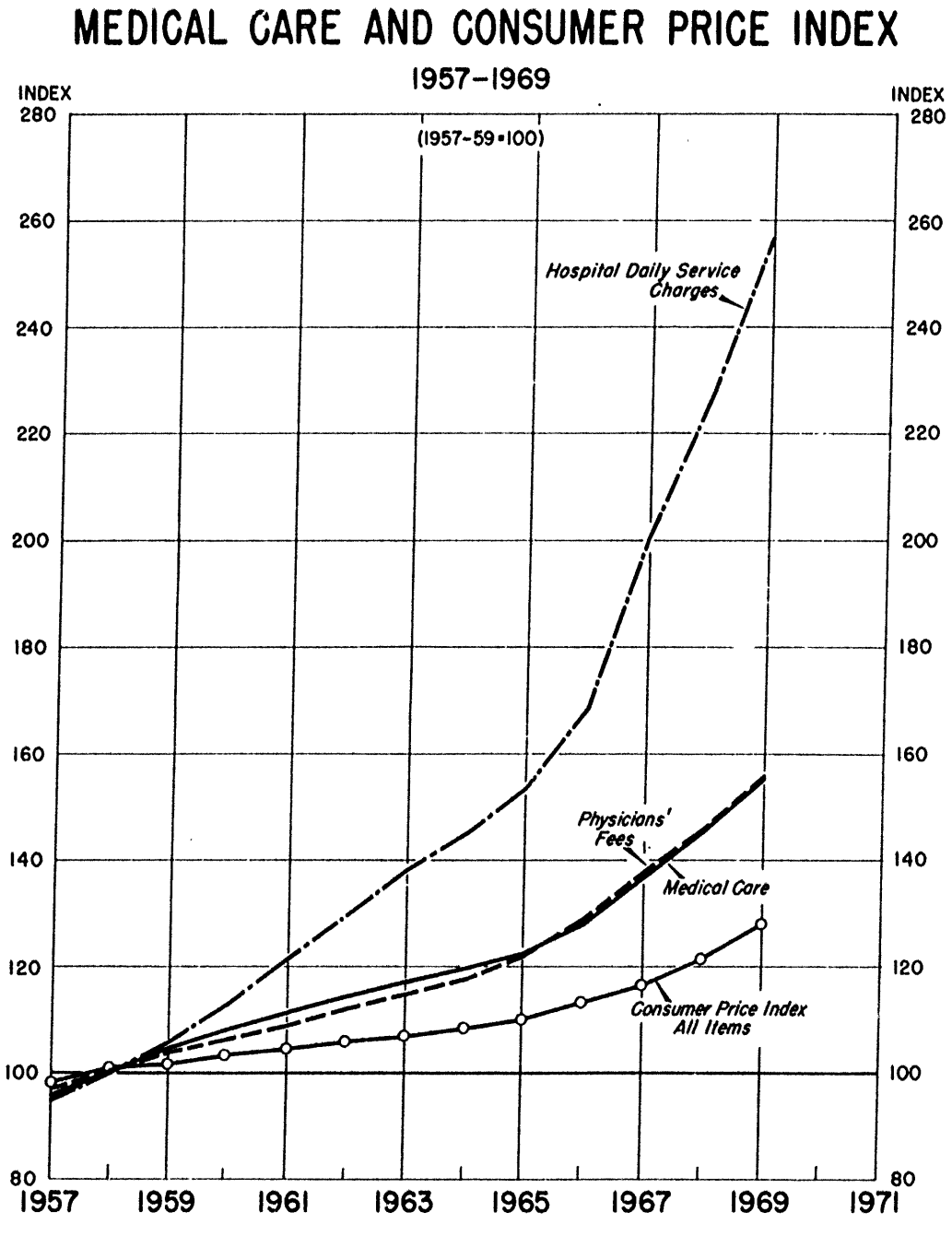
Senator HARTKE. I don't offer it as a panacea, any more than I think you would point to one of your recommendations in this list of recommendations of about 13 or 20—I have forgotten how many you have—as a total solution. But this is an important part.

I would like to ask the permission of the committee to insert into the record two charts, one of them medical care and consumer price index between 1957 and 1969, showing the tremendous sharp incline in the daily hospital costs here which have just astonishingly increased, and also the medical care and consumer price index chart—I mean statistics which accompany this chart to show how the hospital daily service charges, physicians' fee, and medical care programs have increased sharply during this same period of about 12 years. This is also one of the problems medicare is faced with. I just do not think you can talk about medicare and the cost of medicare unless you

talk about inflation and the general increase in medical cost. I can argue with how you are fighting inflation, but I do not think you could have more health care with less facilities. I do not think you can have more doctors without more training. I do not think you can have more health without additional nurses somewhere along this line.

Senator ANDERSON. Without objection, the charts will be inserted in the record.

(The charts referred to follow:)




Source: U.S. Department of Labor, Bureau of Labor Statistics

MEDICAL CARE AND CONSUMER PRICE INDEX, 1957-69

[1957-59=100]

| Year | Consumer Price Index | Medical care | Physicians' fees | Hospital daily service charges |
|---|---|---|---|---|
| 1957 | 98.0 | 95.5 | 96.7 | 94.9 |
| 1958 | 100.7 | 100.1 | 100.0 | 99.6 |
| 1959 | 101.5 | 104.4 | 103.4 | 105.0 |
| 1960 | 103.1 | 108.1 | 106.0 | 112.5 |
| 1961 | 104.2 | 111.3 | 108.7 | 121.5 |
| 1962 | 105.4 | 114.2 | 111.9 | 129.7 |
| 1963 | 106.7 | 117.0 | 114.4 | 138.3 |
| 1964 | 108.1 | 119.4 | 117.3 | 144.8 |
| 1965 | 109.9 | 122.3 | 121.5 | 153.0 |
| 1966 | 113.1 | 127.7 | 128.5 | 168.9 |
| 1967 | 116.3 | 136.7 | 137.6 | 200.3 |
| 1968 | 121.2 | 145.0 | 145.3 | 226.0 |
| 1969 | 127.7 | 155.0 | 155.4 | 256.1 |

Source: U.S. Department of Labor Bureau of Labor Statistics.

Senator ANDERSON. What were the periods on those charts?

Senator HARTKE. They run from 1957 through 1969, but you note on this chart that after medicare went into effect, while the incline was rather sharp, up until basically 1966—after it hit 1966, it almost went perpendicular. Now, that is the problem. This is one that you cannot isolate. And I do not think you can cut down on inflation by cutting down on health care. For that, I would be very severely, as completely and candidly as I can, critical of your Department.

On the other hand, I want to compliment you for the institution of these other reforms in this program, because I think you have done an excellent job in that field. I think it is just a matter of trying to keep your programs coordinated and letting your right hand know what your left hand is doing and trying to keep as much politics as you can out of taking care of these elderly citizens and their health care, which I think you will do. I have the highest personal regard for you. You know that.

Mr. VENEMAN. Thank you, Senator.

Senator MILLER. How many people do you estimate in this country are over 65, Mr. Ball?

Mr. BALL. About 20 million, sir.

Senator MILLER. They are all eligible for medicare?

Mr. BALL. They are practically all eligible for the hospital insurance part. There are a few thousand who have become 65 recently, who are not. But practically all. Then you remember the medical insurance part is a voluntary program, and around 95 percent of the 20 million have elected that voluntary plan.

Senator MILLER. Now, of these 20 million, do you have any estimate of how many are needy?

Mr. BALL. Well, Senator, people can differ considerably on the definition of what constitutes being needy. Only slightly more than 20 percent of the people who are 65 and older have sufficient income to be subject to the income tax.

Mr. VENEMAN. What percentage of the social security recipients are on old-age assistance?

Mr. BALL. Yes, then you can go to the other extreme. As I said 20 percent are well enough off to be subject to income tax. At the other extreme, there are about 10 percent, or 2 million, who have low enough

incomes that they are on the old-age assistance rolls. In between, there are varying measures of poverty and low income that come up with different answers.

Senator MILLER. Do you have any idea how many of the in-between group are in a position where they cannot afford their medical services?

Mr. BALL. Oh, I think, Senator, that without a program like medicare, it would be a very high proportion of the aged who could not sustain the impact of expensive illness. I would say easily the whole 80 percent who do not have enough income to pay an income tax would be in that category and I think quite a few others.

Senator MILLER. You mentioned paying income tax. Does that mean that you are considering only income and not looking at property?

Mr. BALL. Yes; I was just giving you one rough measure by saying how many are subject to an income tax.

Senator MILLER. You see what I have in mind, there are some people today who have a lot of property, for example, farmland. I know one who owns a farm that is worth $100,000, but the amount of income derived last year would be, oh, maybe $2,000. There will not be any income tax to pay on that.

Mr. BALL. There certainly are such cases.

Senator MILLER. Of course, they are in such good shape that they need to pay for medical services, especially of a relatively short duration, wouldn't you say?

Mr. BALL. Certainly, Senator. We have done, as you know, some studies of income and assets of the aged. We would be able to supply that for the record. I would say in general that the assets that people over 65 own are very largely their own homes. There is a very high proportion of the couples that own their homes, and about half the people over 65 are married and about half are not. But the amount of other assets the people have is typically not large. I believe one of the big advantages of medicare has been to protect these relatively small assets and the homes that older people have.

(The Committee subsequently received from the Department, a report dated April 1970, entitled "Income of People Aged 65 and Older: Overview From the 1968 Survey of the Aged." The document was made a part of the official files of the Committee.)

Senator MILLER. May I say to you, I thought that under the medical assistance for the aged program, certainly the way we have it in Iowa, that protection was more than amply provided. Out in our State, we provided that if the cost of medical service reduced the person's income below a certain figure, they would have unlimited coverage beyond that. So they were amply protected.

Mr. BALL. That is under the so-called Kerr-Mills program?

Senator MILLER. Right. So when you estimate that there are 20 percent of those 20 million who actually have to pay an income tax, and you are not even taking into account property in the case of those who may not be paying income tax, it prompts my question as to whether or not, under the medicare program, free medical services are being paid to the rich as well as to the aged?

Mr. BALL. Senator Miller, on the medicare program, the way I look at it is that it is on a long-range basis, a contributory plan that of course protects people regardless of their income, just as the social

security cash benefits program does. It is true that people receive cash social security benefits and people receive medicare benefits as a matter of right without a test of their income and toward which they have contributed.

Senator MILLER. What I am thinking about is the people who are quite wealthy. They just happen to be over 65 years of age, but they are very wealthy. I am thinking about other people who are paying taxes that are going to be paying for their free medical bills, such as a lot of wage earners who are having a tough time nowadays maintaining themselves and their families. And I wonder about the equity of that. I am talking about the tremendous cost overruns on the program.

Mr. VENEMAN. That was the case made in 1965.

Senator MILLER. I understand. You were not here yesterday, Mr. Veneman, when we had a nonpartisan statement made by our colleague from Tennessee that the Democrats made free medical service available to needy people. It seems to me we ought to put that in perspective and add "and rich people, too."

Mr. VENEMAN. I think what we have to distinguish here is the difference between title XVIII, the medicare program, and the medicaid program.

Senator MILLER. I am talking about medical services.

Mr. VENEMAN. Under the medicare program, you are talking about a health insurance program for the aged and you are absolutely correct, it is a payroll deduction program, people are contributing to it and the program pays for your health care after you reach the age of eligibility—no needs test, no other requirement. You can have all the money in the world and still qualify.

Senator MILLER. Right.

Mr. VENEMAN. Under Kerr-Mills, there was a needs test applied to that.

Senator MILLER. Right. I am just wondering whether or not, for the sake of simplicity and universal coverage, we might have overextended our resources on the program. Everybody is alarmed at the cost overrun. It seems to me that, even if it is only 20 percent of the total, 20 percent can comprise a good chunk of that overrun.

Mr. VENEMAN. Well, you see, most of the funds that are utilized in the medicare program are out of contributions except for part B where we match the beneficiaries' premium payment out of general funds. But it is really a participating insurance program that we are talking about in medicare.

Senator MILLER. I was thinking of the hospital program. To me, that is a big part of the overrun. If you have 20 percent of the total people who are taking advantage of this who have no need at all and ample resources, as proven, I think, under the Kerr-Mills program, I must tell you, I cannot get very disturbed about reducing medical services to that group. I can share Senator Hartke's concern about reducing medical services to the needy group. I would never have any question about that. But I am concerned about overruns and looking at overruns and trying to figure out how to cut costs, it seems to me we might look at the area where they do not have any need.

Mr. VENEMAN. Well, you know, my problem here, Senator——

Senator MILLER. You have a problem, and we have a problem too, in facing the taxpayers who are paying for this.

Mr. VENEMAN. To kind of rationalize your statement, if we attempt to cut costs on the group we are talking about, those that are under the hospital part of medicare, under title XVIII, we are not getting to the focus of any money saving as far as general funds are concerned. It relates, of course, in fact, all insurance programs relate to the total cost applied across the consumer market for health services. But really, when we talk about increased costs in health care programs as far as the Federal Government is concerned, I think we are talking primarily about the general fund dollars that are involved.

Senator MILLER. What I think I might get from you and Mr. Ball is some kind of an analysis showing what portion of these costs are the result of blanketing in, say, 20 percent of these people who can afford to pay for their own medical services. I will not even ask you to go further and find out whether or not it might be 25 or 30 percent if we take property into account. What percent of these costs could we save if we eliminated the 20 percent who are able to take care of their medical costs, at least except in catastrophic cases, who could have coverage similar to what they have in my State, where they are protected from unlimited costs if medical costs reduce their income below a certain level?

Mr. BALL. We could develop something like that for the record. I want to be clear that I did not mean to imply that just because somebody has an income sufficient to pay some income tax, that puts him up into a group where he could pay his medical bills. I was taking that as one measure of low-income people in response to that specific question. But we will do it on the basis of 20 percent, as you request.

Senator MILLER. I appreciate it, and with the understanding, of course, that people would be covered in the case of catastrophic illnesses so they would not be out in the street. That is the way we handle it in Iowa, and frankly, I think the needy people in Iowa got a better deal under MAA than they do under the present law, because they had no deductibles, if they were in a low-income area, or even if they were in an area above that. If their costs brought their income down below a certain level——

Mr. VENEMAN. Senator, I think we must emphasize here that for the low income aged, those people who used to qualify under the medical aid to aged program, for the most part, they still qualify under title XIX, where there is no deductible. The poor people are still covered regardless of age or circumstances.

Senator MILLER. I understand. I am interested in medicare aspects.

Mr. VENEMAN. You see, those people have both, both medicare and medicaid.

Senator MILLER. I understand.

I would like to get Mr. Ball's estimate on medicare.

I see Mr. Myers here and I would like to ask him a couple of questions.

Mr. Myers, yesterday, we developed the point that last December, there was an actuarially sound estimate of $131 billion shortfall over the next 25 years on part A, and then, in this current month, that had been changed to upward of $216 billion, is that correct?

Mr. MYERS. Yes; that is correct.

Senator MILLER. All right. Now, in the estimate of these projected costs, I presume you might have used an inflation factor?

Mr. MYERS. Senator Miller, could I explain first about the difference in these two estimates? The estimate that was made last fall was labeled a preliminary and tentative estimate and was made by approximate methods because we still needed some additional data which we later obtained. We then went through a full-fledged actuarial valuation which gave the results which you are talking about now and which are in this memorandum I submitted for the record, showing that figure of $216 billion. Now, this estimate, as you have indicated, is based not only on the experience as to where we are now, but also it is based on projecting this experience according to various trends of costs of hospitalization, costs of extended care facility services, and costs of home health services. Also, it is based on an assumption that there will be an increasing trend in the utilization of these services, which has been the case in the past and which will very likely be the case in the future, particularly these new areas of medical services, the extended care facilities and the home health services.

Senator MILLER. Now, I appreciate that. But my question is, in those assumptions, do you have an assumed rate of inflation?

Mr. MYERS. Yes; I have an assumed rate of increase in both the general wage level of the country, on which the contributions are based, and I have an assumption as to the increase in costs of hospitalization, which in essence involve in part inflation, and in part the general trend of wages and costs of the country.

Senator MILLER. Would it be accurate to say that your projections were based upon an assumption of trends reflecting the current rate of inflation?

Mr. MYERS. No, they are not, Senator, because what I projected was that the current rate of inflation would slow down. Then we would get into what you might call the more normal rate of price increases and wage increases such as that had occurred in the past. Specifically, as to wages, which of course include the two elements of price inflation and the productivity factor, I assumed that in 1970, wages would increase by 5.9 percent over 1969. Then, I assumed that this increase would gradually taper off until by 1976, it would be 4 percent per year and would remain at that level thereafter during the 25-year period of valuation.

Senator MILLER. How much of that 5.9 percent would be inflation, as distinguished from productivity?

Mr. MYERS. Although this does not enter into the cost estimates——

Senator MILLER. As I understand it, you are talking now about wages which entered into the estimates on the basis of wage base and taxes?

Mr. MYERS. Yes, the wage base for payroll taxes. The part of it that represents inflation, I would say, is something around 4 percent, because I would say that in the long run if wages go up about 4 percent per year, as I assumed ultimately, about 2 percent of that would be price inflation and 2 percent would be productivity.

Senator MILLER. So then, as far as 1970 is concerned, you had roughtly a 4-percent inflation factor computed and by the time you got to 1976, you had a 2-percent inflation tax.

Mr. MYERS. Yes; that is approximately correct.

Senator MILLER. The trend going down 2 percent——

Mr. MYERS. Yes, sir.

Senator MILLER. Did you have a similar rate of inflation included in estimating the costs?

Mr. MYERS. Yes, sir. For instance, in hospital costs, I have a much higher rate of inflation than for general prices, because, as you well know, in the past this has been the case. For example, I have assumed that in 1970, there would be a 14-percent increase in hospital costs. Now, this compares with what was apparently about a 15-percent increase for 1969 over 1968. I have then assumed that this rate of increase, which as I have said was 14 percent for 1970, would gradually decline; for example, being 13 percent for 1971, 11½ percent for 1972, 10 percent for 1973, and then declining slowly until in 1978, and thereafter, I assumed that hospital costs would rise at 4 percent per year; in other words, just the same rate as I assume for wages.

Senator MILLER. In that 14 percent for 1970, what portion of that would represent the estimated inflation in hospital cost areas?

Mr. MYERS. Well, Senator, I think you would say the whole 14 percent represents the increase in prices and hospital costs.

Senator MILLER. I find it hard to reconcile that with the Consumer Price Index, which shows hospital costs and services higher than the average of the CPI. I do not believe there is that much spread.

May I ask you this? Have you coordinated these estimates with the Council of Economic Advisers and their people as far as projected inflation rates are concerned?

Mr. MYERS. Only as to the increases that I have assumed in wages for the first couple of years were they coordinated. As I understand, the Council of Economic Advisers generally has only these short-range projections. The ultimate 4-percent rate I assumed is, I think, generally consistent with what many people would say in the long run, a 3½- or 4-percent wage increase per year.

Senator MILLER. As far as the short range is concerned, you did coordinate this with the Council of Economic Advisers or their staff, is that right?

Mr. MYERS. As far as the wage increases are concerned. As to the hospital price increases, my staff and I projected these based on our knowledge and past experience and what we thought was likely to occur in the near future and the longrun future.

Senator MILLER. I think you can understand the reason for my questioning, Mr. Myers; I want to make sure that our departments and agencies are coordinated on these projections.

My MYERS. Senator, I have just been informed that my staff member who worked primarily in this field did coordinate the hospital cost increases with the Council of Economic Advisers, as well as also the wage increases.

Senator MILLER. Thank you very much, Mr. Myers.

Senator ANDERSON. Senator Ribicoff?

Senator RIBICOFF. Mr. Veneman, a New York Times story by Richard Lyons on January 12, 1970, says the following:

> That John Veneman, Mr. Finch's Under Secretary, was asked the other day to equate the administration's statements with its performance since last summer.

I quote you:

Well, I don't see the point of issuing a lot of rhetoric, Mr. Veneman said, shaking his head. The statements were made merely to call attention to the problem, they were not meant to solve them.

Now, don't you feel you have a responsibility to solve the problems, in addition to bringing them to public attention? Could you tell us your views and the views of the Department as to what your responsibility is in meeting the health needs of the American people?

Mr. VENEMAN. You know, I absolutely feel, Senator, that it is our responsibility to provide solutions. I will also stand by the statement that you just quoted from the New York Times. I do not think it solves problems to make speeches about, you know, the problems that exist and the needs that have to be accomplished unless you have the solutions before you. I think really this is what the administration has been attempting to do.

Now, when we first came in, and I have here and I will submit it for the record, the administrative actions we have taken for improvements in medicare during the year of 1969.

(The submittal referred to follows:)

ADMINISTRATIVE ACTION TO IMPROVE MEDICARE OPERATIONS SINCE JANUARY 1969

A. INTERMEDIARY AND CARRIER PERFORMANCE

The key to the relationship between the Social Security Administration and the carriers and intermediaries is that the contractors cannot necessarily do for Medicare what they would do for their private business. Instead, they are required to follow national policies and to meet certain uniform standards of performance. This requires a system of central direction and review of contractor performance. Longstanding elements of that system have included periodic on-site reviews of each contractor by central office personnel of the Social Security Administration and frequent visits by regional office personnel. In addition, contractors are required to follow specific instructions on various policy and procedure matters and regularly to provide a variety of reports to the Social Security Administration.

Several specific actions have been undertaken to further improve contractor performance. These include:

1. Special visits have been increased to emphasize especially important areas of operations such as reasonable charge determinations, hospital-based and teaching physicians, level of care determinations in extended care facilities and claims review techniques.

2. Introduction of test claims into carrier systems to test the accuracy and quality of the claims process.

3. Assignment of full-time, on-site representatives of the Social Security Administration to several of the contractors to intensify liaison and surveillance for the purpose of increasing efficiency and effectiveness of contractor operations. Eventually 92 contractors will be serviced by on-site representatives either fully or in part.

4. Increased emphasis on appraising and tightening duplicate claim screening procedures.

5. Visits to extended care facilities and hospitals to check specific problems from the point of origin and to evaluate the methods being used to resolve those problems.

6. Special reporting on matters of particular concern or emphasis, such as the denial rate on ECF claims, progress in completing audits and reasonable charge reductions.

7. More extensive decentralization to regional offices and the addition to staff of reimbursement and systems specialists to bring control and surveillance closer to the scope of operations.

8. A project to develop further specifications for contractors in the areas of claims processing and cost controls in order to refine performance measures, pinpoint more relevant operating data that permits comparison and analysis of the entire process, and systematize and improve the quality of input data.

9. Standards have been set for carrier control of claims. They are required to process claims in three weeks and to be able to identify and locate any claim which is more than three weeks old. This has speeded up claims processing and has improved service to beneficiaries requesting information on the status of their claims.

10. A requirement that carriers respond to a beneficiary's inquiry about his claim within five days has substantially reduced the number of such complaints.

11. Our continuing review of payment records forwarded by carriers reveals possible erroneous payments. The volume of such cases has decreased substantially since the beginning of the program.

12. A central computer edit program is used to review Part A bills submitted for interim payment. Erroneous bills are returned for correction.

13. Intermediaries are furnished a monthly report on errors found in the bills they have submitted. This not only notifies intermediaries of the areas in which their operations are deficient but also serves as an incentive for them to meet national averages or standards.

14. An increasing number of intermediaries (currently 28) are transmitting their bills to SSA on magnetic tape. This not only saves substantial keypunching costs for SSA but increases the accuracy of the information furnished since the intermediaries have been furnished our EDP edit programs and apply them to the data before transmitting it.

15. We have established controls on the payment records submitted by carriers which enable us to balance the totals against the funds drawn by carriers for payment to beneficiaries and doctors.

16. We are working with both BCA and one of the insurance companies in the development of a Model Part A bill processing system which we hope will both reduce costs and improve operations.

### B. PROVIDER COST REPORTS AND AUDITS

1. Instructions have been issued requiring substantial reductions in provider interim reimbursement rates when cost reports are delinquent. If reports are not filed within two months after a reduction is imposed, all further interim payments are withheld. Follow-up procedures have also been initiated to assure that the reductions-suspension instructions are being implemented.

2. Time limits have been imposed on the providers' exercise of some options in the determination of costs. The options to use gross RCC or the Combination method using estimated percentages have expired and are no longer available to providers.

3. Intermediaries are required to assign priorities in conducting audits. Providers which have changed ownership or leave the program and those which have been overpaid or have unusually high interim reimbursement rates must be assigned top priority.

4. A simplified alternative method has been established for handling minor audit adjustments in cost reports of hospitals and extended care facilities.

5. BHI Regional Offices have been instructed to perform on-site reviews of intermediaries' management of the provider audit program and make recommendations for improvement.

6. Intermediaries were instructed to develop sufficient in-house capability to properly manage the full cost report-audit-final settlement process.

7. In an effort to reduce the cost (both time and money) of auditing providers' cost reports, we have begun a pilot project to assess the feasibility of accepting certified cost reports from hospitals.

8. We have initiated better reporting from intermediaries regarding scope of audit conducted, identification of costs, and activity by intermediary's own audit staff.

9. Instructions have been issued to intermediaries to initiate limited scope audits of providers. A desk review program has also been issued to facilitate the determination of when a limited scope audit or no audit is applicable. Audit subcontract proposals are carefully reviewed to ensure that they reflect the limited scope approach.

### C. COVERAGE AND UTILIZATION CONTROLS

1. Policy and procedural instructions have been refined to permit more accurate determinations by intermediaries as to whether the care provided in an extended care facility is at the level covered by the law. Their effectiveness has

been reflected in the increases in the numbers of claims being denied because the care is not covered.

2. More exacting criteria governing coverage of physical therapy services have been issued. This was in response to increasing evidence that bills were being submitted for services which do not constitute physical therapy within the meaning of the law.

3. Regulations have been changed to reduce the time intervals for physician certification as to medical necessity for continued inpatient hospital care. Hospital discharges tended to peak around the 14th and 21st days, the original times at which certifications were required. It is anticipated that reducing the certification times to the 12th and 18th days might have a corresponding effect in reducing lengths of inpatient hospital stays.

4. Instructions have been issued defining the kinds of skilled nursing necessary for coverage of home health services. There had been considerable confusion and inconsistency among intermediaries in applying this statutory requirement.

5. State agencies are surveying all extended care facilities and providing advice and assistance in correcting deficiencies in utilization review.

6. An overall review and evaluation of the effectiveness of utilization review in hospitals is now being made.

7. A hospital-by-hospital analysis of lengths of stay is being developed to assist all hospitals, intermediaries, and the Social Security Administration in their utilization review activities. Every hospital will be furnished a comparison, based on a 20-percent sample of discharges, between its lengths of stay and lengths of stay of other hospitals in the same locality. The utilization date will be standardized to take account of differences in the characteristics of the patient, his illness, the kind of treatment received, and his hospital.

8. An electronic data system for processing Part B claims has been developed which carriers can readily adapt in whole or part for use in their claims processing operations. A special module which identifies deviant patterns in the provision of services is expected to be valuable as a utilization control mechanism.

9. Experiments are being conducted under which certain medical care foundations in California perform the entire claims review function in certain counties under subcontract with California Blue Shield. One of the principal focuses has been improvement of utilization control.

10. Regulations have been revised to prohibit physician-owners of an institution from participating in the utilization review activities of an institution. This is for the obvious purpose of precluding the exercise of undue influence in the deliberations of those committees.

### D. REIMBURSEMENT AND COSTS

1. Policies and procedures governing payment for services of supervisory physicians in a teaching setting have been considerably tightened, and reimbursement practices with respect to teaching institutions throughout the country are being subjected to close scrutiny. In many instances, payments have been suspended where potential or actual large overpayments are involved or other serious questions are still unresolved as to the propriety of payments requested.

2. A computerized cost analysis system has been developed which will make possible comprehensive analysis of the various elements of provider costs. This system is now operational for hospitals and will later become operational for ECF's and home health agencies. From the system we are able to obtain a variety of financial and operating data which are enabling us to (a) evaluate the program's share of total provider costs; (b) measure the program's effects on hospital profits and financial position; and (c) develop needed benchmarks for the determination of reasonable cost based on comparative costs among providers.

3. Interim payments to providers have been limited to the lower of costs or charges. This should have the significant effect of reducing the incidence and amount of overpayments.

4. The 2 percent allowance for unidentified costs, previously included in the provider cost reimbursement formula, was deleted as of July 1, 1969.

5. Tighter restrictions have been imposed on physician charge increases which the program will recognize this fiscal year. Prevailing charges may not be changed earlier than one year after a prior change and may be increased only with the approval of the Social Security Administration. Customary charges may be increased only in individually identified, highly unusual situations where

equity clearly requires such an adjustment and then only on the basis of adequate evidence.

6. Studies are now under way of alternate reimbursement methods which will provide incentives to providers to reduce costs and improve the efficiency of their operations. Various reimbursement experiments, authorized by the 1967 amendments to the Social Security Act, are being developed and tested.

7. Instructions have been issued that Medicare reimbursement will not recognize an appraised value for provider assets which exceeds the cost basis of those assets for Federal tax purposes. This is especially important in establishing the cost basis for depreciable assets of proprietary providers.

8. Proposed regulations have been published in the Federal Register under the notice of rule-making procedure to preclude excessive reimbursement to providers through use of accelerated methods of depreciation and to prevent inflated valuations of provider assets.

9. Proposed regulations have been published in the Federal Register under the notice of rule-making procedure to make it possible for the program to recoup excess depreciation when a provider leaves the program, or Medicare proportion of its allowable cost decreases substantially, immediately after the years of highest accelerated depreciation allowances. Similarly, we propose to remove restrictions on the recovery of amounts due the program as a result of gains on the sale of depreciated assets.

10. Limiting allowed compensation of owners to amounts that are reasonable in relation to payments to salaried persons performing similar services.

11. Limiting reimbursable franchise fees to the value of management services furnished and advertising costs to those related to informing the health professions of available services.

12. Limiting program responsibility for the cost of goods or services purchased by an institution to those costs that would be incurred by a prudent buyer.

13. Providing that an institution with low occupancy should be reimbursed for no more in variable costs (largely staffing) than is reasonable in relation to the number of patients. (The absence of scientifically arrived-at conclusions —or extensive data on present practice—on staff required for a given patient load complicates handling this area.)

14. Instructions are being developed focusing on means of evaluating the reasonableness of specific costs. For example, a method of evaluating the reasonable cost of drugs purchased under arrangements has been prepared.

15. Proposed regulations have been published in the Federal Register under the notice of rule-making procedure, the effect of which is to exclude goodwill, in general, from the computation of equity capital under Medicare reimbursement.

### E. PROGRAM ABUSE AND FRAUD

1. Fraud prevention, detection, and investigation activities have been generally intensified. A special central office program integrity staff has been established with counterparts in each of the Bureau's regional offices. Similar intensification has occurred with intermediaries and carriers, and specific instructions have been issued delineating their responsibilities in detecting, investigating and reporting instances of suspected program abuse and fraud.

2. There is continuing identification and investigation of doctors with deviant patterns of care and unusually high Medicare payments. Causes of suspected fraud are being referred to the Department of Justice for criminal prosecution. Questionable activities of less seriousness are being referred to State and county medical societies for appropriate action. Where overpayments have occurred, recovery action has been initiated.

3. Penalty notices have been added to Medicare claims forms stating that misrepresentation or falsifying essential information is subject to Federal criminal penalties.

4. Physician social security account numbers are being used to identify the total amount of program payments made to individual physicians. The use of the account numbers will also permit the Administration to identify at various times throughout the year payment amounts which seem to be unusual and require further investigation.

5. Regulations are being prepared providing for analysis of a provider's fiscal records prior to participation in the program. The analysis includes examinations of the adequacy of records for Medicare purposes, basis of fixed asset costs for which depreciation will be claimed, and financial stability.

F. STATE OPERATIONS

1. Survey report forms for home health agencies, extended care facilities, and laboratories have been revised to provide for additional documentation as part of the overall process to ensure closer compliance by providers of service with Medicare requirements. Instructions for preparing the revised survey forms are intended to clarify these requirements to State agency surveyors.

2. Certification procedures for ECF's with respect to restorative services have been expanded to provide for increased involvement by State agencies in instances where there is the possibility of improper utilization of services, e.g., inappropriate physical therapy.

3. Guidelines have been issued to State agencies to provide for strengthening the survey process in situations where problems have been noted, e.g., the extent to which a facility's medical staff bylaws and patient care policies are actually being adhered to; the effectiveness of committees for medical audit, utilization review, etc.; services performed unnecessarily or by unauthorized personnel.

4. With respect to the problem of inadequate pharmaceutical services in ECF's, State agencies have been asked to work toward clarifying and strengthening the activities of pharmacists who offer their services to ECF's on a contract basis.

5. State agencies have been asked to work toward fostering more involvement by non-governmental bodies in peer review in hospitals and ECF's, e.g., hospital reviews by medical and hospital associations.

Mr. VENEMAN. When we first came in, we had to make some major decisions with regard to costs in both the hospital field and the providers' field in the medicaid program, the title XIX program, which had the effect of reducing costs. The message that the President sent up on the health crisis, which was alluded to in the article, did in fact point out a very serious problem that exists. I think the committee staff report that came out from this committee also points out the problem. We are all consistent on the problem that exists and I think we are all trying to find the solutions. I think just to simply suggest solutions without really implementing them is somewhat deceptive.

Senator RIBICOFF. Well, what's being done to formulate a health policy? Basically, as I look at this, we have a sickness policy in the United States and not a health policy. When we look at medicare and medicaid, we look at what we have done in administering, and what we pay doctors or pay hospitals or pay nursing homes. We take the present system, whether it works or not, as the basis for discussion.

Now, should we not start worrying about in this plan and other plans, about the health of the American people? We have 23 departments and agencies involved in the health field. It is completely fragmented. You have one assistant secretary for health, without really much power or much ability to bring any pressure or bring any coordination with these 23 departments or agencies.

Now, I asked Dr. Shannon to comment on the answers I received from the 23 departments and agencies involved in the fragmented departments. This is what Dr. Shannon said.

It was his judgment that the health programs of this government touch on every problem of health care and delivery without dealing decisively with anyone.

Now, this is the basic problem we have in education, we have in health, we have in environment and all these programs. Now, what's being done today at HEW or in the executive branch to bring together the 23 departments which recommends the expenditure for 1971 of $20,602,000,000?

Mr. VENEMAN. I think there has been some action taken, Senator, with regard to the partnership for health, with regard to some of the requirements that we put in, both in Hill-Burton and also that we are recommending in our health cost effectiveness proposals that I suggested yesterday, that we make Federal payment contingent upon approval of plans by the planning agencies so that there is not duplication. There are various things that are being done in the Department. The suggestion that we go to a prospective rate for payment to hospitals—all of these things are efforts to attempt to alleviate some of the problems that occur in the total health field.

The 23 different agencies and departments that are involved probably can be expanded even further than that when you stop and recognize that it is even further fragmented when you get on the State levels and on the local levels. You are just talking about the problem that we have here.

Senator RIBICOFF. Federal involvement.

Mr. VENEMAN. I am certainly the first one to suggest, collectively, again—I do not have the instant answers—that we do have to get some coordination in this thing and we have to break through some of the traditional barriers that have existed among some of the constituent groups in the health field in order to alleviate this problem, which is not an easy task.

Senator RIBICOFF. Who do you think should have the basic responsibility over this $20 billion expenditure?

Mr. VENEMAN. I think it should be—does that include the Veterans' Administration? I think that all of us have a basic responsibility, those of us that have been placed with this public responsibility. I think it is also in HEW, but you have some other departments and programs that should be coordinated.

Senator RIBICOFF. That is the point I make. We are spending all this money and we have no coordination. We have duplication. We are concerned about the overall costs of health services and the effectiveness of health services. And we are not going to get it as long as we have 23 departments and agencies on the Federal level spending a total of $20,600 million. This is what we are trying to arrive at, now. I know this is not your responsibility because it has not been set up to give HEW the responsibility. But do you think that HEW or a Secretary of Health or an Under Secretary of Health should have some responsibility for coordination of all these programs?

Mr. VENEMAN. Well, I think we assume our share of the responsibility.

Senator RIBICOFF. You assume a share, yet you have no basic authority?

Mr. VENEMAN. We have authority to coordinate, which we are doing.

Senator RIBICOFF. Well, what are you doing with all these 23? I mean, the Department of Defense, Veterans' Administration, Department of Housing and Urban Development, Department of Agriculture, Agency for International Development, OEO, NASA, Atomic Energy Commission, Civil Service Commission, Department of Labor, Department of State, National Science Foundation, Department of Commerce—other agencies. I mean what authority, really, are you as Secretary exercising over any of these agencies?

Mr. VENEMAN. I am glad you asked that, Senator. I don't think the Secretary of HEW can coordinate any of it.

Senator RIBICOFF. That is right. So basically, we have a weakness here in the whole system that we are talking about. Is that it?

Mr. VENEMAN. Do you want to extend that? We can extend that list to the problems that we have in the health field. We have licensing problems within the State. There may be a variety of 50. We have constituent groups within the health manpower fields. We have problems trying to bring in paramedicals because it is going to offend somebody who feels that they are infringing upon their jurisdiction. We can go beyond just the departments of the Federal Government.

Senator RIBICOFF. But basically, as a Federal Government, all we can handle really is the Federal problems. There is nothing much we can do with the State.

Mr. VENEMAN. We cannot solve the Federal problems until we break some of these other barriers, Senator.

Senator RIBICOFF. But, Mr. Veneman, before talking about the cities and the States and the private agencies, we should have the responsibility to put our own house in order first. Or do you not agree?

Mr. VENEMAN. I would agree.

Senator RIBICOFF. Now, with all due credit to the committee's staff, they make the point that they believe that the majority of physicians provided medically necessary services. Frankly, I am not so sure how the staff came to this conclusion. Now, it seems to me that the Social Security Administration should have some data to confirm or deny the assertion—do you have any data to show that the doctors provided all the medically necessary services that are performed?

Mr. BALL. Senator Ribicoff, I interpreted that comment to mean not that they provided all medical services that were necessary, but that by and large, of the services that were provided, most of them were medically necessary.

Senator RIBICOFF. That is right.

Mr. BALL. I think that is a very hard judgment to make. The staff report also points out that the Government and, really, the health institutions of the country as a whole, are not organized at this time to conduct adequate medical audits and to determine exactly when there is a need for a medical service and make sure that only such services are given, I believe that the staff was probably making an assumption and one that I would agree with. I would assume that most of the services that are supplied were needed services. But I do not have the data to support it and we do not have the kind of medical audit that can really make sure that this is so.

Senator RIBICOFF. Is this not one of the problems, and the high cost we are experiencing in medicaid and medicare may not be just the charges alone, but may involve the fact that suppliers of services are charging for services that are not medically necessary.

Mr. BALL. Senator, I think that is absolutely correct, that probably the biggest problem in the control of costs as we look down the road, the biggest problem is to make sure that only services that are needed at a given level of intensity of care are the ones that are given.

Senator RIBICOFF. All right, now. Basically, what's the social security agency doing to make sure that the services that are given are the services that are necessary and that we are not paying large sums of money for services that are not necessary?

Mr. BALL. Well, there are a variety of activities, Senator, that I would be glad to mention to you. I would not, right at the beginning, want to give the impression that taken all together, they are an air-tight system. But some of the things that are done to move strongly in this direction—first of all, there are two requirements in the law. First, you will remember, the physician must certify the medical necessity for a service. For hospital care he has to certify—it was originally on the 14th day—that this individual still needed to be in that institution, then every seventh day thereafter. We have reduced that first certification to the 12th day. What that does is to be a reminder to the physician to look at his case and make sure he could not move the patient to a less expensive facility. I think the provision has merit.

The second device that is in the law is the utilization review committee, where a physician is subject to the judgment of his peers, particularly on these long-stay cases, as to whether the individual still needs to stay in the institution.

Then increasingly, we are in the position, as a result of the data collecting system to provide institutions and the carriers with comparable information about length of staff in different kinds of diagnoses so that they have a basis for review and a basis for comparison. You can say this institution is way out of line, for example.

Senator RIBICOFF. But along that line, the recent HEW audit agency report on performance of intermediaries and carriers notes "to all intents and purposes, the intermediaries had abdicated responsibilities for overall reviews and management of provides cost reports and audits."

That is quite a serious charge you make here against the intermediaries and carriers. What are you going to do about it?

Mr. BALL. Senator, that report is, first of all, related to quite a limited number of intermediaries and carriers, and secondly, is the result of audits that were conducted some time ago. We immediately moved in when we got that kind of information and are positive that the performance of those particular intermediaries carriers and intermediaries and carriers in general is significantly better in that respect than it was at the time of the audit.

Senator RIBICOFF. Now, HEW's audit agency has recently criticized your permitting hospitals to elect the combination method of payment, instead of requiring departmental costs. They said this method permits hospitals to pay for private room and delivery costs, both prohibited types of costs under the statute. GAO estimates that the combination method adds some four percent to hospital payments. Do you agree with the HE Waudit and GAO?

Mr. BALL. No, I do not, Senator. This is a very complicated matter, if you will indulge my going into it in some depth.

Senator RIBICOFF. By the way, what would 4 percent amount to in dollars? In other words, add some 4 percent to hospital payments. If the Audit Division of HEW and GAO are correct, what would four percent amount to a year?

Mr. BALL. This is hospital payments only?

Senator RIBICOFF. Hospital payments.

Mr. BALL. $200 million.

Senator RIBICOFF. You see, what we are trying to get at here is why we have all these costs, and we get into all these problems; here are HEW and GAO saying one thing; you say no. Why is HEW's audit agency and GAO wrong and why are you right?

Mr. BALL. It seems to me, Senator, the problem we are addressing ourselves to is not how to pay the hospitals of the country the least amount of money. The problem we are addressing ourselves to is how to pay them a fair amount of money for the services they are rendering to the medicare patient. I can think of other ways you can cut down $100 million or $200 million, but the result might be that people under Blue Cross or the private patient would have to pay even more.

What the statute tells us to do is to make sure that we are paying the full cost of the care for a medicare patient, but not for the care of anyone else. Now, in arriving at that—and here is where I will have to ask your indulgence to take a little time to explain the situation—in deciding upon reimbursement in the hospital area, one can't expect to go at it with the degree of precision that would absolutely make certain that only this part of a nurse's time and only that part of an administrator's time that was directed to medicare was included in the cost. It is quite clear that you have to arrive under the statute a approximations that are reasonable in the division of cost between medicare and nonmedicare patients. Most hospital employees and most other costs are involved with medicare and nonmedicare patients. When the program started, we allowed four different methods of allocation because there were many hopsitals and other institutions that were not set up on an accounting basis to handle a very sophisticated division. We have cut those methods down to two.

The issue really is, Senator, whether the degree of precision that comes from the departmental method, which the GAO and the HEW audit agency argues ought to be the exclusive method, is now one that is both fair for all institutions and which the great majority of institutions that are using the other method would be able immediately to use.

I would not want to argue that over time, it might not be desirable to get to a single method. But I would say that with the other actions that have been taken so far in reducing reimbursement to hospitals, there is great question in my mind whether it would be fair to them at this point to require them all to go to the so-called departmental sophisticated method.

The CHAIRMAN. Could the chairman interrupt just one moment, Senator Ribicoff?

I would like to state that I have been discussing these matters with other members of the committee, and it is rather obvious to me as chairman that these problems are going to require a great deal of intensive interrogation to obtain all the information that we want for this committee. I have in mind that we should name a special ad hoc subcommittee to continue this inquiry after each Senator has had an opportunity to ask the questions he had in mind of the witnesses.

I have in mind, Senator Ribicoff, that you would be asked to serve on that subcommittee because you have had a great deal of experience and you have given a lot of study to this medicare problem.

I would like to ask if I might impose on you for one moment, because I have to go to the floor and manage the revenue bill that is now over there. I might ask just one or two questions of the witnesses here.

There are certain areas where I think a lot of money could be saved. Well, just to give an example. If you will read the book, "The Citadel"—a book written by a doctor about the medical profession. He is no longer a doctor. He was practicing when he wrote that book. He thought there was a whole lot wrong with the medical profession. Of course, that book was a bestseller for many good reasons.

There is one episode in there where this doctor learned that it would really set him back in his practice if he told a malingerer that there was nothing wrong with him and if he didn't give him a slip saying he should be excused from work and paid for not working because he was ill. Of course, we do not have quite that problem, but I would assume that we have a lot situations where people come in and call for medical services and hospitalization that is not necessary.

Then there is another episode in that same book where the doctor, having learned how to make a lot of money practicing medicine, would give anybody who came in just some kind of medicine, whether it helped him or not. I recall one particular point, where he had a lot of people in the office and he charged back to his wife, who was supposed to be mixing a lot of medicines, and said, "Give me a bottle of that iron medicine for that patient." She said, "I am sorry, we are out." And he said, "Just give me anything."

You just hand a person a bottle of medicine and that makes him feel better and you charge him for that.

I asked one doctor friend of mine and he told me that in his opinion about 30 percent of medicine doctors give to patients is not necessary at all. He said these patients are going to get well—nature will take care of all that—but they perhaps feel better and it might have some psychological advantage to give them the medicine, even though it is not really necessary. That seems to me to be a big waste of money, for us to be paying for a totally unnecessary service, when a fellow is going to get well anyhow, and probably get well just as soon without the medication as with it.

An anesthetist told me the other day that he is well aware of the fact that a great number of operations for which he administers the anesthesia were totally unnecessary—need not have been performed at all.

Now, what do we have in this program to stop people from making money by doing those three things?

Mr. VENEMAN. I do not know how to legislate it, Senator.

The CHAIRMAN. Well, I know what the answer is in the VA program. We pay the doctor to be up there in the hospital and look after the patient. If the doctor thinks there is nothing wrong with the fellow, he says, "I am sorry, but I just can't find anything wrong with him." I have quarreled with the doctors about that sometimes. Sometimes I have found them in error. But it seems to me sometimes it is better to have it that way than to have an incentive to put the fellow on the operating table and slice him open performing an operation that is totally unnecessary.

It also seems to me that we ought to have some way—if you cannot provide a disincentive—at least not to have an incentive for a fellow to just hand out a bunch of pills and charge us a lot of money for a call and for a lot of medication when none of it has any therapeutic value whatever. Have your people worked out some solutions to where at least it would not be to a doctor's advantage to make money that way or to a hospital's advantage to make money through those methods?

Mr. BALL. Senator, I believe that this new way of reimbursing institutions has promise of some help in this area where, if the management and policymakers in the hospital can keep down their costs, in general, they will share a part of the savings of doing that. I think that has some merit.

But other than that, I would say the approach has been largely to try to control it rather than provide incentives, and it is my own personal thought that it might be highly desirable to build into our new incentive approach to institutions an actual plus for institutions, for example, to shorten the length of stay. If they could prove that their length of stay had gone down and that they were working to control the situation, reducing costs, that maybe you could give them more than just what the formula would have brought out and that would help to keep down the length of stay in those institutions. This is what they are doing in New York. This is one of the things your staff, I believe, was interested in in the New York experiment as well.

The CHAIRMAN. I can recall one time when I went to see Dr. Calver when he was still the attending physician at the Capitol. I thought something was the matter; that perhaps I was getting ready to have a heart attack. After he looked me over, he said there is not a thing wrong with you but a little gas on the stomach and probably it would help if you just took a deep breath. Now, he had no incentive at all to encourage me to think that there was something the matter with me. So I went on my way without any medication. I think he might have given me a little baking soda or something to take at that point.

Now, I would hope that we would at least not just fritter away fantastic amounts of money for those kinds of things.

For example; here is a statement by Dr. Edwin L. Crosby, M.D., head of the American Hospital Association. He said: "Personally, I don't think utilization review has ever worked."

It would seem to me that we ought to have some sort of a program somewhere for people to pass on how long these people ought to be in the hospital, and somebody who would not make any money, who would at least have an incentive to get them out of the hospital instead of keeping them in.

Mr. VENEMAN. Senator, when we talk about those things, we are really talking about utilization review. Let's face the basic fact of life: that to qualify for either one of the programs, it is a decision that is made by a physician. To go to a facility, it is a decision made by a physician. How long you stay in the facility is a decision that is made by the medical group. Whether or not you get drugs is a decision made by the medical profession.

Are we, as administrators, or you as legislators, going to overrule that? I think you have to have some kind of utilization review by someone in that particular peer group.

Now, whether or not it will work, I think what we really need is some good faith in the profession among people in this country.

The CHAIRMAN. There are certain groups, Mr. Secretary, who get together; one of them being perhaps a surgeon, another a general practitioner, another a specialist in one category or another, enough doctors to operate a clinic and provide necessary services. These fellows may just look after the health of all the people working in a single large plant—perhaps their wives and chilldren, too. They have no incentive at all to provide or prescribe a lot of drugs which are of no therapeutic value or to be keeping patients in hospital beds when they no longer need hospital care—things of that sort. Now, approaches like that have been known to work to provide low-cost medical care. I am just trying to consider how we might have some incentives to keep the costs down rather than run them up.

Mr. VENEMAN. I think it has been done and we have had some experiments that have done it. I alluded to one of the programs in California. We have also seen costs reduced by going to the group practice concept, which is the Kaiser Foundation. I am more familiar with the California program. These are incentives that I think you are directing yourself toward. You still, you know, you get the basic factor there and you have to have confidence and faith in the medical profession to even make those work.

Senator RIBICOFF. Will you yield for a second?

Is the administration ready to take on the AMA on prepayment and preventive medicine and group practice and the Kaiser system? I think we are getting down to it.

Mr. VENEMAN. I don't think we are in conflict.

Senator RIBICOFF. I didn't agree with the chairman yesterday when he said it is up to you to take on the AMA and the doctors; I think it is as much our responsibility. But if the administration truckles with the AMA as it did on Dr. Knowles, one of the most able men in the country, to bring—and you truckle to the AMA, you will never solve this problem, because the problem is a lot bigger than the cheap costs.

Mr. VENEMAN. I will not concede this was truckling to the AMA.

Senator RIBICOFF. I think it did in the Knowles' appointment.

The CHAIRMAN. I would like to correct the record on that statement I made yesterday. I did not make it to evade responsibility. I think we will take on whoever we have to take on to cut a $200 billion prospective tax increase.

Mr. VENEMAN. Let me say I do not think we are in that posture with the medical profession, whether it is the organized AMA or any other organization of the medical profession. I think the AMA itself suggested there had to be alternatives. In its convention in New York, I think they made the suggestion that we use the public dollar for some kind of prepaid insurance for the low-income groups. So I do not think there would be a confrontation, so to speak.

The CHAIRMAN. I want to thank the Senator and I have to excuse myself to look after that revenue bill we have on the floor right now. I would urge you to continue.

Thank you.

Senator RIBICOFF. We are committed to medicare and medicaid, and there is not a Senator who wants to eliminate social security, no matter how he felt before it was adopted, nobody is going to advocate today that it be repealed. Now the problem is how are we going to make it work? How are we going to make it work to bring better health care to the people of this country at a cost that won't break the taxpayer and won't break the trust fund? This is the question we are trying to address ourselves to.

Bob, when I was interrupted by the chairman, you started to comment on the so-called combination method. The audit report out of HEW is dated April 5 and it contains this line:

> Most importantly, the combination method permits a hospital to be reimbursed for costs applicable to private room and accommodations and to delivery rooms. Each of these types of costs appears to be specifically excluded from reasonable costs as defined in the medicare law.

It goes on to point out that to take your formula, your system, into a large hospital could add to the costs of medicare that medicare pays out to the hospital about a million a year. You estimate $200 million a year overall. If there are these loopholes in your reimbursement formulas you can sense the trouble that Bob Myers, your actuary, is in, trying to estimate the costs. My feeling is when Mr. Myers first sat down when we were formulating medicare and working on your actuarial programs, you figured everybody was going to be honest. Now we find ourselves that everybody is dishonest all the way down the line in the whole medicare program. I do not mean every individual, every hospital, every carrier, but basically, we find a situation that has developed that everybody has their hand in that bag to get as much as they can from the trust fund.

Now, what are we going to do to make sure that we do not throw away the money on regulations that are not proper. Whom do you go by, Mr. Veneman? Social Security or the Office of Assistant Secretary, Comptroller?

Now, here is an audit report of February 5 on HEW which says the social security system is wrong. And Bob Ball comes in and says they are right. Who do you take when you have a conflict like this?

Mr. VENEMAN. The audit is done independently, Senator, as I am sure you are aware. When the audit report is filed, copies are sent to the Secretary and to the Commissioner. They in turn take it under advisement; point by point, and I think that is a stage that they are in at this present time on this present audit report.

Now, recommendations by Mr. Mallen, the auditor, are subject to discussion and deliberation also, to determine who is right.

Senator RIBICOFF. In other words, is it possible that when social security does not agree with the audit, you have a situation where the Secretary makes the decision who is right?

Mr. VENEMAN. That is right

Those are the tough ones.

Mr. BALL. We are at the stage now where we have made comments on this disagreeing with it.

Just as a factual matter, could I clear up this $200 million? You asked me what 4 percent of hospital costs would be and that is the answer. The General Accounting Office said it would be 4 percent. We did not agree with that. It is not based on scientific sampling, this is their guess as to what it would be.

Senator RIBICOFF. I would say this, as I watched this develop, if I may have the attention of the Senator from Delaware for a second, because I think in a previous discussion he and I have talked about the necessity of having an independent inspector general in HEW to oversee the administration of this entire program. And furthermore, it is my feeling that the GAO, which is the arm of the Congress, and we are in the process in my subcommittee of enlarging the function and authority of GAO, has a very big role to play to make sure that Congress has the responsibility not to let this go out of hand and to see that GAO also has a definite role to play to ride herd on these programs. And I would hope that the Senator from Delaware and myself, whatever amendments that we formulate in medicare and medicaid will have an independent inspector general at HEW to oversee medicare and medicaid.

Senator WILLIAMS. If the Senator will yield, I would say I concur completely on that point and we are going to try to do it.

Senator RIBICOFF. May I say that the GAO estimate of 4 percent is not a guess but based on samplings they have made in various hospitals about the country.

Mr. BALL. I do not dispute that. They were in hospitals about the country, Senator. I am sorry, but I would dispute that this was a sample that you could project to the universe on a scientific basis.

In any event, I do not think the main point that you were questioning about was related to this particular estimate. I think it was raising the question of whether hospitals should continue to have the opportunity to be reimbursed on this combination method. I was about to explain first what the two methods are that hospitals are now allowed to have. First, there is the so-called departmental method which the auditors believe should become the only one. But the departmental method is also an approximation. We cannot guarantee that there will not be costs in that that should not be in there. Under the departmental method you take every revenue-producing department of a hospital—X-ray, laboratory, routine nursing, and general board and room, and so on—each revenue-producing department. You distribute to those revenue-producing departments overhead, administrative costs in proportionate shares, building, depreciation, and so on, so you get the cost of operating that revenue-producing department on an accounting basis. Then what the method does is to say that the medicare share of those costs are the ratio of the charges to the medicare patient to the charges to all patients. This uses the charge structure of the hospital. The ratio of the charge to medicare patients to the charges for all patients produces a fraction department by department which when applied to the allowed costs incurred determines the medicare share.

Now, the combination method that is being objected to is a rougher approach, but not necessarily, in my opinion, one which, in any given situation, would be always more or less accurate, than the department method even though rough. In the combination method, you take all of the routine costs, room and board and nursing, and you put them together. You take the average of these costs per day for all patients and use that average to estimate the medicare share. Then you lump all the costs of the ancillary services together and apply to them the proportion of medicare charges to all patient charges for ancillary services. As you can see, much less accounting

is required; it is a much simpler system because of this grouping.

And it is true, there are pluses and minuses in this, because you have all ancillary services in it. You would have elements in the base to which you apply your fraction that you would not directly want to reimburse.

Senator RIBICOFF. How do you handle a situation that is prevalent among many hospitals that if the hospital is filled and their patient population is high for a certain operation, they will allow their patients to stay for 5 days. But if the hospital occupancy is down low, they will keep that patient 7 or 8 days. Now, how do you find that out?

Mr. BALL. There are only three devices we have for that and I already mentioned two of them. One is the physician certification, which is at least a reminder to him to check this case and find out whether or not he could remove the patient. The utilization review committee is the major innovation in the medicare program, Senator, that you will remember was put into the program for this purpose and was a pretty new thing. A few hospitals had tried it more or less experimentally. This is now a requirement, that you have an organized medical group in the hospital that reviews the long-term stay cases of the patients—not their own patients, but others. Now, they also have to review, Senator, not just the long-term, but the whole utilizaion pattern in the hospital.

Senator RIBICOFF. But it is broken down. The doctors play with the hospitals, the hospitals play with the doctor. It is a pretty closed-in group. When you are dealing with a hospital staff and the hospital administrator, you have an in group there who are taking care of themselves. Now, this has been indicated by the staff report, which has indicated some abuses that if this were working or they were performing their proper function would not take place. Yet it has taken place.

Mr. BALL. Senator, I do not agree. This is so difficult an area that you are going to have to use a variety of devices and we ought not to give up on anything that does work partly. The utilization review committee, in the major hospitals, at least, has made a good contribution. I do not agree with Dr. Crosby—if that is an actual quotation that was read into the record earlier. They are by no means a failure, and on the other hand, by no means the whole answer.

One very good thing that I think is going to be a real aid in this area is what I would call statistical monitoring. Out of medicare, like you have never had in any insurance program before, we are collecting data by diagnosis, by length of stay, hospital by hospital, that can be used by the carriers in their review to say to the hospital, you are way out of line. And that is just getting underway, we are just getting in the position now to do it. That is the third thing.

Senator RIBICOFF. Out of consideration for my colleagues, I will suspend. When they are through, I will have some more questions. I want to apologize for taking so much time of the committee. But, Mr. Chairman, after Senator Jordan and Senator Byrd make inquiry, I would like to have another opportunity.

The CHAIRMAN. I appreciate the Senator's problems. The questions he is asking are fine questions.

Senator Jordan.

Senator JORDAN. Mr. Secretary, I think in your statement yesterday, you said medicare and medicaid had been superimposed upon a health

system that was already pretty well taxed. Suddenly, in 1966, we have made services available to 20 million additional people, of whom 12 million have availed themselves of the services. That in itself would put a present pressure on all services to escalate their prices, would it not?

Mr. VENEMAN. Well, Senator, I think I made reference yeterday in the numbers to 20 million people that were covered under medicare and 12 million that were covered under title 19 the medicaid program. Those would not necessarily be all new cases. Many of those that were already covered, were being provided health care, either through the county hospital or——

Senator JORDAN. Many of them were?

Mr. VENEMAN. Right.

Senator JORDAN. What percent of them would, would you think?

Mr. VENEMAN. Mr. Ball, how much did the caseload increase when medicare went into effect?

Mr. BALL. About 20 percent of total patient-days among the aged.

Senator JORDAN. Many of those indigents were already receiving hospital care?

Mr. VENEMAN. Right.

I speak to the other part of your summary, Senator, we did enact these programs and impose them upon the existing health system that was in this country. We made some modifications, because our public hospitals or county hospitals, instead of institutions that took care of the needy for nothing, suddenly became reimbursed for it.

Senator JORDAN. Yes.

I think in your statement or someone's statement, the point was made that the government at all levels—Federal, State, and local—now purchase 37 percent of all health care services and over 50 percent of the hospital care.

Mr. VENEMAN. That is right.

Senator JORDAN. Yet it is still essentially a private health system in this country.

Mr. VENEMAN. For the most part, it is a private health system.

Senator JORDAN. Have any studies been made as to the deficiencies that exist in health care systems as to doctors needed, trained nurses needed, hospital facilities needed?

Mr. VENEMAN. Yes.

There have been many studies on that. I think the figure, the projected need for physicians in 1975—I believe it was changed—is something like 50,000 additional physicians. I do not have the time frame, but——

Senator JORDAN. Will you get that for us? In manpower need for additional doctors that are needed, for additional trained nurses that are needed, then for capital expenditures that are needed, for hospitals, and for nursing.

Mr. VENEMAN. We have all that material. Those are all figures that are available, Senator.

Senator JORDAN. I wish you would.

Mr. VENEMAN. Let me point out a problem. It is not only the need for numbers.

Mrs. Hanft can get it. She will have it for the record.

Senator JORDAN. Supply it for the record, please.

(The information was received and appears as Appendix A, p. 153.)

Mr. VENEMAN. Let me point out a problem, it is not only numbers, it is a need for distribution. I think Senator Ribicoff touched upon a significant point. We can put all the dollars in the world into more money for facilities, but if they are not going into the right places, they are really not going to affect the health system of this country. A constructed hospital room is for the most part a filled hospital room. We might as well face that.

Senator JORDAN. What program has the administration for suggesting ways to fill the requirements, the deficiencies in doctors, nurses, facilities, and to give it proper distribution? Are there any incentive plans?

Mr. VENEMAN. Right.

In most of the programs we have proposed, we have called for approval by regional medical councils before a facility is constructed and before Federal participation is available. This is one of the—I think it is in one of the bills that we have proposed now for payment under medicare, that the facility would have to be approved by the regional planning council. That is it can't be out of conformity—which is saying it the other way—if a planning decision has been made.

Senator JORDAN. Yes.

Mr. VENEMAN. But as far as the manpower needs, of course, we have tried to increase the output of any existing institutions. We anticipate, we hope there will be at least 8,000 medical students admitted.

Senator JORDAN. Will this call for construction of more medical hospitals, the whole proposition of purchasing new equipment and acquiring additional training facilities for more doctors and nurses before we finally meet this need?

Mr. VENEMAN. Yes.

Mrs. Hanft is referring specifically to the reduction in Hill-Burton. But I think as far as the facilities and the construction of training centers is concerned, those are all projected as priority items within the budget.

You see, what we are trying to do in the Hill-Burton funds again is in the original bill that was proposed—I think it is now before a committee here in the Senate—was to suggest that we go to a guaranteed loan program for acute bed facilities and that we use the grant powers, the grant funds for outpatient facilities and extended care facilities, so that we are really putting the dollars in the lower cost facilities.

You know, I think this is the direction we have to go.

Senator JORDAN. Yes; we met with some Governors this morning. One of them raised the point that frequently a patient is assigned to a hospital bed for $50 a day when he might be just as well off in a nursing home.

Mr. VENEMAN. If it were available.

Senator JORDAN. And this is one point they made.

So much for the facility end of it. What are we doing with respect to scholarships for personnel, for professional people?

Mr. VENEMAN. I will have to submit that, Senator.

Senator JORDAN. Supply it for the record, please.

(The information requested follows:)

## HEALTH MANPOWER

*To carry out, to the extent not otherwise provided, sections, 301, 306, 309, 311, title VII, and title VIII of the Public Health Service Act, $242,234,000: Provided, That no institutional grants shall be made to schools of veterinary medicine under section 771 of said Act.*

*Loans, grants, and payments for the next succeeding fiscal year: For making, after March 31 of the current fiscal year, loans, grants and payments under section 306, parts C, F, and G of title VII, and parts B and D of title VIII of the Public Health Service Act for the first quarter of the next succeeding fiscal year, such sums as maybe necessary, and obligations incurred and expenditures made hereunder shall be charged to the appropriation for that purpose for such fiscal year: Provided, That such payments pursuant to this paragraph may not exceed 50 per centum of the amounts authorized in section 306, parts C and G of title VII and part B of title VIII for these purposes for the next succeeding fiscal year. (Additional authorizing legislation to be proposed.)*

NOTE.—The regular appropriation for this account for 1970 had not been enacted at the time this budget was printed. A temporary continuing appropriation is in effect for the period from July 1 to January 30. A current estimate of the amount of the annual budget authority required is shown in the budget schedules.

PROGRAM AND FINANCING
(IN THOUSANDS OF DOLLARS)

| | 1969 actual | 1970 estimate | 1971 estimate |
|---|---|---|---|
| Program by activities: | | | |
| 1. Institutional support: | | | |
| (a) Medical, dental, and related | 56,288 | 101,400 | 113,650 |
| (b) Nursing | 5,657 | 7,000 | 11,000 |
| (c) Public health | 8,429 | 9,471 | 9,071 |
| (d) Allied health professions | 8,598 | 10,988 | 14,245 |
| 2. Student assistance: | | | |
| (a) Traineeships | 19,381 | 30,027 | 23,220 |
| (b) Scholarships and opportunity grants | 20,071 | 34,857 | 37,000 |
| (c) Loans | 30,602 | 22,473 | 21,610 |
| 3. Manpower requirements and utilization: | | | |
| (a) Grants | 3,895 | 4,082 | 4,082 |
| (b) Direct operations | 9,046 | 11,003 | 12,508 |
| 4. Program direction andtmanagement services | 1,297 | 1,668 | 1,798 |
| Total program costs, funded [1] | 163,263 | 232,969 | 248,184 |
| Change in selected resources [2] | 23,420 | | |
| Total obligations | 186,683 | 232,969 | 248,184 |
| Financing: | | | |
| Unobligated balance available, start of year | −158 | −11,421 | |
| Unobligated balance available, end of year | 11,421 | | |
| Unobligated balance lapsing | 876 | 25 | |
| Appropriation available from subsequent year | −61,923 | −71,160 | −77,110 |
| Appropriation available in prior year | 32,745 | 61,923 | 71,160 |
| Budget authority | 169,643 | 212,336 | 242,234 |
| Budget authority: | | | |
| Appropriation | 172,176 | 218,021 | 242,234 |
| Transferred to other accounts | −2,533 | −6,581 | |
| Transferred from other accounts | | 896 | |
| Appropriation (adjusted) | 169,643 | 212,336 | 242,234 |
| Relation of obligations to outlays: | | | |
| Obligations incurred, net | 186,683 | 232,969 | 248,184 |
| Obligated balance, start of year | 107,047 | 178,551 | 265,989 |
| Obligated balance, end of year | −178,551 | −265,989 | −305,173 |
| Adjustments in expired accounts | −666 | | |
| Outlays | 114,512 | 145,531 | 209,000 |

[1] Includes capital outlay as follows: 1969, $25,000; 1970, $43,000; 1971, $55,000.
[2] Selected resources as of June 30 are as follows: Unpaid undelivered orders, 1968, $27,064,000; 1969, $3,644,000; 1970, $3,644,000; 1971, $3,644,000.

NOTES

Includes $896,000 in 1971 for activities previously financed from:

| | 1969 | 1970 |
|---|---|---|
| National Library of Medicine, NIH | $10 | $10 |
| Office of the Director, NIH | 14 | 14 |
| Research Resources, NIH | 888 | 872 |

Excludes $137,000 in 1971 for activities transferred to "Departmental management: Office of the Director, NIH," and "Office of the Administrator, HSMHA," 1969, $90,000; 1970, $129,000.

1. *Institutional support.*—The principal agents of this activity are grant programs directed toward enhancing the educational experience of students entering the health and allied health professions resulting ultimately in better health service to the Nation. Schools use these funds to support and enlarge faculty staffs, expand library holdings, modify existing and add new curriculums, modernize teaching laboratories, and purchase educational aids and equipment. A substantial increase is requested in 1971 for these activities, of which $5 million is for the Physician Augmentation Program initiated in 1970. The support for nursing schools and other agencies in 1971 is for project grants provided in the Health Manpower Act of 1968.

Number of institutions receiving basic support and improvement funds:

| | 1969 actual | 1970 estimate | 1971 estimate |
|---|---|---|---|
| Medical | 107 | 107 | 109 |
| Dental | 51 | 52 | 53 |
| Nursing | 479 | 130 | 187 |
| Public Health | 15 | 16 | 17 |
| Pharmacy | | 70 | 74 |
| Veterinary medicine | | 18 | |
| Other health related | 15 | 16 | 17 |
| Allied health | 258 | 308 | 330 |

Number of persons trained:

Improving the utilization of limited resources of health professionals requires appraisal of the various types of personnel needed and the identification of new categories of allied health professionals and technicians for more effective team practice. In 1971, allied health new methods grants will support an additional 44 projects for a total of 60 projects to develop curriculums to produce personnel requiring newly identified skills.

2. *Student assistance.*—Student assistance is of two kinds: graduate and specialized, comprising traineeships and research fellowships; and undergraduate, comprising scholarships and student loans. Research fellowships support candidates at the predoctoral and postdoctoral levels for research training in special fields related to studies for improving nursing care. Traineeships support the graduate and specialized preparation of teachers needed to expand and improve curriculum offerings, and the advanced training needed by supervisors, administrators, and other specialists in nursing, public health, and the allied health professions. Allied health short-term training will be provided for the first time in 1971, to an estimated 2,000 persons.

| | 1969 actual | 1970 estimate | 1971 estimate |
|---|---|---|---|
| Nursing fellowships | 140 | 140 | 140 |
| Nurse traineeships | 4,500 | 4,500 | 4,500 |
| Public health traineeships | 6,284 | 7,250 | 6,920 |
| Allied health traineeships | 400 | 400 | 2,000 |

Nursing and health professions scholarships enable deserving students from low-income families to pursue their education. Students of veterinary medicine became eligible for scholarships for the first time in 1970. Schools make scholar-

ship awards to students who, in the judgment of the school, have an exceptional financial need. The student loan programs for the health professions, including nurses, are also designed to help provide an adequate supply of health manpower and to assure that the needed supply of health professions and nursing manpower is drawn from the most capable individuals, but particularly to assure that students from low-income facilies can enroll for health professions training. The 1971 program, as did the program in 1970, concentrates on making these loans to students from lower income families. Loans from the revolving funds are not planned for 1971.

Number of recipients (including student loan revolving fund recipients) :

| | 1969 actual | 1970 estimate | 1971 estimate |
|---|---|---|---|
| Scholarships: | | | |
| Medical | 6,582 | 8,556 | 8,071 |
| Dental | 3,135 | 3,694 | 3,402 |
| Nursing | 12,370 | 13,319 | 17,000 |
| Other health related | 4,435 | 5,898 | 6,193 |
| Student loans: | | | |
| Medical | 13,858 | 7,405 | 5,478 |
| Dental | 6,375 | 2,910 | 2,163 |
| Nursing | 27,000 | 17,544 | 13,728 |
| Other health related | 4,772 | 3,740 | 2,861 |

Pursuant to authority contained in the appropriation language, under certain conditions sums may be obligated for student assistance programs in advance of their being appropriated in order to facilitate the enrollment of students in health profession and related schools. The timing of these obligations, which is reflected in the schedules, does not affect the actual training of the students which is by academic year as shown in the two preceding tables. Increases in appropriations for allied health traineeships and for nurse scholarships are requested.

3. *Manpower requirements and utilization.*—(a) *Grants.*—Research grants support studies in the areas of physician methods and techniques, continuing physician education, effective use of health manpower, nursing care, and methods to deliver nursing care to patients. Research training grants enable institutions to establish training programs in fields where there is unusual demand for researchers having skills in nursing specialities and in the field of educational research.

(b) *Direct operations.*—Funds are provided for programs to assess requirements, availability, and quality of health discipline education; provide professional guidance and leadership to meet the goals of nursing care by means of research, consultation, application of research findings and administration of grants; develop, administer, and support grant and operational programs to increase the supply and improve the education, utilization, and effectiveness of manpower in the health occupations; for servicing training and construction grants, student loans, scholarships, and operational programs for training of personnel. The budget for 1971 includes increases for services and technical assistance related to expanded grant programs continuing education and other physician manpower programs; nurse recruitment and refresher training contracts; and initiation of a program to encourage returning veterans to enter the health field.

4. *Program direction and management services.*—The Bureau of Health Professions Education and Manpower Training provides a national focus for health manpower activities. The Bureau guides and supports health manpower programs, designs proposals to meet needs for new or revised health manpower programs, coordinates research and program reporting activities, and provides technical guidance and coordination to Bureau activities.

OBJECT CLASSIFICATION (IN THOUSANDS OF DOLLARS)

| | 1969 actual | 1970 estimate | 1971 estimate |
|---|---|---|---|
| Personnel compensation: | | | |
| Permanent positions—civilian | 5,113 | 6,304 | 6,576 |
| Positions other than permanent | 135 | 397 | 397 |
| Other personnel compensation | 32 | 56 | 57 |
| Total personnel compensation | 5,280 | 6,757 | 7,030 |
| Personnel benefits: Civilian employees | 485 | 630 | 647 |
| Travel and transportation of persons | 503 | 567 | 592 |
| Transportation of things | 16 | 32 | 34 |
| Rent, communications, and utilities | 258 | 266 | 282 |
| Printing and reproduction | 138 | 152 | 167 |
| Other services | 4,540 | 4,137 | 5,404 |
| Supplies and materials | 84 | 87 | 93 |
| Equipment | 61 | 43 | 57 |
| Investments and loans | 31,002 | 25,473 | 24,610 |
| Grants, subsidies, and contributions | 144,316 | 194,825 | 209,268 |
| Total obligations | 186,683 | 232,969 | 248,184 |

PERSONNEL SUMMARY

| | | | |
|---|---|---|---|
| Total number of permanent positions | 449 | 498 | 517 |
| Full-time equivalent of other positions | 17 | 49 | 49 |
| Average number of all employees | 440 | 531 | 546 |
| Average GS grade | 8.2 | 8.3 | 8.4 |
| Average GS salary | $10,089 | $11,315 | $11,503 |
| Average salary of ungraded positions | $7,972 | $8,481 | $8,567 |

## Dental Health

*To carry out, to the extent not otherwise provided, sections 301 and 311 of the Public Health Service Act, and for training grants under section 422 of the Act, $10,954,000.*

NOTE.—The regular appropriation for this account for 1970 had not been enacted at the time this budget was printed. A temporary continuing appropriation is in effect for the period from July 1 to January 30. A current estimate of the amount of the annual budget authority required is shown in the budget schedules.

PROGRAM AND FINANCING (IN THOUSANDS OF DOLLARS)

| | 1969 actual | 1970 estimate | 1971 estimate |
|---|---|---|---|
| Program by activities: | | | |
| 1. Grants: | | | |
| (a) Research | 651 | 1,259 | 1,259 |
| (b) Fellowships | 63 | 150 | 150 |
| (c) Training | 1 | 4,301 | 4,301 |
| 2. Direct operations | 2,808 | 5,114 | 5,244 |
| Total program costs, funded [1] | 3,523 | 10,824 | 10,954 |
| Change in selected resources [2] | 5,266 | | |
| Total obligations | 8,789 | 10,824 | 10,954 |
| Financing: Unobligated balance lapsing | 1,435 | 63 | |
| Budget authority (appropriation) | 10,224 | 10,887 | 10,954 |

[1] Includes capital outlay as follows: 1969, $24,000; 1970, $23,000; 1971, $23,000.
[2] Selected resources as of June 30 are as follows: Unpaid undelivered orders, 1968, 0; 1969, $5,266,000; 1970, $5,266,000; 1971, $5,266,000.

Senator JORDAN. Mr. Secretary, you have said in your statement:

> We have made tremendous strides in the search for more definitive medical procedures, but we have not yet succeeded in evolving an efficient and equal system for the delivery of useable knowledge to those who can benefit from its applications.

It seems to me that our own staff pointed up what is essentially wrong with it when they said that under present law, the institutional suppliers of covered health services under medicare and medicaid in large part, also, are paid whatever it costs them to provide the services and physicians billed under medicare are essentially paid at random. Now, we get tremendous cost overruns in defense procurement. Cost overruns in medicare and medicaid have topped all defense costs. Would you not suspect that these are the underlying cause: No. 1, the shortage of existing personnel and facilities, and No. 2, the payment of costs at about whatever they say the bill ought to be?

Mr. VENEMAN. Well, physicians are paid on the basis of usual and customary—reasonable fees—in medicare. But we have also, in the medicaid program, as I have indicated earlier today in testimony, we have put a limitation on it, last year, at the January 1969 level and at the 75th percentile, which is the proposal we recommended in the testimony yesterday as it relates to medicare.

Senator JORDAN. Yes.

Mr. VENEMAN. Now, also, in order to try to attack that particular problem, we have made the recommendation for prospective rate setting for facility care.

Now, presently, the physician bills that have come into the carriers—they are not just paid, you know. It is not a carte blanche operation. About 30 percent of the claims involving physician bills that come in that are submitted are rejected; I mean reduced in at least one item.

Senator JORDAN. As being too high?

Mr. VENEMAN. Being too high, correct. So the carrier does serve its function of monitoring the charges that are made by the providers of services.

Senator JORDAN. How many hospital bills have been refused for being too high?

Mr. VENEMAN. I will let Mr. Ball speak to that. It is a cost reimbursement program.

Mr. BALL. We do not pay the bill that is submitted, Senator Jordan. In the hospital service program as I was discussing with Senator Ribicoff, there are alternative measures for finding out what the costs of supplying the services are and then those are paid. Now, there are items of service that are rejected as not being covered by the program, such as an operation that is entirely for cosmetic purposes or a luxury item like a telephone in a room, something of that kind. That would be rejected as not covered. But what we are after is to determine the cost of service.

Senator JORDAN. It seems to me that breaks itself down into two general fields, one having to do with the physical properties and operation of the plant and so on, with which all of us are familiar in other lines of business, and the other having to do with professional judgment of a doctor as to what is required. In the one area, I think we

can make great improvement, but I doubt if we could ever legislate what a doctor should prescribe when he diagnoses the ills of a patient.

Mr. VENEMAN. That is a difficult area.

Senator JORDAN. That is a tough one, isn't it? And that is the one with which we are most concerned.

Mr. VENEMAN. It is very difficult to write into law and I do not know how it can be done. I did serve as chairman of a study group studying the title XIX question before I came back here, and this is essentially the problem the committee is listening to now. How do you write into law how many days a person should stay in the hospital? That has to be a medical judgment. Or what condition he is in? That has to be a medical judgment and we have to grapple with it. You have to depend on the judgment of people that are professionals in that particular area. That is why the utilization review, I think, is an essential element.

Senator JORDAN. Our staff in their studies have found in many instances that medicare patients and medicaid patients have a much longer stay in hospitals for the same ailment than their private patients. How do you get at that kind of thing?

Mr. VENEMAN. I have not seen it.

Mr. BALL. Senator Jordan, I am not familiar with their making a finding like that, medicare encompasses, really, the entire aged population. They do have much longer stays than younger people. They average up around 13 days as compared with an average stay for a younger person of perhaps 7 days. But that is the nature of the ailment and the age factor; that has always been true.

Senator JORDAN. Are you testifying now that to your knowledge, there is no difference in the time spent by people under medicare or medicaid and people who pay their own bills of the same age category?

Mr. BALL. That is correct, Senator. I am talking about medicare experience. I have not studied medicaid. But before medicare, the average stay before it went into effect for people 65 or over as far as we can determine is about the same as today.

Senator ANDERSON. And I think you had better check your answer carefully, because the staff has a different viewpoint, I believe.

Mr. VENEMAN. Does the staff also go into the question of medicaid patients?

Senator WILLIAMS. Yes.

Mr. VENEMAN. Does a maternity patient under a public program stay longer in the hospital than one under private care? Do you have evidence of that?

Senator WILLIAMS. Could be. But if the Senator will yield, another point I am interested in is this question of material care under the medicaid program; surely you know what the medicaid program has been doing, too, don't you? Has that not been called to your attention, too?

Mr. BALL. Senator, I have not been studying the length of stay experience under medicaid. To tell you the truth, I have enough to do with the cash benefit, social security, and the medicare programs, which are my responsibility.

Senator WILLIAMS. That is true. I do not want to interfere.

Mr. VENEMAN. Senator, I think that would depend upon the State. The medicaid program is really 50 programs, 48, I guess. Two States still are not in.

Senator WILLIAMS. That is true, but one of the problems that gave us so much concern when we first got into this was the lack of communication between the administrators of medicare and medicaid. Apparently, they were not conversing, not on a talking basis. I hope you have developed your relationship so you can at least associate with each other and each can find out what the other is doing.

Mr. VENEMAN. They are communicating through me, Senator.

Senator JORDAN. Mr. Secretary, yesterday you said, and I read from your statement, in the 4 years since these programs started, we have learned rather traumatically that the ability to finance care does not guarantee the availability, adequacy, or reasonable cost of care; that the health system has severe problems in the supply and distribution of facilities, manpower, and services, and in the organization and delivery of these services, and that the payment and benefit structures, both public and private, placed barriers against efficiency, economy, and productivity.

What barriers were you talking about? It is on page 13?

Mr. VENEMAN. One of the barriers that we have as far as some of the programs are concerned is that in many cases, because of the type of payment system that we have, it lends itself to higher cost institutional care versus preventive care where payment will be made in a facility as opposed to the doctor's office call. There are a variety of things depending upon the locality and upon the availability of the facilities and the type of services that are available that reduce the effectiveness of health services.

Senator JORDAN. Are there any areas of removing those barriers or improving the system that call for legislation as against regulation, the ability to do it administratively?

Mr. VENEMAN. I think so. I think again, we are going to have to have legislation as far as the reimbursement formulas are concerned, prospective versus retroactive, reimbursement. I think we probably have to have— I don't know if we need legislation for it, but we have to expand, I think, some of the demonstration programs, some of the experimental programs, prepayment and new programs, to try to alleviate some of these barriers. You are dealing with literally thousands of providers individually.

Senator JORDAN. Some of these fees can be determined prospectively instead of retroactively and that is the direction you are moving in now?

Mr. VENEMAN. For the facilities. That is where it can be done.

Senator JORDAN. Thank you.

Thank you, Mr. Chairman.

Senator ANDERSON. Senator Byrd.

Senator BYRD. Thank you, Mr. Chairman.

Mr. Veneman, I have always felt that a company, to be a progressive company, needed to be financially sound and I feel the same way about government, that in the long run, the Government, if it is going to be progressive, must be financially sound and that applies to the programs it has. If we have these programs we want them to succeed.

I am concerned about the citizens who need health care and I am concerned about the taxpayers. Now, is it accurate to say that the medicare and medicaid programs are bankrupt?

Mr. VENEMAN. No.

Senator BYRD. That is not correct?

Mr. VENEMAN. No.

Senator BYRD. Now, as I understand it, HEW only a few months ago estimated it would need an additional $131 billion over the next 25 years. Is that correct?

Mr. VENEMAN. That would be for the hospital insurance portion of the medicare program.

Senator BYRD. Now, as I understand it, that was in September. Five months later, the cost overrun during that 25-year period is now estimated at $216 billion. Is that correct?

Mr. VENEMAN. That is a new figure—that is correct, $215.8.

Senator BYRD. So in September, 5 months ago, it was estimated that an additional $131 billion would be needed. Now it is estimated, 5 months later, that 60 percent more than that, or $216 billion, will be needed?

Mr. VENEMAN. That would be over a 25-year period.

Senator BYRD. That is correct, is it?

Mr. VENEMAN. That is right.

Mr. BALL. That is correct, Senator, under the assumptions that have been used since 1965 in the making of these estimates. As Mr. Myers testified the other day, he now feels that the preferable way to make the estimates is to assume that the Congress will, as it has in the past, increase the maximum earnings base under social security from time to time to keep it up with wages. You know, since 1950, when it was $3,600, it has been kept up to date with wage increases. If one were to assume that, which our actuaries believe is the preferable method, then over the 25-year period, the deficit would be $94 million. This table, I believe, was submitted for the record, Senator.

Mr. VENEMAN. I think the last assumption is the more accurate, Senator, to be honest with you. We have assumed that the earnings base will be adjusted upward.

Senator BYRD. If you make your assumptions, as I assume you have done, on the law as it stands today, it will require $216 billion over the next 25 years if you are going to finance these programs.

Mr. VENEMAN. That is assuming a static wage base.

Mr. BALL. It is assuming a static wage base and at the same time, Senator, assuming that the level of earnings over the 25-year period will rise very substantially. Our reasoning on this suggestion of using the other assumptions is that in the cash benefit program, if you assume rising earnings but do not raise the maximum earnings base, the protection under the cash benefit program very greatly deteriorates and the Congress has never allowed that to happen. It seems reason, therefore, to expect that in the future, too, the earnings base will be kept up to date.

Senator BYRD. Why do you say the program is not bankrupt if it will need $216 billion additional in the next 25 years?

Mr. BALL. The hospital insurance program, taken alone——

Mr. VENEMAN. I have great confidence in the Congress of the United States that will not allow it to go bankrupt, Senator.

Senator BYRD. What are you saying is that you have confidence that the Congress will impose additional taxes upon the people so that it will not go bankrupt. But without additional taxes on the people, it will be bankrupt. Is that correct? Or is it bankrupt?

Mr. VENEMAN. Well, you know, if you do not appropriate the funds, if the funds are not appropriated, either through the trust funds or through appropriation by the Congress, then you do not have a program. It is not a question of bankruptcy.

Senator BYRD. Under the same rate of taxation, without a change in the tax base or the tax rate, it would be correct to say that the fund would be bankrupt. Would it not be correct to say that?

Mr. VENEMAN. You eliminate a program is what you do.

Senator BYRD. Do you feel the medicare-medicaid program can survive without a major overhaul?

Mr. VENEMAN. I think, and I think I indicated yesterday, both in the testimony and in the questioning, that I think the whole health system of this country needs a major overhaul.

Senator BYRD. And you favor a major overhaul?

Mr. VENEMAN. Correct.

And it is not just on one side. I am not saying we need an overhaul in financing. We need an overhaul in the delivery health services, too.

Senator BYRD. Of course, the only place the Government can get money is out of the pockets of the wage earners. That is why I think that the Congress has a very great obligation to safeguard tax funds and I think the administrators in the executive branch of Government have a great obligation to safeguard tax funds. Is it correct that the workingman today is confronted with social security tax increases to pay for medicare?

Mr. VENEMAN. In order to finance a program, there will be, even at the present level—what do we have here?

About 0.3 percent.

Mr. BALL. The answer is yes, on the hospital insurance program, Senator, that the present contribution rate is six-tenths of a percent of payroll, rising gradually to 0.9 of 1 percent in 1987. One way that it could be brought about over this 25-year period to fully cover the costs that we have talked about—that is, on the basis of the rising earnings base that I was suggesting—is to have a 1-percent rate level throughout the period rather than this schedule of rates rising from six-tenths to nine-tenths of 1 percent. We have not fixed on that as a recommendation yet. I am just saying that is one way this could be done. And it would be a higher rate.

Senator WILLIAMS. Would the Senator yield?

Senator BYRD. Yes.

Senator WILLIAMS. Would you reduce that to dollars?

Mr. MYERS. A 1-percent tax rate on employers and a 1-percent tax rate on employees, plus a 1-percent tax rate on the self-employed, would at the present moment, say for calendar year 1971, which is the first year it could be put into effect, would bring in total tax income of $9.3 billion.

Senator WILLIAMS. So you are recommending an annual tax increase of $9 billion?

Mr. VENEMAN. Not an increase.

Mr. MYERS. Senator, first, this is not a recommendation. This is one way it could be financed. The $9.3 billion is the total.

Senator WILLIAMS. Total over 25 years?

Mr. MYERS. No, it is the total tax income for 1971 at a 2-percent rate, instead of the present 1.2 percent.

Senator WILLIAMS. How does that compare with the existing tax?

Mr. MYERS. The existing tax would be $5.5 billion.

Senator WILLIAMS. And it is a $3.8 billion increase annually for next year?

Mr. BALL. Not that much increase annually, though, Senator. As you get to a later point, the present law calls for nine-tenths. This suggestion is for only a one-tenth increase, you see? So it starts out at this larger amount, but the difference does not stay that great.

Senator WILLIAMS. The difference would increase, as I get it, because your wage base would rise.

Mr. BALL. Using the same approach—down the road, in 1987, assuming a higher wage base is in effect then, the difference would be between nine-tenths and 1 percent.

Senator WILLIAMS. I do not want to interrupt the Senator from Virginia, but using the same formula you are using now, you are bankrupt before you get to 1987.

Senator ANDERSON. I wish we would not talk about bankruptcy. There are some of us who have been here a long time. I came here in 1935 during the social security debate. There were even people on the staff who did not speak the English language. They were imported from Germany. There was nobody who had this experience when we came in. We passed the bill—passed the laws. I became State administrator in my home State and got staff from other groups, and nothing terrible happened. We were not bankrupt at all. Yet there was speech after speech after speech that we would go bankrupt. It has not happened, won't happen now, I believe.

I have great faith in what the Secretary is saying, that he is trying to work these things out. He can work these things out other ways besides raising tax rates too much. I have great hopes that this can be done promptly. I am not trying to argue with what the Senator from Virginia said. I think he has real reason to worry about it. So has the Congress. But I do not think there is any reason to assume it it will be bankrupt. The social security fund is not bankrupt.

Senator BYRD. If the Senator is saying social security, I was not talking about social security.

Senator ANDERSON. I realize that. I am merely trying to say the talk is of bankruptcy. It doesn't happen this way.

Senator BYRD. Not if you keep raising taxes.

Let me ask this: Is it correct, Mr. Veneman, that the workingman today is confronted with increases in his private health insurance premiums?

Mr. VENEMAN. That is absolutely correct. The rising health care costs of the country are reflected across the board, for those paying out of their pocket, for those paying for a private insurance program, and for those covered under a Government policy.

Senator BYRD. Is it correct that the workingman today is confronted with increased State and local taxes from medicaid?

Mr. VENEMAN. Fifty percent of the cost of title XIX is, I think, State and local funds—for the most part, State funds so that would be a correct statement.

Senator BYRD. Is it correct that the workingman today is confronted with more of his Federal tax dollar going to the Federal share of medicaid and medicare costs?

Mr. VENEMAN. Well, I do not know, really, because, you see, your contribution out of the payroll on the medicare portion is a payroll deduction program. Now, I think in order to answer that question, we would have to make some assumptions. We would have to say, what amount of Federal dollars would have been going into the old system. You know, previously, we did have MAA, the Kerr-Mills business. We did have public assistance medical care programs. They were, to a degree, controlled by the States—the level of service, the quality of service, the eligibility.

Now, assuming that if you lived in a State that was very liberal, you might be spending—he might be spending as much of his tax dollar for medical services as he would be under the present program. So that would be a variable thing, Senator.

Senator BYRD. Would it be accurate to say that to simply expand the medicare-medicaid programs as now constituted and operated would compound the costs and confusion?

Mr. VENEMAN. Are you talking about expansion as far as eligibility is concerned or expansion as far as level of service is concerned?

Senator BYRD. In either case.

Mr. VENEMAN. I think if you try to expand the levels of service, you might add to the confusion. If you are strictly expanding eligibility, you would add to the cost, but the confusion would stay on a static level.

Senator BYRD. Let me try to get a couple of facts clear. The actuarial estimate made in 1965 insofar as the projected costs for 1970, the 1970 costs are involved, was $3.8 billion. Now, the current estimate for the 1970 cost is $5.8 billion, is that correct?

Mr. VENEMAN. I will yield to Mr. Myers on that, Senator. I was not here in 1965.

Mr. MYERS. Senator, that is essentially correct, but I believe that the $5.8 billion that you are quoting for 1970 includes both the insured persons and the noninsured persons, whereas the earlier figure that was prepared in 1965 was only for the insured persons. So, the proper comparison should be $5.3 billion in 1970.

Senator BYRD. In any case, the $5.8 billion is what it is costing the Government, the total cost of the program, I mean?

Mr. MYERS. Yes, that is the total cost of the program, but the figure that was developed in 1965 should have added to it the costs of the noninsured persons, who, as you know, are paid by the General Treasury and not by the payroll taxes.

Senator BYRD. So the comparable costs would be $5.3 billion then?

Mr. MYERS. Yes, there is a definite difference.

Senator BYRD. In relation to the $3.1 billion?

Mr. MYERS. Yes, sir.

Senator BYRD. What is the cost for fiscal 1971, which will be the upcoming fiscal year? 1971?

Mr. MYERS. I have the figures here on a calendar-year basis. The total cost of the program, including the uninsured, for calendar year 1971 is estimated at $7 billion. If you just consider the insured, it is $6.3 billion.

Senator BYRD. What is the comparable cost or comparable figure—you use the calendar year basis and I was using the fiscal year basis. Give me the calendar year 1970.

Mr. MYERS. I am sorry, Senator, I was using the calendar year in both cases.

Senator BYRD. In both cases?

Mr. MYERS. Yes, sir.

Senator BYRD. In other words, in 1970, it would be $5.3 and the comparable figure to that would be $7 billion for 1971.

Mr. MYERS. No, $6.3 billion for calendar year 1971.

Senator BYRD. That is for medicare?

Mr. MYERS. Yes, just the hospital insurance portion of medicare.

Senator BYRD. Let me get clear on the costs for medicaid.

In fiscal 1965, the total Federal-State expenditures amounted to $1.3 billion, of which the Federal share was $555 million—$555 million.

Mr. VENEMAN. Senator, what figures were those? That was in 1965 for what program?

Senator BYRD. For medicaid. Fiscal year 1965.

Mr. MYERS. I think that is correct. I do not have the figures for the earlier years here, but that sounds correct.

Senator BYRD. Then we get to the fiscal year 1970. The Department of Health, Education, and Welfare estimates total expenditures of $5.5 billion, including the costs of intermediate care facilities. Is that the correct figure?

Mr. MYERS. Yes, sir; that sounds correct.

Senator BYRD. Of which the Federal share is $2.8 billion?

Mr. MYERS. Yes, sir; that is correct.

Senator BYRD. Now, what is the corresponding figure, for fiscal 1971?

Mr. MYERS. The estimates I have in front of me here may not be the latest. They were submitted to your committee staff about a year ago. That was $7.5 billion for the total costs, of which $4 billion was the Federal cost, for the fiscal year 1971.

Senator BYRD. The Federal cost is how much?

Mr. MYERS. $4 billion.

Senator BYRD. You say that was a year ago?

Mr. MYERS. That is the only information I have with me, estimates which I prepared jointly, which were submitted to your staff about a year ago.

Mr. VENEMAN. Senator, our budget figure for the fiscal 1971 of Federal money for title XIX is $2.85 billion.

Senator BYRD. We will go over this again then.

For fiscal year 1970, HEW estimates total expenditures of $5.5 billion, including the cost of intermediate care facilities, of which the Federal share is $2.8 billion. I was told those figures are correct.

Mr. VENEMAN. $2.7.

Senator BYRD. What are the comparable two figures for fiscal 1971?

Mrs. HANFT. They are estimated at $2.85 to $2.87 for the Federal share.

Senator BYRD. The Federal share is estimated as the same for 1970 then?

Mrs. HANFT. Just slightly higher.

Mr. VENEMAN. For the record, this is Mrs. Ruth Hanft, of the Department of HEW.

Senator BYRD. What is the figure comparable to the $5.5 billion, which is the total?

Mrs. HANFT. It is about $5.6 billion.

Senator BYRD. So your estimate for fiscal 1971, as a practical matter, will be almost the same as fiscal 1970?

Mrs. HANFT. Almost the same.

Mr. VENEMAN. I think we have to recognize that we are really not making fair comparisons when you talk 1965 estimates against 1970 and 1971 estimates. This was an evolutionary process when we initiated title XIX. The bill was passed in 1965, California implemented it in March of 1966. There were few States that were in it in the first year. I think California right now is getting probably $500 million out of the Federal Government for their title XIX program, as much as you estimated for the first year. We are now in a position where 48 States do have a title XIX program in effect. So, you know, you do not have that wide variation. They are becoming more static because all the States are covered.

Senator BYRD. Now, with respect to your willingness to certify extended care facilities with significant deficiencies, what objections, if any, were raised by the U.S. Public Health Service to your approach?

Mr. VENEMAN. The question is did we have public health service objections to coverage of extended care facilities—was that the question, Senator?

Senator BYRD. Yes.

To certifying extended care facilities in hospitals with significant deficiencies.

Mr. BALL. In the extended care facility area?

Senator, the standards that were developed for what constitutes a basis for certification on a quality basis was developed jointly, with the Public Health Service. The Public Health Service, I would say, really made the major contribution. I believe what you are referring to is that at the beginning of the program, there were about 250——

Senator BYRD. Did the Public Health Service object to the criteria used or object to the programs that were established?

Mr. BELL. I do not believe so, Senator. They were the major factor in developing the criteria but I thought you were also asking about the application of the criteria to a group of extended care facilities that were allowed in the program at the beginning. There were about 250 extended care facilities that were allowed in the program that met all the statutory requirements in the law but did not fully meet the criteria that we had established. We really had a choice at that time of leaving areas of the country completely uncovered or following this procedure.

Senator BYRD. Let's talk about the present time. How many of the thousands of extended care facilities certified with deficiencies in 1967 still have those same deficiencies?

Mr. BALL. I would think there would be hardly any at all that would have the same deficiencies that they had in 1967, Senator. The 250 that I was referring to that were certified, provisionally, usually because they could not meet the nursing requirements, they did not have enough nurses in the area, have all either been terminated or have obtained the required nurses. We do not have that group any more at all.

Now, there still are in the extended care facility area quite a substantial number that do not meet all of the standards that the Secretary has established.

Senator BYRD. What is a substantial number?

Mr. BALL. I can give you the exact number.

Senator BYRD. Will you supply the number for the record?

Mr. BALL. Yes.

(The following information was received for the record:)

As of January 1, 1970, of a total of 4,786 extended care facilities certified for participation in the Medicare program, 3,399, while not in full compliance with the standards set by the Secretary, were in substantial compliance with those standards. The remaining 1,387 were in full compliance.

Senator BYRD. I yield to the Senator from Delaware.

Senator WILLIAMS. I appreciate that.

Earlier today, we were discussing the cooperation which the administration might expect from the AMA. I think it was implied that they were not cooperating. I think in fairness, there should be incorporated in the record a release dated February 9 by the president of the American Medical Association and the president of the National Medical Association wherein they wholeheartedly support the purpose and the intent of the Senate Finance Committee's staff report on deficiencies and abuses, and pledge their full cooperation with our committee toward correcting and restoring some semblance of sanity. I think that this type of cooperation which we are getting from the AMA is very much needed. I thought they should be given credit for it because working together, I am sure we can restore some semblance of order.

Mr. VENEMAN. Senator, just in case the record did leave the wrong impression as far as the relationship of the Department of HEW with their provider groups and their organizations including the American Medical Association, the American Hospital Association, the Nursing Home Association, and others we have had complete cooperation. The point I was making this morning is that I did not anticipate a confrontation with these associations in trying to bring a semblance of order to these programs.

Senator WILLIAMS. I understand that was your position. I knew that is what we all intended.

The CHAIRMAN. Without objection, that press release will be inserted in the record at this point.

(The press release referred to follows:)

NEWS RELEASE FROM THE AMERICAN MEDICAL ASSOCIATION

CHICAGO.—The President of the American Medical Association, Gerald D. Dorman, M.D., and Julius W. Hill, M.D., President of the National Medical Association, issued the following joint statement regarding the Senate Finance

Committee staff report titled, "Medicare and Medicaid Problems, Issues and Alternatives":

The American Medical Association and its 217,000 physician members, together with the National Medical Association and its 5,000 physician members, wholeheartedly support the purpose and intent of the Senate Finance Committee's staff report on deficiencies and abuses by health care providers in the Medicare and Medicaid programs.

Pending detailed analysis of this valuable study, comment on specific findings must be necessarily limited. However, we were greatly encouraged by the committee's comment that it "believes that the majority of physicians for whom information was requested with respect to Medicare and Medicaid as presently structured have dealt fairly with these federal programs and with the federal government."

While we share the belief of the committee that the great majority of physicians are providing their services in a dedicated manner, we are aware that the committee's investigation has disclosed some abuses and outright frauds in the programs under review.

Where these abuses exist, they must be rooted out. Both the AMA and the NMA are prepared to take every vigorous action within their power to help the committee and the government accomplish this.

But, while acknowledging that these programs have flaws, we believe with the committee that they are correctable. In the case of Medicaid, where it has been well administered, it has brought adequate health care into the ghettos for the first time.

It would be tragic, if in seeking to correct defects in Medicaid, regulations were adopted whose effect would be to deny a greatly improved level of health care to the ghettos.

Many months ago, the AMA asked the committee for the names of physicians involved in its investigation so that organized medicine, through its constituent societies, could make its own inquiry. The request was declined.

Despite this, the AMA and NMA through their own resources have been able to identify a number of physicians grossing more than $25,000 in these programs. This information was obtained through the cooperation of state and medical societies.

This is consistent with the committee's conclusion that the key to making Medicare-Medicaid work is the "physician and his medical society."

In some instances, medical societies had already taken appropriate action against individual physicians where the evidence warranted. In other instances, however, the AMA and NMA have found that many of the physicians presumably included in the committee's study are dedicated physicians working in isolation in slum and rural areas who are literally being overwhelmed by a tide of sick humanity.

These physicians are working in areas of greatest medical need, where most of the patients are entitled to either Medicare or Medicaid benefits.

We therefore believe it would be unfortunate if the committee's report leads the public to believe that Medicare and Medicaid are riddled with fraud or that the number of physicians abusing the programs is large. Such is not the case. As the committee itself has stressed, its recommendations are "designed to repair rather than retrench."

Representing as we do the physicians of America, white and black, we feel feel that the larger meaning of the committee's staff report is that the need for more health manpower to serve the needs of the American people is truly desperate.

The AMA and NMA have taken the lead to provide that additional health manpower, which is an essential component in improving the Medicare and Medicaid programs.

The AMA and NMA will study the committee report carefully and will welcome the opportunity to testify on all aspects of the problem, should hearings be held.

The CHAIRMAN. Senator Byrd?

Senator BYRD. Mr. Secretary, the nursing home in Ohio in which some 30 people were killed, that was certified with deficiencies by the HEW?

Mr. BALL. I will have to check to be sure, but I believe so. That was a relatively new institution and I believe it was probably fully certified. I am told it was fully certified as meeting the standards.

Senator BYRD. It was certified as meeting the standards?

Mr. BALL. Right.

Senator BYRD. In the Senate, we have no rules of germaneness, I assume, Mr. Chairman, that that would apply to this committee? I have four questions that do not pertain to the subject matter at hand. Would that be satisfactory?

Senator ANDERSON (presiding). Go right ahead and ask them. We have had plenty of questions in that category.

Senator BYRD. I would prefer to put these questions to Secretary Finch, but since he is not present——

Mr. VENEMAN. I think I would prefer that, too, Senator.

Senator BYRD. I want to thank Mr. Veneman. I remember the last time he was before the committee and just prior to that, too, I had sent four different telegrams to Secretary Finch over a period of 6 weeks and gotten no reply from him and Mr. Veneman very kindly got a reply shortly thereafter.

I might say that when I communicate with the President, I get a prompt reply. When I communicate with the Secretary of Defense Mel Laird, I get a prompt reply. When I communicate with the Secretary of Treasury, I get a prompt reply. When I communicate with Secretary Finch, I do not get any reply. So I am pleased that we have his top assistant today.

Mr. VENEMAN. I think perhaps, Senator, one of the problems, and I think we have ironed most of that out, is the volume of mail in HEW during the early months was tremendous.

Senator BYRD. This was 2 weeks ago.

Mr. VENEMAN. The volume of mail is still tremendous.

You can't win them all.

Senator BYRD. Now, Mr. Veneman, the Secretary has repeatedly been quoted as stating that your Department, HEW, does not force localities to bus schoolchildren to achieve racial balance. Is that correct?

Mr. VENEMAN. That is correct.

Senator BYRD. But is it not a fact that your Department has refused to approve desegregation plans of individual school districts while at the same time indicating that plans involving busing would be acceptable?

Mr. VENEMAN. As a means of achieving desegregation.

Senator BYRD. Is this not what was ordered this month in the case of Newport News, Va.?

Mr. VENEMAN. I am not familiar with that particular case, Senator. But the decision as to how they achieve desegregation—you know, there are various alternatives. One means, of course, is busing. But that determination is made by the local district, the local school board. The Department of HEW can't, by law, compel busing and there have been no court cases that relate to them.

Senator BYRD. Would you in your capacity have an appropriate official in the Department communicate with the city of Newport

News and tell them that you have no right to require them to bus students?

Mr. VENEMAN. We do not have a right to require them.

Senator BYRD. And you do not require them?

Mr. VENEMAN. We require compliance with title VI of the Civil Rights Act. We require desegregation if it is a segregated school system. One of the means of achieving this is through the transportation of students. If this is the means that they have selected, they can comply with the Civil Rights Act.

Senator BYRD. Newport News has not selected the system. Newport News was informed that their funds would be withheld unless busing was instituted.

Mr. VENEMAN. I think the issue was that their funds would be withheld unless they desegregated and integrated their school system.

Senator BYRD. Let me ask you this: What is the difference, legally or morally, between ordering busing to achieve racial balance and issuing rulings which, in effect, leave the community with no choice but to bus to achieve racial balance or lose Federal funds? What is the difference?

Mr. VENEMAN. The Department—I really would like to make this clear. The Department has not required the transportation of students to achieve racial balance. And I do not think there is a court decision on that as yet.

Senator BYRD. Well, would you indicate what is the difference, legally or morally, between ordering busing to achieve racial balance, which you say you do not do, and issuing rulings which, in effect, leave the community with no choice but to bus or lose Federal funds?

Mr. VENEMAN. I do not think we have issued that ruling that leaves a community with no choice, Senator.

Senator BYRD. Would you do this? Would you look up the Newport News case and have someone communicate with me?

Mr. VENEMAN. I will have someone look into this specific case. I certainly will.

Senator BYRD. Thank you very much, Mr. Secretary.

Thank you, Mr. Chairman.

Senator ANDERSON. One or two final questions. The fiscal 1971 budget, on pages 330 and 331, shows that the part B matching payments run about $1,289 million. It is a premium payment. This is the largest insurance company in the world that we have set up. They pay premiums for health insurance.

Mr. VENEMAN. And we also have premiums for retirement. It is a big insurance company.

Senator ANDERSON. Yes, it is. Now, the expenditures, it looks like they are going to run a little more than that. When did the Department first find out that the part B expenditures were going to exceed the revenues?

Mr. BALL. Senator, I guess you really have to decide who officially makes that decision. The last trustee's report indicated that on the basis of the actuary's estimates, it was out of balance at the time that the former Secretary continued the $4 rate. But it also showed another alternative that would have shown it in line.

My own view was, I personally supported Mr. Myers' estimate and advocated that there be a rate increase to $4.40 at the time of the original promulgation. Then I later suggested a possible compromise to $4.20 by reason of taking at the same time these restrictive measures not to recognize fee increases. But as you know, the $4 was continued. I would say that I personally felt that it was inadequate at the time it was originally promulgated.

Senator ANDERSON. It is recommended to go to $5.30, is it?

Mr. VENEMAN. That it is going to $5.30 for the next fiscal year.

Senator ANDERSON. Who ordered the $4 rate to be effective?

Mr. BALL. That is the decision of the Secretary, and, of course, at that time, it was Wilbur Cohen.

Mr. VENEMAN. That was just about December 29, as I recall.

Senator ANDERSON. Senator Hartke.

Senator HARTKE. I want to continue my line of questioning which I had to cut short because I had to go to another meeting at Commerce. It is not true that medicare and medicaid constitute about 20 percent of the total amount of money spent on medical cost.

Mr. VENEMAN. Probably around that. We mentioned yesterday Government pays 50 percent of hospital costs; 37 percent of all health care services.

Senator HARTKE. And also, we know, as demonstrated by the charts I put into the record, that medical costs have been higher than the Consumer Price Index. Just to give you a quick comparison, the Consumer Price Index for 1966 was at 113.1, medical care was at 127.7, physicians fes at 125.5, and hospital daily services at 168. Now by 1969, the 113 Consumer Price Index had gone to 127.7. The medical care provisions index had gone to 155, physicians fees from 128.5 to 155.4 and hospital daily services charge from 168 to 256. Now, for all these people who are old, and really no matter what age you are, there has been a tremendous increase in the overall expenses for medical care.

Mr. VENEMAN. That is correct.

Senator HARTKE. So what we have we have here, we have increased the demand for medical services without increasing the supply—a classic cause of inflation. I think we were right to provide for medicare but there are people, some on this committee who are not worried about the sabotage from within the Department, they would like to sabotage the whole system. I am not sure where the Secretary is, whether he wants to expand it or keep it where it is.

Mr. VENEMAN. He wants to produce effective quality health care for needy people.

Senator HARTKE. We are not doing it yet, I can guarantee you. I have a remarkable situation. A young boy in Indiana needs a liver transplant to live and I have asked everywhere to find somebody to get that boy into a hospital and because of cost involved; no Federal, no State, no private charity will help this boy. He is just destined to die because of lack of money. I think that is a tragic shame in this Nation, and it can probably be repeated time after time.

Mr. VENEMAN. How old is he?

Senator HARTKE. He is about a year and a half old. The doctor is ready to do it, they have a donor, everything. I have talked to the people in your Department. All I get is sympathy.

Mr. VENEMAN. What is the economic status of the family?

Senator HARTKE. This operation would cost them beyond anything they have. They are not in bad shape, they are not destitute. But they will pay everything they can. They are willing to mortgage their house, home, their future. Outside of that—they had mortgaged beyond their future if they had a chance. But I have talked to Secretary Finch about this. I have talked to the Surgeon General. They have all turned me down. I have talked to NIH, talked to every private charity that I can think of. I get a lot of sympathy.

What we have increased here is the demand for medical services in this country, but we have not increased the supply. I grant you all these other things you are doing in the field to try to pay for these costs is admirable. I compliment you. I think you have taken forward steps in incentive plans. I think you could have done more earlier.

But the point is that there is a shortage of doctors, a shortage of nurses, a shortage of medical facilities, and a shortage of medical training facilities. The charts I have talked about here demonstrate quite conclusively that this problem is not about to be solved. In fact, at this moment, it is getting worse. And it is one of the major problems in this country at the moment. You can talk all you want to about how much we worship the dollar, but when a man is in the hospital, he will give all the money he has in his pocket for health and to be well again.

Yet it is estimated that we need 50,000 doctors right now. Loan applications for medical school run four times more than are approved, and only 10 percent of all applicants receive any scholarship assistance. Yet when we come back to the HEW bill, we find a continued refusal to recognize the need.

The President requested $135 million for hospital construction. Congress put that up to $258 million, an increase of $105 million, and even this was $45,000 less than was appropriated a year before.

Mr. VENEMAN. But, Senator, let's put this whole thing into perspective when we talk about hospital construction.

Senator HARTKE. That is what I am trying to do. Let me give you one statement. The National Advisory Commission on Health and Manpower reports that a tremendous savings in hospital costs would be achieved by more adequate hospital facilities. That is the point I am making. In other words, I want to increase the supply of medical services in order to accommodate this tremendous demand.

Mr. VENEMAN. I think what we have to do here, Senator, is point out that the proposal we have under Hill-Burton calls for a guaranteed loan program up to the extent of what—$400 million, I think—plus this figure for grants. But let's also remember another thing that has occurred since 1965 when we passed medicare and medicaid. That is that we do in fact reimburse for capital to the facilities in their charges. So we are actually pumping about another $200 million plus a year, if I am not mistaken—I think that is fairly accurate—I think it is about $250 million a year—into facilities for capital purposes which can be used. So when you take the whole thing collectively—the guaranteed loan program, the grant program, and the amount of

reimbursement being made through titles XVIII and XIX, we have about three-fourths of a billion annually going into the system for hospital facilities.

Senator HARTKE. I say well done, thou good and faithful servant, now go out and do more.

Mr. VENEMAN. Well, Senator, dollars——

Senator HARTKE. No, these are the facts. I am telling you, you know this is the truth, and this country is not facing up to the truth on this. This country is faced with a health crisis and it does not do any good to blame the doctors, the medical association or the cases of fraud or charges——

Mr. VENEMAN. I don't think we are blaming anybody.

Senator HARTKE. There is a study that reveals we need 2,300 diagnostic and treatment centers which need to be rebuilt or modernized. If we don't provide the funds for these, we will have an additional shortage of facilities.

Let me go through here. On research facilities, the budget estimate was $126 million. The Congress, in the vetoed bill, had authorized $149,500,000. But the new bill comes back with $126 million. In other words, a cutback, despite the appauling lack of educational medical facilities in this country.

Health manpower, this also gives support to institutions. The Budget request in April, was for $128 million. The vetoed bill provides $135½ million. The present bill holds at $135½ million.

For health manpower training and direct loans, the April request was for $24 million, the veto bill put that up to $40 million and the present bills hold at that figure.

These are all increases that are fully justified and should not be vetoed. We should remember that with the increasing cost of medical care for many people the first time they are poor is when they reach 65. This is a unique situation, that people who have been able to buy their homes, take care of their children, pay their bills, pay their medical bills but at the age of 65 plus one, for the first time in their lives, find they are poor, because their income is sharply reduced.

What happened to the HEW bill? The increases for medical research and training were not accepted by the administration. In toher words, what we provided, they would not accept.

For example, under the President's alternate budget, research training programs are still being curtailed below the 1969 level. The implication of this action is unmistakable. The cutback in health research is not intended to be temporary. Lurking below the surface of the budget for health research training is a subtle budget policy with long-term implications for the production of the future research scientists and most important, the production of future teachers of physicians and medical technicians, the supply of which is already falling further behind with each and every passing day.

I do not expect you to do anything except defend the position of the administration but I cannot in good conscience see how you really can come before us here and complain about the sharp increase in medical costs and at the same time, ask for a cutback in the provision to supply additional medical facility for training doctors and medical technicians.

Mr. VENEMAN. We have not attempted at any time to discount the need for medical manpower. I think there is a lot of emphasis upon priorities being directly related to dollars. I do not necessarily accept that as a premise. I think in the health manpower field, the budget request was $6 or $7 million below what the Congress put in. If the dollars are not being spent appropriately, that $7 million additional is not going to produce additional people. I think this was what we are trying to do in the Department, adjust our priorities, not saying that we are taking away the emphasis upon the need for health manpower, but trying to redirect them and it may take more, may take less dollars. I don't see the direct relationship.

Senator HARTKE. I can accept that is a nice argument to give in front of the Rotary Club, where everybody has enough money to pay their bills. It is not a very convincing argument to these old people who want help.

Since we are not under the rule of germaneness, let me give you a concrete example.

Senator ANDERSON. We are going to be under the rule of lunch after a while.

Senator HARTKE. I will quit after this reminder of what really happens.

I called the Surgeon General and asked him, after I had received a letter from my son—who is married, no children yet—about a little item he sent me on rubella, German measles. Rubella caused a great epidemic in 1964, which resulted in, more than 100,000 stillborns, blind, deaf, mentally retarded children. It is the No. 1 cause of mental retardation in America. The next epidemic is expected in late 1970, 1971. We have developed in the meantime, an effective vaccine.

Mr. VENEMAN. Developed out at NIH.

Senator HARTKE. I also talked to the Under Secretary of Health, Education, and Welfare, Dr. Cavnaugh, and he told me that this is a joint State/Federal effort and that the States were more than able to provide additional funding. That was untrue then and is untrue now. So I put in an amendment on the floor of the Senate and it did carry to provide enough money for a massive vaccination program so we don't have an epidemic in 1971.

My son said, "Dad, what if Joan gets pregnant and has a retarded child; do I have you to thank for this?"

I put in the $10 million. It was approved by the conference. Then it was vetoed and Tricia got measles. And I want you to know that in the new bill submitted by the President, he provides for the additional funds for rubella vaccination.

But that does not happen all the time. The President's daughter can't always get——

Mr. VENEMAN. That is not a fair judgment, Senator.

Senator HARTKE. It is in the new program.

Mr. VENEMAN. It is there and it would have been——

Senator HARTKE. I asked the Under Secretary and he would not approve of it. I asked him—I said, I don't even care if I put it in, let somebody else put it in, get a Republican to put it in.

Mr. VENEMAN. Last spring, we came before Congress and asked for a supplemental appropriation, if I remember right, of something

like $16 million for the rubella program. I have checked with our health people as recently as 4 or 5 weeks ago and I said, where are we in the program, and we are right on their time schedule. Precisely on it. That program is moving along.

Senator HARTKE. The point is only the additional funds provide for a sufficient number of vaccinations in time to prevent a epidemic in 1971.

Mr. VENEMAN. It is going to be a Federal-State program.

Senator HARTKE. We can't have it both ways. Either the President made a mistake in requesting additional funds now or he made a mistake the last time when he didn't request them. It is in the program in his request in his letter to the Speaker. He has asked for it now. He did not ask for it before I put it in. I mention this just as an example.

Mr. VENEMAN. I will have to check it, but I do not recall it ever having been cut out of the budget.

Senator HARTKE. If you are going to have a continued shortage of medical facilities and people who can treat medical cases, then the skyrocketing of medical costs is not going to come down. You can eliminate all the fraud and all the unreasonable charges you want to. These are going to be reasonable charges and you are just going to crucify this program.

That is all I have to say, Mr. Chairman.

Senator ANDERSON. We will meet again at 2:30 this afternoon.

Thank you, Mr. Secretary.

AFTERNOON SESSION

Senator ANDERSON. We are going to start. Members of the staff will question later this afternoon.

STAFF. We just have a few questions, actually, in the beginning. We wanted to ask Mr. Newman whether he has had a chance to review the staff's medicaid recommendations and to evaluate those recommendations. Which of those, if any, do you intend to implement without legislation?

Mr. NEWMAN. I have read the report. I have not, in my 9 days in this position had a chance yet to thoroughly digest them. I will certainly do so and I would fully expect that to the extent that we can implement changes without legislation, consistent with our policies and practices, we will do so.

Mr. VENEMAN. May I respond by suggesting, Mr. Chairman, that we submit for the record a paper that was developed into the recommendations that were made by the staff through the staff report of February 9? These are comments which were developed by persons in Social Security and other areas of the Department, related to your recommendations as they pertain to both medicaid and medicare. I could comment on a few of these if it would be desirable, or we could just submit it for the record.

Senator ANDERSON. We will put it in the record.

(The information referred to appears in appendix B, p. 161.)

STAFF. Senator Williams, did you want to proceed now?

Senator WILLIAMS. Yes.

During the July hearings, we had testimony to the effect that there had been a substantial medicaid overpayment, about a million and a half dollars, in the State of Texas. We were told the State of Texas recognized that and would take steps to collect it. How much, if any, has been collected and what is the status of the Government's claim?

Mr. VENEMAN. I am just reading whether or not we have collected any at this point.

Mr. NEWMAN. It is my understanding, Senator, that the outstanding balance is in the amount of $800,000. This is currently being reviewed. The earlier balance, which was substantially greater than that figure, has been adjusted and is no longer a balance.

Senator WILLIAMS. When you say adjusted, what did you do, just mark it off? Because the Comptroller General's report was very specific as to the amount of overpayment, and the accuracy of it was confirmed here by one of you gentlemen. Now, what do you mean by adjustment?

Mr. NEWMAN. It is my understanding, and I request permission to review this because of my own inexperience. However, it is my understanding that the balance was used to pay subsequent bills which developed since that time.

Senator WILLIAMS. Well, Mr. Ball, maybe you could answer it, because you were present at the earlier hearing. I would just like to have a report as to the current status and what you have collected. And, if you have not done anything, I would like to know that.

Mr. BALL. Senator Williams, I want to make it absolutely clear that my own responsibility is related only to the medicare program. Title XIX is in social and rehabilitation services.

Senator WILLIAMS. Then I will excuse you. Whom should I ask that question of?

Mr. VENEMAN. I think I have the question.

Mr. BALL. These gentlemen.

Mr. VENEMAN. It is going to bounce around, Senator. It will settle down here in a minute.

Let me just read a portion of this report. It is my understanding that the $887,866 representing the difference in the Federal potential participation rate has been eliminated as of June 30, 1969.

Is that correct?

Mr. SPIEGELBLATT. May I just straighten this out a little bit?

Mr. VENEMAN. I hope so.

Mr. SPIEGELBLATT. There were two points at issue in the audit agency report. One was a large amount of about $14 million. That represented premium payments for medical services which were in excess of the actual program costs. Now, after the Senate Finance Committee met and reviewed this report last July, there were meetings between the HEW officials and the Texas agency. It was explained and figures were produced to document the fact that this large amount had been offset by no premium payments for several months being made by this Texas agency. As of June 30, 1969, there was in fact a minus balance of about a half million of this amount that the Texas agency owed to the Blue Cross agency.

The other amount that was discussed was the amount of about $800,000, which the audit agency claimed represented the difference between matching at the 50 percent rate for administrative costs and

matching at the medical assistance rate. The Department of HEW, and specifically, Miss Switzer as the Administrator of the Social and Rehabilitation Service, in September sent a communication to Texas advising them that she was supporting the HEW audit agency finding and that this amount of money was due to the Federal Government. Within the last 10 days, a brief has been submitted by the Texas State agency appealing this decision and asking that it be reconsidered. This brief has currently been sent to legal counsel, to general counsel, for review.

Senator WILLIAMS. To sum it up, thus far you have not finally corrected it?

Mr. VENEMAN. There are two features to it. One was the $14,090,000 that represented the premium payments which were claimed to be in excess. That has been wiped out. Now, the $887,000 I said was wiped out is actually in litigation. I have Miss Switzer's letter here to the regional commissioner.

Senator WILLIAMS. It is still under litigation? Then it has not as yet been settled?

Mr. VENEMAN. The $887,000.

Senator WILLIAMS. I hope you will furnish the committee with a report as to the progress that has been made.

By the way, your name, please?

Mr. SPIEGELBLATT. Henry Spiegelblatt of the Medical Services Administration.

Senator WILLIAMS. I like to have that identified, because we are interested in the kind of followthrough on it and the adjustment that has been made. Was that solution accepted by the Comptroller General's Office? They were the ones who came up with these recommendations, as I understand it.

Mr. SPIEGELBLATT. I do not believe it was, sir.

Senator WILLIAMS. As I recall it, I wasn't sure whether there was a Comptroller General's report or an audit agency report. Apparently, it was your own audit report that showed the discrepancy, correct?

Mr. VENEMAN. That is right. It was an HEW audit agency report, which is Office of the Assistant Secretary, Comptroller Kelly.

(The audit agency report referred to follows:)

CURRENT STATUS OF THE HEW AUDIT REPORT FINDINGS ON TEXAS MEDICAID PROGRAM COVERING PERIOD SEPTEMBER 1, 1967 TO JUNE 30, 1968

The Audit Agency report stated that Group Hospital Service, Inc., had accumulated $14,096,153 representing premium payments for medical services which were in excess of actual program disbursements for medical services. The State agency concurred in this finding and stated that it was its practice to permit premium payments to accumulate in this fashion as a hedge and periodically to use the funds as offsets against premiums due. By February 1969, the balance was $11,961,571.02 which was used to pay the monthly premiums due Group Hospital Service, Inc., for the months of February ($3,949,182.26), March ($4,001,697.66) and April 1969 ($4,010,690.10). No additional Federal matching was claimed since this money had already been matched. Since then disbursements by GHS for program purposes exceeded receipts from premiums and as of June 30, 1969, there was a minus balance with GHS of almost one half million dollars. Therefore, there is no surplus of premium payments for program benefits over disbursements for services to be recovered.

The second Audit Agency exception is based on a determination that the arrangement between the State agency and Group Hospitalization, Inc. could

not be supported as insurance because of a "no risk" feature and that resultantly, $887,868 represents the difference in the FFP rate applicable to administrative costs claimed as assistance costs.

The Administrator, SRS, has made the following decisions:

"With respect to the nature of the arrangement between the Texas State agency and the Group Hospital Services, Inc., I find that the arrangement cannot be supported as insurance in view of its 'no risk' feature. It does not comply with the requirements of the Handbook of Public Assistance Administration. Supplement D-5520A and D-5830.

"It follows from the finding above that we cannot recognize any of the costs related to administration of the program for participation at a rate other than 50 percent. This means that we will have to support the exception in the amounts determined to be appropriate."

The above decision was communicated to the State. On appeal by the State, the Administrator, SRS, sustained the audit exception.

On January 12, 1970 the State transmitted an appeal brief in support of its position that its arrangement with Group Hospitalization, Inc. was in fact in the nature of insurance. On January 30, 1970 the brief was sent from the Regional Office to Central Office, SRS. The appeal brief is being studied within the department to determine whether there are any additional facts which might justify reconsideration of the original decision.

Senator WILLIAMS. We have had a report on one of the nursing homes up in the northeastern area. I do not have the name at the moment. But there were substantial charges by physical therapists—excessive charges of several hundred thousand dollars. You wanted to recover that, as I understand it, by withholding payments to that nursing home.

We have a vote about to come up in the Senate and we will go over to the floor, but while we are gone, maybe you can check this out. You were going to withhold future payments that were due them as a means of recovery. Later, we were advised that the nursing home had quit taking medicare and medicaid patients, therefore escaping repayment. The suggestion was made that you should institute legal proceedings to collect the money. When I come back, I would like to have an answer as to what steps were made to protect the Government's interest in that case and whether they actually stopped taking medicare and medicaid patients following that.

We will recess for a moment to go vote. It was the Hollis Park Gardens Nursing Home, I understand.

(Short recess.)

Senator ANDERSON. Mr. Secretary, do you have an answer to Senator Williams' question?

Mr. VENEMAN. I think Mr. Tierney will handle the answer.

Mr. TIERNEY. Senator Williams, the institution you referred to was the Hollis Park Gardens in New York. We had an audit of all the bills from that institution by an intermediary and it determined that there was an overpayment of $335,720. We made demand in that amount. But also because of some other circumstances which indicated at least the possibility of fraudulent action, Senator, we turned the whole case over to the Justice Department and requested that they institute a recovery action and terminated the institution.

Subsequent to that, there has been an action filed in the district court here in the District of Columbia by the institution, Senator, in which they have challenged the determination of overpayment and are seeking a declaratory judgment establishing the amount of the overpayment. So that is where that matter now stands.

Senator WILLIAMS. Now, in one of your audit agency reports under date of February 5, I was interested to note the comment—I am quoting:

> Duplicate payments of such bills is a continuing serious problem in Part B carriers. In view of the overall magnitude of these payments and the need for finding solutions as quickly as possible, we have recommended a number of measures.

Then it goes on.

Could you tell us something about these duplicate payments—where, in what areas of the country they took place, and why? Who was the carrier? Was this widespread?

Mr. VENEMAN. Again, I think Mr. Tierney can handle that.

Mr. TIERNEY. Senator Williams, that report which you referred to refers to audits for periods ending at various times in 1967—three of them in December of 1967 and three in June of 1967. Since that time, action has been taken in all six of the carrier institutions, which were ordered to screen the duplications. I might say, sir, that three of them were very small county bureaus out on the west coast and were not significant organizations. Three others were; and we have worked on further computer capacities with each of them to eliminate the duplicate problem.

The duplicate problem itself, Senator, arises out of the fact that there are two mechanisms for billing under medicare—either through an assignment, as you know, where the doctor sends in the bill, or through simply providing the bill to the patient and he sends it in. If both send in a bill, either through inadvertence or deliberately, you have a problem of screening out the duplicate.

There is no question, Senator, that early in the program, there were carriers that did not have screening capacities to screen out all possible duplicate bills. But I would point out to you, sir, that that report does cover periods in 1967 and we have worked with all of the carriers involved to perfect their duplicate screening.

Now, it is possible, sir, in a given instance, it is impossible, rather—to absolutely guarantee against any duplicate payment. We have, for example, developed so-called test decks of cards which we send out to the carriers and run through their computer operations. One of the things we test on its whether or not their computer capacity will screen out duplicates. We think, sir, for the most part, those situations have been very substantially tightened. But I do not think any computer in the Nation can absolutely guarantee that a duplicate will not on occasion get through a screen.

Senator WILLIAMS. I would like to read to you from the report:

> At six carrier locations, we found that substantial number of duplicate claims for medical services had been paid to physicians or beneficiaries. Based on statistical samples of paid claims, we estimated that duplicate payments—many of which were voluntarily refunded—total more than $1,500,000 at these locations. The basic cause of these overpayments was the carriers' lack of adequate manual or data processing procedures for detecting duplicate claims.

This was sent to us on February 5, 1970, it says:

> This report summarizes the findings in the 72 audit reports in Medicare fiscal intermediaries issued by the HEW Audit Agency during the 12 month period ended April 30, 1969.

Am I to understand that this audit report dealt only with 1967 and 1968 audit reports? If so, what happened in 1968 and 1969—or aren't you going to audit that for a couple of years?

Mr. TIERNEY. The audit report makes reference to six carriers. Those audits in those six carriers were made for periods ending either June or December of 1967.

Senator WILLIAMS. I can understand that.

Mr. TIERNEY. All I am saying to you is that since that time, we have been in every one of those places to make sure that they have perfected a sounder screen than they had at that time.

I might also add, Senator, that we have done the same thing with all carriers. Those happened to be six which the audit agency identified as having a problem back in 1967.

We have also, Senator, developed what we call a model part B system. The Social Security Administration itself has done this and now made it available to all carriers. We think we have built into that system, sir, a very highly technical screen to eliminate duplicate payments.

Senator WILLIAMS. Well, passing over this for a moment, do you know of any other instances where you found duplicate payments by any other carrier or in any other period since that time, or is the record clear since that time to this?

Mr. TIERNEY. Yes, sir; we have in surveillance, carrier surveillance, identified other instances.

Senator WILLIAMS. Tell us about them.

Mr. TIERNEY. I do not have them in mind at the moment, sir. I would have to give you an action report on them.

(Information requested follows:)

DUPLICATE CLAIMS CONTROL

The Social Security Administration has taken several steps to institute controls for carrier detection of duplicate claims:

1. Uniform criteria for duplicate screening has been established for use by all carriers.

2. A systems testing program has been in operation for more than one year. Test claims are introduced into carrier systems to test the accuracy and quality of claims processing, as well as the potential to detect duplicate claims. This permits determination of which carriers need assistance in devising systems to detect duplicate claims and to take necessary corrective action.

3. Another test provided that all carriers employing electronic data processing systems reprocess one day's claims in order to validate the effectiveness of basic criteria (Date of Service and Supplier/Doctor Number) in relation to the criteria previously used in the carrier system. The findings were analyzed and a series of educational contacts were made with carriers based on the analyses. As a result, a number of changes have been made to upgrade these carriers' controls.

As a result of these steps, carriers' systems have been upgraded. Some carriers have instituted private, packaged electronic data systems and an increasing number of carriers are using the Model Part B System which also has built-in controls for the detection of duplicate claims. The remaining carriers have improved their systems of detecting duplicate claims to a point where a sound, early detection system is a reality.

Senator WILLIAMS. If there are so many that you cannot remember them all, tell us some of them.

Mr. TIERNEY. No, I do not think all of them were that bad. But we have identified ourselves at least four other carriers who had prob-

lems of duplicate payment. If you want me to name them—do you, Senator?

Senator WILLIAMS. Yes, it's just as well.

Mr. TIERNEY. Blue Shield of South Carolina, Colorado Blue Shield, General American Life Insurance Co., and Occidental Life Insurance Co.

Senator WILLIAMS. Do any of these duplicate the previous six?

Mr. TIERNEY. No, sir.

Senator WILLIAMS. All right.

Mr. TIERNEY. Blue Shield of California, Senator, had very serious problems, brought about largely because of their very heavy workloads to handle not only medicare but medicaid, and thereby developed about 125,000 claims a day.

On January 1 of this year, we redistributed the workload in California and took away seven counties of the medicare operation from California Blue Shield in an effort to reduce that workload.

There have been other carriers at other points in time, Senator. This has been a case of constantly perfecting techniques.

I am mindful of the Texas Blue Shield. They had a serious duplicate payment problem. They instituted a whole new electronic data processing system in early 1968, I believe it was, Senator. I would have to confirm that. And we think they have licked the problem.

Senator WILLIAMS. If I recall correctly, the GAO criticized the cost of the system that Texas was establishing, did they not?

Mr. TIERNEY. I do not think they criticized the cost of the system, Senator. They criticized the fact that through their interpretation of the contract, they did not regard it as a contract requiring prior approval by the Secretary. What they contracted to do was turn over their entire operation, both their own private business and medicaid business and medicaid business, to contract for electronic data processing service. Since medicare did not comprise a majority of that total operation, they did not think they had to submit it. We felt they did have to submit it because it was a substantial contract and part of it distinctly for medicare.

I believe the principal GAO criticism was not so much about whether or not it was a reasonable contract, as to whether or not it should have been submitted for prior approval.

Senator WILLIAMS. On another matter. You will recall that the General Accounting Office was highly critical of the performance of the Travelers Insurance Co.—part B carrier for railroad retirees. Was that also the Bureau of Health's evaluation of Travelers Insurance performance—both for railroad retirees and as a carrier or intermediary for regular beneficiaries?

Mr. TIERNEY. Senator Williams, we have been taking a long look at Travelers, just as you were at the time of the last hearings. For a long time, we suspended the availability of Travelers as a nominee for any further providers until we could satisfy ourselves that they had improved what they admitted was not a good part A operation at that time. They have done a lot of very effective things, Senator, to the extent that some institutions are now claiming that they are overadministering and that they are turning down too many claims.

As far as their function as a carrier for the railroad retirement system, Senator, I think the problem probably goes deeper than simply Travelers. This is a national operation, with relatively few people in some areas qualifying under the railroad retirement system program; therefore, it makes it very difficult for one carrier on a nationwide basis to develop reasonable criteria as to customary and prevailing charges. I think that particular problem is under study by the administration to make an ultimate determination as to whether any carrier should operate on that kind of a nationwide system or whether it would be preferable to have local carriers in each area handle that as they do the rest of the business.

The Railroad Retirement Board is given delegation to select a carrier under the original arrangements of the program. Of course, they continue their desire to exercise that prerogative. It was the Railroad Retirement Board that made the selection of Travelers.

Senator WILLIAMS. Well, the reason for pressing these questions to see what steps were taken to correct those problems and abuses brought up in earlier hearings and not to repeat them unnecessarily. But as one member of the committee, I am very much concerned about the projected cost of this medicare program. Our whole committee was concerned when we had a projected deficiency of $131 billion over 25 years over what had been anticipated. We are now told that the deficit is $216 billion. That is a little better than an average of $8 billion a year more in cost than Congress was told it would cost in 1967. In order to raise this $8 billion a year more, something has to give, either at one end or the other.

Earlier in the discussion, there was a little concern that maybe we should not use the word "bankruptcy," so I will not use the word "bankruptcy." But I will ask this question: What is the recent financial balance of the health insurance program? It is around $2 billion, is it not?

Mr. TIERNEY. I would have to ask Mr. Myers. He tells me that is correct; yes, sir.

Senator WILLIAMS. It is around $2 billion. The claims that are paid under the health insurance program are contractual claims that are agreed upon by the Government agencies or its representatives under law. In other words, they are obligations, are they not? As long as this law is on the books?

Mr. TIERNEY. Yes, sir.

Senator WILLIAMS. Now, assuming that Congress takes no action to amend this law and it is allowed to continue as is, assuming the same tax rate which we were told was sufficient, and the same benefits, when would this fund run out of money?

Mr. MYERS. In late 1972.

Senator WILLIAMS. In late 1972, it would be out of money?

Mr. MYERS. Yes, sir.

Senator WILLIAMS. Now, in late 1972, assuming we have done nothing, this fund would be out of money and you would have nothing with which to pay those bills which are contractual obligations. Is that correct, Mr. Tierney?

Mr. MYERS. That is correct.

There would be some income coming in, but it would not be enough to——

Senator WILLIAMS. It would not be enough to pay your bills?

Mr. MYERS. That is correct.

Senator WILLIAMS. Do you agree with that, Mr. Tierney?

Mr. TIERNEY. Yes, sir.

Senator WILLIAMS. If it were private business and an operation had obligations far exceeding their income and they had no cash with which to pay, what word would you use to describe that situation? You would not use the word "bankrupt," but what word would you use?

Mr. TIERNEY. I think they would be somewhat under financed.

Senator, I am not trying to beg your question.

Senator WILLIAMS. I am not either. But I think we might just as well face the facts of life on this. They have been ignored too much and I think that we just ought to face up to what this program is going to cost and what the results will be if there is no action taken either to reduce the benefits—which may not be advisable—I am not suggesting that they should—or to raise taxes. But something has to give and we are not going to get anywhere by this shadowboxing. So how would you describe the situation of this fund and its future if there is no action taken by Congress?

Mr. TIERNEY. Senator, I think it would be in exactly the same position that private insurance companies are in. If their costs go up, as they have, of course, just as fast as medicare's, and if they do nothing about their premium income and they continue to pay out more than they take in, obviously, they would be faced with the same position.

Senator WILLIAMS. And what position would that be at the end of 3 years if this were a private insurance company with all these contractual obligations and funds down to zero, as you say this would be? What would be their position? Would they end up in insolvency?

Mr. TIERNEY. Presuming that they went along blindly and never raised their premium; yes, sir. But I might point out to you that rates are going up in the private sector, and I do not say this in any defense of the public programs, or any effort to mitigate the concern for the entire health system of the Nation. But the rates are going up in the private sector just as fast as in the public; in some instances, faster.

Senator WILLIAMS. I will get to you in a minute, Mr. Myers.

I am interested in Mr. Tierney's observation, because as one who operated a small business, before he came to Washington—and maybe will operate one later—I just want to know how to describe myself if I ever get into a situation such as that you may be confronted with, and what situation it would be other than bankruptcy. I do not see why you are so sensitive about that point, and I am willing to drop it. But I do want to get a substitute word. You have been with this program for a long time and you must know where you are headed.

Mr. TIERNEY. I will not quarrel with words. I think you would be in bad shape, sir.

Senator WILLIAMS. We will let it rest at that. But I think I must say, that some of the abuses that were disclosed even in the short period we held hearings earlier, I am somewhat disappointed that most of what we get in response is that you are studying this. I think we

have reached the point where studying is all right, but we do need action.

Mr. TIERNEY. I certainly would not want to leave you with that impression. We are not studying these situations at all. The cases that we reported to this committee, to the committee staff, we have undertaken action in every one of the instances and I think you might want to know the results.

There were some 18 facilities in that report which we made which indicated that there were problems of either abuse or overcharging or deficiencies in accounting practices, or something else of the sort. In 14 of the facilities, we suspended payments immediately. We then went in and did detailed audits. In three of them, we found that no overpayments were established. In 11, we found that there were overpayments involved. In five of them, we have gotten back the full amounts of those overpayments. In two of them, there has been a partial overpayment recovery made and escrow accounts have been established to cover potential overpayment that we had decided upon. One recovery action, as I have told you, was referred to the Justice Department. Another recovery action is referred to the General Accounting Office. And we are still in negotiation with only two of those facilities, Senator. So I do not want to leave you with the impression that no action is being taken.

Senator WILLIAMS. I have noticed that there were 14 cases of possible misutilization or overutilization of physical therapy, and other abuses. In view of the high proportion of abuses and other problems, I will ask you this question: Why were your people forced to find these problems and abuses? Where were the intermediaries who were administering this program? What were they doing? What were they supposed to be doing? Aren't they supposed to monitor these payments?

Mr. TIERNEY. The basic responsibility for not only processing claims but as a byproduct thereof, Senator, to detect patterns of overpayment or abuse or overrendering of services, does lie with the intermediary. I think on the whole, they do a very good job of it. Our job, we think, is to follow up and make sure they are doing a very good job.

These were institutions, not taken in any kind of random sample, but rather institutions in which, through our statistical analysis, we had discovered that there were aberrant patterns of practice or charges or too much physical therapy. So, we went into these facilities knowing ahead of time that there was something wrong. I do not think you should conclude, sir, that therefore they represent a sample of what is going wrong in the whole Nation.

Senator WILLIAMS. I do not think they do, and I never tried to make that point. I am concerned that the intermediary was not picking up some of this. Apparently, it could be going on even now if you had not moved in.

Now, to what extent are the State health agencies supposed to examine these facilities and these payments and to what extent were they doing it, or is the responsibility primarily that of the Federal Government?

Mr. TIERNEY. The State health departments don't actually examine payments or have anything to do with the claim process.

I am talking about medicare, sir.

Mr. VENEMAN. Senator, I would like to, if I may, just tick off a list of things that have gone into effect through regulation and in other forms during 1969, since Secretary Finch took over as Secretary of the Department. We had a regulation that went out, regulation 30–9, which went out to the States for the States to establish utilization review for each item of service provided.

We had another regulation which requires States to reimburse hospitals for inpatient services on a reasonable cost basis using title XIX reimbursement formula, which was consistent with a formula used by title XVIII, so that a State could not pay under the 19 program higher than it has been paying in the 18.

Senator WILLIAMS. I have been noticing those utilization control steps you are taking and think they are constructive. But what is hard to understand is that after we started the work of this committee examining this program and after you started making some corrections, administratively and otherwise, for the benefit of the program—since that time, we are now told, medicare is going to cost a minimum of $3 billion a year more than was estimated before we started these corrections. Now, perhaps Mr. Myers can answer that.

Mr. VENEMAN. We are talking about medicare again now.

Senator WILLIAMS. Medicare now.

Mr. VENEMAN. OK; we are back to that.

Senator WILLIAMS. Before we got into this hearing, we were told it was going to cost $131 billion more than anticipated in the next 25 years. Now in the last 2 or 3 months, you have been taking some administrative actions to impose corrections, to reduce the cost and put more efficiency in the program. Apparently, you must have been operating in the other direction because the latest estimate we get is that it is going to cost us an average of $3 billion more in the next 25 years than the projected deficit.

Mr. VENEMAN. We changed one of the assumptions there. I think that is one of the problems you have to recognize.

Senator WILLIAMS. What assumptions are present today that were not before us 60 days ago?

Mr. VENEMAN. I think for one thing, there was a different assumption on the amount of increase for hospital care projected over the coming years. That is different from the last one. Whether or not this comes to pass, we do not know. Those figures were given this morning, I believe.

I think that is somewhat speculative. I think this thing is going to level off. I think we saw a rapid increase again during the early stages of this program, but I cannot conceive that this thing will continue particularly if we get the prospective rate provisions in and get the other limitations in.

Now, what we have done, Senator, is we have brought some actuaries in as consultants in the Department to review all of these cost estimates so that we will have a check against these within a matter of weeks.

Senator WILLIAMS. This staff report for which the figures were furnished by Mr. Myers projected this deficit at $131 billion. That represents the amount by which medicare expenditures are expected to exceed its anticipated income in the next 25 years. Now, this report is

dated February 9, 1970. Staff got these figures from the Department just before it went to press. And this is still February. We now get another revised figure of a deficit $85 billion higher than the $131 billion reported.

To be frank with you, I do not understand the errors in the first place and I certainly do not understand this $85 billion error in 30 days.

Now, Mr. Myers, you have been wanting to speak. I am looking forward to hearing just how you have picked up $85 billion or found $85 billion that you had not picked up in the 30-period, and what assumptions are before us today that were not before you in December when you made those estimates. That is what I want to know.

Mr. MYERS. Yes, sir.

I am very anxious to talk about the changes in the cost estimates and also, if I have the opportunity, I would like to talk about the question of bankruptcy of a social insurance system.

Senator WILLIAMS. We are not using that word. We are using financially embarrassed.

Mr. VENEMAN. Or underfinanced.

Mr. MYERS. There is a difference between the bankruptcy concept as it relates to social insurance and private insurance, as Senator Anderson well knows because of his association with private insurance companies. I would like to answer this first, and then go into the other subject so as to try to set the record straight as to what is meant by bankruptcy.

First of all, as to the preliminary cost estimate that you referred to that shows this excess of $131 billion of outgo over income over the 25-year period, which was made last September. As I indicated previously, it was a very preliminary estimate. It was made by shortcut methods and approximations, because at that time, I was required to develop something quite rapidly. I know that the costs were higher than they had been estimated in the previous estimate, which had been made in approximately February 1968.

Senator CURTIS. May I interrupt? What do you mean by quite rapidly? A matter of a few days or——

Mr. MYERS. No; this was a matter of a few weeks. At the same time that we were going through the process of making the very detailed cost estimates, we were awaiting some necessary basic data as to where we stood at present as to hospital utilization rates and costs. But this other estimate, as I say, had to be fairly rapid because of the need of developing a legislative program at that time.

Naturally, I hoped that this quick estimate, this shortcut estimate that I made, would be fairly close to what the detailed estimate would subsequently show.

Senator WILLIAMS. Might I ask, what was the legislative program that gave the urgency at the time?

Mr. MYERS. This was the President's legislative program, which was introduced last fall. It did not contain any changes in the medicare program; except that it provided more financing for the hospital insurance program.

As I say, the more detailed cost estimates were worked on for several months, and they were finished up just a week or two ago. When

I was asked by your staff for figures, I told them, I think quite accurately, that I was in the process of making new estimates and that the latest ones we had available were the ones of last September. After I make my estimates, I want to review them carefully. I show them to the officials in the Department for their reactions. They might think the assumptions are way off or something, and the estimates just were not available for release when your staff called.

Senator WILLIAMS. What reaction did you get when you showed them the $216 billion?

Mr. VENEMAN. Interesting.

Senator WILLIAMS. No; seriously. I would like to know just what the reaction of the Department was.

Mr. MYERS. The reaction was just like my reaction. I was very unhappy about it. They were very unhappy about it.

Senator WILLIAMS. That is a good word.

Mr. MYERS. Here is the way that my staff and I made these estimates. As a general procedure, we first develop what we think are the most reasonable assumptions. We talk these over and then agree on them. After that, we go through the mathematics of making the estimates. When the results come out, we examine them to see if they are reasonable. In this case, it seemed like a much higher cost than I ever expected. We went back very carefully through all the calculations to make sure that nothing had gone wrong. And it had not. This was the unfortunate story. The cost was much higher than in the previous preliminary estimate. I would have made everyone, including everybody on your committee and the Secretary and myself, much happier if the cost had been shown to be what it was last fall. But if I made the estimates, and they come out this way, I have to present them that way.

Senator WILLIAMS. Now, going back beyond that period and going back beyond your preliminary estimate when you came up with the $131 billion deficit. Prior to that, when was the most recent solid estimate that you made as to the cost?

Mr. MYERS. Those estimates were made in connection with the 1969 trustees report that was filed about January 19, 1969, and the estimates were made just a bit before then.

Senator WILLIAMS. And they were solid estimates?

Mr. MYERS. Yes, they were complete cost estimates—not shortcut or approximate estimates.

Senator WILLIAMS. What was your projected cost estimate on that? That was about a year ago?

Mr. MYERS. The comparable figure to the $131 billion figure was——

Senator WILLIAMS. That is the $216 billion we are talking about.

Mr. MYERS. The comparable figure to the $216 billion, as I recall, was somewhere in the neighborhood of $60 billion. I do not have that exact figure here, but I would put it in the record at this point if I might.

(Subsequent, Mr. Myers supplied the correct, comparable figure as being $49 billion).

Senator WILLIAMS. I was interested that in the colloquy yesterday, they were talking about rounding out to the nearest even $1 billion. I thought that was a rather interesting observation. I want to round it out to the nearest $50 billion. $216 billion is your projected estimate now, that is solid, 25 years ahead.

Mr. MYERS. Yes, sir.

Senator WILLIAMS. Well, it is solid as of today. It may be changed tomorrow.

Mr. MYERS. No, Senator; this estimate will be kept for at least until we have made our annual revision, so we will be keeping this estimate at least for a year, as long as the law remains unchanged.

Senator WILLIAMS. That is fine. Now, we will go back to the estimate last year. You say there was about a $60 billion deficit then. That would put it up another $156 billion now. If you project a solid estimate last year of $60 billion, how did you come up with a preliminary estimate of $131 billion last December?

Mr. MYERS. No, I am sorry, Senator. The figure was $60 billion. It was not a $60 billion difference.

Senator WILLIAMS. The figure was a $60 billion deficit last year. And that was solid. Today it is $216 billion. In other words, based upon the solid figures, we have $156 billion more projected cost over 25 years than was projected a year ago?

Mr. MYERS. That is correct. The reason for this, as I indicated, I believe, yesterday, is that we have made much more conservative assumptions as to the future trend of hospital costs. In other words, we now assume that hospital costs will keep rising much more rapidly in the future than we had assumed before. We are also including in this cost estimate, for the first time, an assumption that utilization of hospital services will increase gradually for a number of years, whereas before we had assumed that there would be unchanged utilization rates in the future.

Senator WILLIAMS. I understand you get some change, but this is about 400 percent variation. I would like to ask Mr. Veneman, whether you think that it may be a good idea to have a real reappraisal of the projected costs of this by some outside, competent actuarial group that is in no way connected with the Federal Government, even though it may cost—I do not know what it would cost to get them to give us an appraisal. But do you not think that in the light of the fact that we have a 400-percent variation in one 12-month period—a misguess of $150 billion—that a few thousand spent for a real, independent, non-Government agency appraisal would be advisable?

Mr. VENEMAN. I would agree.

Senator WILLIAMS. Don't you think it would be worth whatever it might cost?

Mr. VENEMAN. I think it is extremely advisable, Senator. That is precisely what we are doing. We have two actuaries plus the four medical economists who will be reviewing these figures.

Senator WILLIAMS. Perhaps that is adequate and I will not pass on it and do not mean to pass any reflection on those who were mentioned. I do not know any of them. They may be the world's best. But I had more in mind than a group who did nothing but that type of estimating—an actuarial group that works for insurance companies to bring in for a complete, independent report. Now, maybe we will get it with this group. I cannot say.

Senator CURTIS. If the Senator will yield, I would like to ask the Secretary something.

Senator WILLIAMS. Go ahead.

Senator CURTIS. Mr. Secretary, do you expect that they will come back to you and inquire about certain assumptions that they should make?

Mr. VENEMAN. Certainly. We would have to start with the same base if we are going to have comparative figures—I mean the same assumptions.

Senator CURTIS. Do you think that you would be able to give them a correct assumption on the rate of inflation in the next 25 years?

Mr. VENEMAN. No, I do not think that that would be the administration's responsibility.

Senator CURTIS. I do not care whose responsibility it is. I am asking do you think you could give it?

Mr. VENEMAN. That is part of the judgment. That is part of the judgment. That is what we are hiring them for. You are bringing them in so they could provide us with that kind of information to the best of their judgment.

Senator CURTIS. A lot of our trouble is that we have not recognized all along that this is not an insurance system, that it has no actuarial basis. It is a political system. Suppose they ask you to predict how many times Congress will raise benefits without an accompanying increase in taxes? What are you going to tell them?

Mr. VENEMAN. I cannot predict that, either, Senator Curtis.

Senator CURTIS. I am not trying to make it difficult for you. I am trying to point out what the problem is here.

Mr. VENEMAN. You can stipulate to certain given situations. You can say give us an estimate on a figure given the present level of service, scope of service under the present program, given a $7,800 wage base, then you use that as a base for comparitive purposes to what Mr. Myers has come up with. Then you can make assumptions based upon what if we include drugs, what if we include disabled, what if we have a rising wage base—all of these things.

Senator CURTIS. I am listing some important factors. If these actuaries ask, What can we rely upon as the Federal deficit, not the social security alone, but the general fund deficit that is going to be over the next 25 years. There is no way you can give them a figure on that, is there?

Mr. VENEMAN. No.

Senator CURTIS. That is going to have a lot to do with the costs and every time we have inflation, it is a demand for not only a raise in benefits, but more benefits. If medical costs are rising, there is a greater demand that we include drugs, and a greater demand that we include more ambulance service.

Mr. VENEMAN. We can estimate the costs of those.

Senator CURTIS. Well, I do not think so. I think the sooner we realize that we are running a political system that has had woven into it almost as a matter of trickery over the years terms like calling it an insurance and so on, it has led people to believe that you could arrive at an actuarial cost of the program. It was only in 1968 that one candidate for President in the last few weeks of his campaign, made a bid on increasing social security benefits of 50 percent. Now, we will have quite a few elections in the next 25 years. There is not an actuary in the world who

can predict what kind of promises will be made, by anyone running for the Senate or the House. There is no one who can predict what this committee will do. We have the benefits of a good committee here, good staff, and others. And this committee would be the first group who would say that you cannot predict what will happen on the Senate floor. You have a system here that has no earthly resemblance to financial programs run on an actuary basis.

You did not start it. I am not scolding you.

Mr. VENEMAN. Mr. Ball was here in the early days.

Senator CURTIS. Well, he was an exception.

Mr. VENEMAN. But I think, Senator, we have to recognize that as these changes are made and the way the program is written, you do have to have actuarial information because it has to be a self-supporting program. This is part of the provision of the act.

Senator CURTIS. Well, you need some information on costs. But we have misled, and it has not been just the Congress—we have misled the American people on the whole idea that there could be actuarial answers to this program. This is my 32d year in Congress. I do not think I have ever seen them pass a social security bill but what several Members got up and said, what we have planned here is actuarially sound.

Mr. VENEMAN. They all had to say it.

Senator CURTIS. Every one of them, except this last time, they raised benefits without raising taxes.

Now, there was no such way to write such a statement, because you do not know how many times Congress will change the law in the next 5 years, increasing benefits and so on. You do not know anything about, for sure, about the inflation situation, or how long we will live in this world of deficits. We might be fortunate enough to have to endure gradual inflation. But it might get out of hand. It might go zooming. If anyone feels that you can get an actuarial prediction of what politicians will do to get elected, or an actuarial prediction of what they will do after they get elected, then we can talk about the program being actuarially sound.

Now, I agree with you, Mr. Secretary, that we need as much information as we can get to see just what is happening in costs and where we are going. I am not shocked at what has happened here. I anticipated it because you have not an actuarial system. We have a political system. All us politicians are responsible in one degree or another for it. And it is going to go on and get worse.

Mr. VENEMAN. I think we have two things, Senator. One of them, I do believe that on the benefit side, we can be relatively accurate. For example, the President has recommendations for some reforms in the social security system. Each one is priced out as to what it will cost per percentage payroll. But where we got into trouble on this thing was on the health insurance side, where we are dealing with intangibles. We were not able to say we have X number of people that are going to receive *x* amount of benefits. We said we had a certain number of people that are going to be eligible for medicare. But we had little control over what was a usual or reasonable cost or amount of utilization that would be taken into effect, or the amount of services prescribed. This is where the intangible thing is that is difficult to estimate.

Senator CURTIS. Oh, yes. You have said it more eloquently than I could. It is intangible. You cannot predict it. A long time ago, insurance companies quit writing insurance agreeing to pay somebody's hospital bill. They agreed to pay so much per day.

Mr. VENEMAN. That is what we have recommended, yes, essentially.

Mr. BALL. Senator, you and I have been differing on some of these matters at least since 1952, and I would not want to spoil the record.

Senator CURTIS. It might hurt both of us.

Mr. BALL. One point, though, I really do think deserves emphasis and is a great credit to the U.S. Congress, and that is, in my experience, no social security bill and no health insurance bill has ever been passed finally without the Congress having information and a conviction that the financing that they provided for that package of total benefits was sufficient to cover the cost. And in the cash part of the program, I think with very few, very small exceptions, that has always been borne out. And I am sure that when the Congress voted for this health insurance plan, they accepted the assurances that the contribution rates were sufficient to carry the cost of the program over the next 25 years and that it was an actuarially sound system.

Senator CURTIS. Here was one Member who did not believe any such thing. No reflection on you, but I just did not believe in the prediction, because I think we are running a political system and there is no way that you can predict whether or not projected increases in taxes will take place or whether they will be frozen—all of these intangibles,

Mr. BALL. That is true, Senator——

Senator CURTIS. They always came up with a piece of paper that carried some ifs, and ifs, and if this rate goes into effect or this goes into effect and this benefit stays, we have an actuarially sound program. Well, there was no assurances in any of this.

Mr. BALL. Obviously, the estimates never included the possibility of changes in the level of benefits. All that could be said was that if this level of benefits stayed and this level of contribution rates went into effect then on this assumption, this will be sufficient to meet the costs as they fall due.

Senator CURTIS. But Congress changes the level of benefits just before every election.

Mr. BALL. When that happened, the new contribution rates took that into account. They were always raised commensurately, with the need, but not always with the amount of increase in benefits because in the cash benefits program, savings had developed. Frequently, costs were overestimated in the cash benefits part of the program.

Mr. VENEMAN. That is why they were able to get a 15-percent increase.

Senator WILLIAMS. There is one thing I want to ask. I understand it is your opinion that the 15-percent across-the-board increase in social security could be financed without any increase in taxes. Is that right, Mr. Myers?

Mr. MYERS. That is right, Senator Williams.

Senator WILLIAMS. On that basis then, there would be no need for the Congress to consider approving the previously recommended increases in social security taxes unless we were going to raise benefits accordingly—because it is all solvent as of now.

Mr. MYERS. Yes.

The cash benefits program as it now stands is on an actuarially sound basis.

Senator WILLIAMS. The administration, with its 10-percent request, as I understand it, suggested raising the base to $9,000. Later, the actuaries suggested that you could raise the benefits 15 percent, not 10 percent, across the board, without jeopardizing the financial stability of it.

Mr. VENEMAN. But, Senator, when we submitted the administration's social security amendments, it contained more than just a 10-percent increase.

Senator WILLIAMS. I know it did.

Mr. VENEMAN. It contained other elements of reform that the President and others in the administration felt would be desirable in the program which cost additional money.

Senator WILLIAMS. Only those need refining from this time on, whatever is adopted.

Mr. VENEMAN. That is correct. The 15 percent they were able to get by without additional financing. But we cannot do another thing in the widows' benefit or——

Senator WILLIAMS. And you will not need an increase in taxes?

Mr. VENEMAN. Not if you leave it alone. But the administration is still supporting those reforms.

Senator WILLIAMS. In this same audit report we referred to earlier it says that one of the most widespread deficiencies is the lack of effective intermediary systems for monitoring provider audits. Now, these reports are critical of these intermediary actions. Are you still using the same intermediaries? Has there been no disciplinary action?

Mr. VENEMAN. We made a change in California, I know.

Senator WILLIAMS. Then you read in this HEW report that a large proportion of hospitals are compiling their medicare costs by the combination method because it provides a simpler method of reimbursement than does the departmental method. It indicates that while you have no data as to the total dollar effect nationwide of the inclusion of private rooms and delivery room costs in combination reimbursement, information developed by one intermediary shows that for the largest hospitals, these costs can range as high as $1 million annually in additional payment.

If these are $1 million annually for some hospitals, which hospitals did the report have reference to and what steps need we take to correct this problem?

Mr. TIERNEY. I could not tell you the name of that hospital.

Senator WILLIAMS. Well, what steps have you taken?

Mr. TIERNEY. In your absence this morning, Senator, Mr. Ball reviewed the whole reimbursement mechanism. We started out to point out to the other Senators——

Senator WILLIAMS. I was here, I thought.

Mr. TIERNEY. I am sorry, sir. I forgot.

We started out, as Mr. Ball said, with four different mechanisms by which institutional providers could try to get a fix on the cost of providing services to medicare patients as opposed to providing care for all other patients. Let me say to you, Senator, this is the first time in my knowledge that any insurance program tried to make such a

segmentation of costs. To the private insurer, Blue Cross or others, they pay the same amounts whether people are 6 years old or 65 years old. It is an average per diem across the board.

We were here trying to determine not only what the hospitals costs were, but then to make an allocation of those costs between medicare patients and nonmedicare patients. They did that at the time, Senator, when I think any hospital admisintrator, or virtually most of the administrators in the Nation, would be willing to tell you that cost accounting was not characteristic of the hospital system. There had never been any reason, as I said before, for that kind of precise cost accounting. So we started with that kind of a background.

We first said that they could use a gross RCC method. In that method, you just simply took all of the costs of the hospital and took the ratio of medicare charges to total charges and applied that ratio to cost and that was a way of estimating medicare costs.

Then we had another method which we called the estimated percentage method. There you tried to make an estimate of various costs to be allocated to the different departments.

Both of those methods, sir, in the last 3½ years, we have eliminated and wound up with two methods which are left, one the full departmental and one the combination method.

Now, both of them are mechanisms by which you try to estimate costs. If a hospital's costs, Senator Williams, or if its charges are actually related to its costs, then the two methods work out identically. If, however, there are areas in which there is a great differential or a gross differential between the actual costs of a given service and the charge that that individual hospital makes for that service, then you can get distortions both ways. We do not think at this point in time that it is feasible to impose the most highly sophisticated method on all of the hospitals of the Nation.

I might point out, that in the staff report, they say that they think we have made a good effort but that we perhaps should not be guilty of, if I recall the phrase, an overkill in accounting mechanisms. So that is where the situation is.

I would like to agree with you, sir, that the most precise method which we think now is available to estimate this cost differential is the full departmental step down, cost by cost center, charge by charge center mechanism. But we do not think it is fair to the Nation's hospitals at the moment that this be made absolutely arbitrary.

However, I would point out that this again is the thing that Mr. Veneman was predicating his whole presentation to you on yesterday, sir. As long as we go along retroactively picking up costs and in trying to make these allocations, he does not feel, and I agree with him, that we will have as effective control on costs as we would have if we could prospectively establish what the program will pay and that is it.

Senator WILLIAMS. Perhaps it is right and all we want is a correction and I am not going to pursue this further. But I repeat what I said earlier. As one member of the committee, I am very much concerned at these wide discrepancies in the projected costs of these programs. I realize that we cannot predict what Congress is going to do. But as I understand it, the projections are made on the sched-

uled financing in the law as it was at the time the projections were made. They are made on the basis that there will be no change in the benefits structure and no change in the tax structure. That is the way the projection was made. Then to the extent that Congress changes them later, that has to be taken into consideration at the time. As I understand it, there have been very little, if any, change made between the time of the projection a year ago as far as benefits are concerned and yet a $60 billion deficit was estimated and then $216 billion. I do not recall being given an estimate that the additional $156 billion cost results from changes by the Congress.

Mr. VENEMAN. I think, Senator, you are absolutely correct. There has been nothing in the statute or action by Congress that has changed or modified this. As a matter of fact, as far as administrative restrictions are concerned, it should have reduced costs because we have tightened up on some of the administrative aspects of the medicare program.

But what has changed and what makes the differential is that the assumptions that Mr. Myers has indicated have changed based upon additional information that he has received and more refined figures. He is now making assumptions that the cost for care and facilities will increase in 1971 over 1970 approximately 14 percent. The following years, assuming they will increase almost as much. This is where I think he changed the figures.

Senator WILLIAMS. You realize that we as members of the committee have to deal with the financing of this deficit.

Mr. VENEMAN. We do not appreciate it either, Senator.

Senator WILLIAMS. I think you said this morning medicaid would cost about $2.8 billion in Federal funds?

Mr. VENEMAN. In medicaid?

Senator WILLIAMS. Right.

Mr. VENEMAN. That is right.

Senator WILLIAMS. That was presented to the Congress in 1965 on the premise that it would cost $238 million more initially than the existing program which was then about $400 million. In other words, the adoption of the medicaid program was projected at the outside of around $700 million. Now just a few years later it is high, and going up higher. We wonder sometimes whether we get these low estimates when they want a program and get the real costs later.

This is not—again, I want to emphasize, and I think it is understood—not your problem. You have been most cooperative with us in helping us examine this program. As one member of the committee, I appreciate your cooperation and I compliment you on the steps that you have taken. But as we approach this question of raising the tax rate to finance this program without using the delicate word of "bankruptcy"—as we approach the financial embarrassment situation—somebody is going to have to reassure me that we do have a more accurate estimate of the projected costs before I am willing to support any steps toward increasing the financial provisions of this program. And I would hope that the Congress itself would just say we will stop, look, and get this program started right. So I hope that in any estimate of costs that comes up on any recommended program or any change in program, expansion or otherwise, we will get an outside

cost figure—not just one attractive enough to get the program started, but get the outside costs. Estimates which the administration will be willing to accept if enacted into law with the understanding that a provision could be written into the same bill that if the costs ever exceed the estimates, the administration will automatically stop and come back to Congress for a reexamination of the program. Further, that it will be in effect only so long as it remains in the cost figure that is prepared at the original time.

I am not sure that we are not going to have to put some kind of outside limitation on those programs—to put them on at the time they are enacted. Then there will be some responsibility on the Government official that presents them to make sure he has maximum cost figures.

What would you think of that?

Mr. VENEMAN. I think it could be done. I think we have to recognize again the distinction here that under the medicaid program that you make reference to, the increase in the Federal cost there, we would have to project what the Federal contributions would be had the former program stayed in effect, given caseload increases and other problems that would have occurred.

Also, in that particular program, I see some difficulty in putting a fixed fee on it when we are in fact dealing with 50 States who are moving in, I think, for the most part, with open-ended appropriations.

Now, we have, as Mrs. Hanft testified this morning, we have predicted that this year, the cost of the medicaid program will be just slightly higher than the total Federal cost last year because of some modifications that we are making, some legislative requests that we will be making, including a reduction in our budget amount of some $235 million because of a change in reimbursement formula that we will ask Congress to pass, which was announced this morning.

Now, the only problem I have with trying to close it in on the trust fund side, on the hospital insurance side, would be—and it may be able to be done, may be able to do it there—would be what do you do about the eligibles that may become eligible when you run out of money? That would be one of the problems. An equity problem, I think I am speaking about.

Senator WILLIAMS. Well, perhaps it is not feasible, but I think you will agree that the system we have been operating under for the past 2 years is not at all satisfactory, either.

Mr. VENEMAN. I would be the first to agree to that.

Senator WILLIAMS. And a variation in one 12-month period in the same program, based on the same tax structure, with a $156 billion variation, is quite a variation. I am not an economist nor a mathematician, but I would never have gotten out of the sixth grade with my mathematics teacher if I had made such an error as that.

I am just worrying—maybe I had better not state what I am worried about.

Senator ANDERSON. What estimate has been made by the Social Security Administration of the amount of money that will be saved under this prospective rate proposal?

Mr. VENEMAN. You mean the prospective rate and the doctor's fee proposal we had yesterday?

Senator ANDERSON. Yes.

Mr. VENEMAN. Senator Anderson, I understand from Mr. Ball that an estimate on that has not been made.

Senator ANDERSON. Could you answer, Mr. Ball?

Mr. BALL. I think it is probably very difficult. I would be glad to ask Mr. Myers to comment, Mr. Chairman. There are immediately obvious difficulties in comparing it in a changing situation. But let Bob speak.

Mr. MYERS. I would like to study that proposal a little more, Senator, if I could, and then put something in the record on it.

Senator ANDERSON. All right. I am just hopeful that at least some estimate has been made. We are talking about estimates right along here. If you have some sort of document that might show that there might be some savings, that there might be some worthwhile control in the program, we would like to know it.

Mr. VENEMAN. We will have those figures developed, Senator, and have them submitted for the record.

Senator ANDERSON. Fine.

(The data referred to follows:)

MEMORANDUM

From: Robert J. Myers, Chief Actuary, Social Security Administration.
Subject: Cost Estimate of Savings Arising From Proposals to Modify Medicare Reimbursement Principles.

This memorandum will present cost estimates as to the effect of certain proposals to modify the Medicare reimbursement principles that were contained in the testimony of Under Secretary Veneman in his testimony before the Senate Committee on Finance on February 25.

As to the Hospital Insurance program, it is proposed that providers should be reimbursed prospectively, instead of on a cost basis retroactively as at present. By being challenged with rates set in advance, the theory is that the providers would be more apt to hold down costs, especially if they can share in any savings that are actually achieved. For the purposes of actuarial cost estimates, it does not seem prudent or feasible to make any specific estimate of cost savings now—at least, until some experience under this approach is available to be analyzed.

As to the Supplementary Medical Insurance program, there are two proposals. Under the first one, allowable charges to be recognized in the next fiscal year would generally be limited to the higher of (a) presently recognized charges or (b) a new prevailing level set at the 75th percentile of calendar-year-1969 average customary charges in the area. Under the second proposal, in the future, the prevailing-charge screen would move up only in proportion to increases in an index made up of pertinent portions of wage and price indices.

The "75th percentile" proposal, it is estimated, would reduce total program costs in FY 1971 by about 2.4%, or $60 million. The "index-adjustment of prevailing charges" proposal cannot be accurately cost-estimated, since it is not, as yet, spelled out in full detail; however, it would appear that it might result in relative savings in total program costs of about 1½ to 2½% in the first full year of operation.

ROBERT J. MYERS.

Senator ANDERSON. Senator Curtis?

We have a whole series of questions that the staff has prepared.

Senator CURTIS. I just want to make this observation for the record, I have not been in attendance because I have had another committee meeting. I rather think that we have a system here that has a lot of problems in it. Some unsound things have been done. I have the ut-

most confidence in Mr. Myers' integrity and competence, and I think the majority do. I do not want to be repetitious, but I think it is the type of program, the whole social security system is the type of program that is not subject to actuarial predictions. Mr. Myers may have made some mistakes, I suppose everybody else has. He has performed in an excellent manner.

A friend of mine was in my office this week. He told about calling on an elderly lady in another city. He described her elaborate apartment and said that he knew her well, that she is worth about $50 million. He said, "I was surprised to see on her lampstand near her bed the book she was reading. It was 'How To Avail Yourself of Medicare Benefits.'"

I think it is pertinent to this subject—Congress made the decision to give everybody medical care, hospital care, regardless of their need. It has a lot of ramifications. People who feel that they have paid so many taxes all their lives and that they have it coming—all of this has given us a monster of a program. This will be hard to pay for, it is hard for the local hospitals to get along. When they are behind in the money that they collect from the Government, they have problems.

I am concerned about the raised benefits without raising taxes this past year. I think there is a great political factor involved. The Congress will decide what we did once, we can do again. And I think that we departed from an important principle of restraint in this program. Regardless of what the adding machines add up as to what could be done. We are not dealing with contracts and exact figures. We are dealing with a political system.

Mr. Myers, I know you have problems on your hands. We may have had some great imponderables, but I want you to know I have confidence in your basic integrity and I think I understand a little bit about how tough your problem is.

Mr. MYERS. Thank you, Senator Curtis. What I am more concerned about is my integrity than my smartness.

I would like to say a few words at this point, if I might, Mr. Chairman.

Senator Williams, at least in partial defense of the cost estimates and to give a little more explanation as to just how much they were at variance or at error, whichever phrase you want to use.

First of all, I should point out that, as you well know, when medicare was enacted, there was a controversy between the insurance business and myself as to the costs of the hospital insurance program. The controversy was not over the methodology that I used or the accuracy of making the estimates. The controversy was entirely over the assumptions that were made. And on assumptions—particularly before a program is started—reasonable men could very well differ. They can still differ on the assumptions, because even though we have been in operation for 4 years, there is still no certainty as to just what the future trends are in hospital costs or hospital utilization.

In any event, the insurance company estimate, under the assumptions therein, was about 20 to 25 percent higher than my estimate. Obviously, they were much closer to the truth of the actual experience than I was, but they were too low too.

Now, I think in comparing the cost of the program, if I might say so, Senator Williams, a better way of comparing it is to consider what I call the level cost of the program; in other words, what tax rate you would have to charge from now on out, on a level basis, to support the program, rather than considering, as you did, the excess cost.

Now, as to the reason I say this, let me give an extreme example.

Suppose something is estimated at $200, and another estimate is made of $201. Then, a third estimate is made of $204. The error or the variation, to use perhaps a nicer word, for the second estimate over the first one is $1. The error in the third estimate over the first estimate is $4. Therefore, someody could say, look, there was four times as much error in the third estimate as in the second estimate, and look at how terrible a job it was. Yet the estimates of $200, $201, and $204 are all very close to each other. That is why I think using just the residuals has certain limitations.

Now, as to the estimates of the level cost, let me say that I estimated originally that the level cost of the program would be about 1¼ percent of the payment. The insurance business estimated higher, around 1½ percent. My current estimate, which is the one I have been describing here, and which is the best I believe that I can make at the moment, is just a little over 2 percent. Now, that is a big error. I am not proud of it at all. It is an error of 60 percent. But the fact is that the present estimate is 60 percent higher than the original one.

(Mr. Myers, on reviewing the transcript, noted that the level-cost of 2 percent that he gave as the present level-cost estimate actually applies under the assumption that the earnings base is increased in the future to keep up to date with the assumed increases in earnings. To be comparable with the original estimate of 1¼ percent (based on the assumption that the earnings base remains fixed at the figure prescribed in the law), a figure of 2¾ percent should have been given for the current estimate. If the latter, proper figure is used to measure the variation, then it becomes 120 percent.)

The reason for the variation, I believe, is largely in the assumptions I have made. I think, based on the experience to date, the original assumptions as to what were going to happen to hospital costs were far too optimistic.

Finally, and I appreciate very much my opportunity to make this statement, I might say that any actuarial committee that is brought in, I would welcome. I trust that I will get a great benefit from their views as to the assumptions made. I certainly hope and trust they will not find anything wrong with the methodology. The big difficulty in cost estimates of this type—as several of the committee have said—is in making assumptions as to what is going to happen in the future with a service-benefit plan like this, where the benefits are not tied to the wages on which taxes are paid. That is the beauty, from an actuarial standpoint, of making estimates for the cash benefits program. The benefits are related to the same base as the taxes.

Thank you very much, Mr. Chairman and Senator Williams.

Senator WILLIAMS. I want the staff to go on so we will get these questions in. I am not talking about the difference between $201, $203, $204. Let's face it. We are talking about a projected cost estimate 1 year ago of $60 billion more over the 25 years. Today we are told it

is a $216 billion deficit and that is $156 billion more than last year's estimate and we are told there is still variation. But it is there.

Let's let the staff proceed with its questions.

Senator CURTIS. Are you talking about the total cost of $60 billion or the excess cost?

Senator WILLIAMS. We are both talking about the same thing, the deficit estimates.

Mr. MYERS. It is the estimated excess of the cost of the program over the contributions or the taxes that would be collected at the present scheduled tax rates over the next 25 years. And of course, much of this difference comes in the later years of the 25-year period. The estimates for the early years were not that much different.

Senator CURTIS. But the $60 billion is not total cost?

Mr. MYERS. No; that is the excess of the costs over the tax income. In other words, a deficiency that will have to be made up in some way or other if the program is to be solvent for the 25-year period.

Senator CURTIS. What will the tax income be over that period?

Mr. MYERS. It is in the memorandum I submitted for the record. Over the 25-year period, the tax income is $263 billion. The outgo for benefits and administrative expenses is $479 billion; and the difference between these two figures—in other words, the deficiency or the deficit—is $216 billion.

Senator CURTIS. Now, a year ago, the deficit was figured at $60 billion?

Mr. MYERS. Yes, sir.

Senator CURTIS. What's the latest one?

Mr. MYERS. $216 billion.

Senator CURTIS. But the $216 billion——

Mr. MYERS. The figure in last year's cost estimate for the tax income was somewhat lower.

Senator CURTIS. But the long range is approximately $216 billion?

Mr. VENEMAN. Senator Curtis, I think we should point out that that is assuming that Congress is not going to do what they have traditionally done in the past. This is assuming that there will be no increase in the wage base. This is assuming that over 25 years, the wage base is going to remain at $7,800. That has not been the case.

Senator CURTIS. That is why I totally defend anybody who is called upon to make an estimate with regard to these things. We are running a political system.

Mr. VENEMAN. We can judge a little from the past and we are assuming that the earnings base is to be adjusted similar to the lines Congress has adjusted it in the past, that deficit instead of $216 billion would be $94 billion.

Senator ANDERSON. They are going to ring that bell pretty shortly. I want to get started on these staff questions.

STAFF. Is HEW considering modifying its regulation which requires States to pay hospitals on the same basis under medicaid as they do under medicare, Mr. Secretary?

Senator ANDERSON. Mr. Secretary, if you desire to submit answers to any of these questions later on——

Mr. VENEMAN. On page 3 of our memo commenting on the staff's suggestions, we have that. We are not suggesting the change by regulation. If any change is made, the statute ought to give the meaning to the program.

STAFF. In other words, you want Congress to clarify it.

Mr. VENEMAN. If we can have a legislative clarification, that is all we are suggesting here.

STAFF. In December 1969, you decided to give hospitals a 8½ percent nursing time plus factor. We understand the hospitals wanted considerably more than 8½ percent based upon the data they supplied to you. How valid were their data and what deficiencies did you find in the request of the hospitals?

Mr. VENEMAN. We agreed after we took away the 2 percent—as you will recall, on July 1, the 2 percent allowance was available to hospitals to cover otherwise unidentifiable costs was eliminated——

STAFF. We are talking about the calculation of the 8½ percent.

Mr. VENEMAN. That is right. Following that, we recomputed the formula by which we reimbursed hospitals. Mr. Tierney was in on the negotiations and I will let him answer on the 8½ percent and how it was arrived at.

Mr. TIERNEY. I am sure you know from the report that the 2 percent was applied to the total of all expenses. The 8½ percent nursing service differential was based largely on time and cost studies and the type of things people do in providing nursing services only to aged persons and the nonaged. There was an original indication or assertion that the factor used ought to be somewhere around 13 percent. Mr. Wolkstein, a much better economist and statistician than I, analyzed that data. It finally appeared that the data did support the contention that nursing costs to aged people are in the realm of 8½ percent in excess of those for persons under 65.

STAFF. Was the hospital data faulty? Is it correct that they sought to have you pick up maternity costs, that they had other add-ons in there?

Mr. TIERNY. There were other things; yes.

Mr. VENEMAN. I do not think there would be much maternity under part A.

STAFF. If medicare picks up a disproportionate share of hospital nursing costs under the change in the formula, does that mean that less of the hospital's nursing costs should be payable under medicaid? Have you answered that in your statement?

Mr. BALL. I do not believe it is in the statement, but you are absolutely correct. It should go down. It is our intention in issuing the new regulation to handle that point for medicaid in the same regulation.

STAFF. You conducted, Mr. Tierney, a survey in 1968 which showed that 47 percent of the hospitals in your study were not conducting sample reviews of admissions—a statutory requirement. How many hospitals today are violating the statute? Do you have any later data?

Mr. TIERNEY. We do not have any later data than that. We think that was a projection, if I recall, of a review made of a sample of hospitals, that many of that group were not doing—they were doing review of long-stay cases but not reviewing the sample of all admissions. We have instructed intermediaries to enforce the regulation that that be done. As you may know, in the new cost effectiveness amendments, we have further provisions in this regard that would eliminate reimbursement where there was no medical necessity estab-

lished in the first place. You will recall that originally in the law, there was a requirement of physician certification of necessity, which was, in 1967, eliminated.

Senator CURTIS. Mr. Chairman.

Senator ANDERSON. Senator Curtis.

Senator CURTIS. I wonder if I might have unanimous consent to submit just a few questions in writing and have them answered for the record? I may elect not to do so, but I was unable to be here and I do not want to take up the time to do this.

Senator ANDERSON. The Senator from Nebraska has been a long-time associate in this committee and in the Congress. You should have that privilege.

Senator CURTIS. Thank you. I shall so advise the staff.

(The questions of Senator Curtis, with answers supplied follow:)

*Question. Mr. Myers, unfortunately I could not be present on February 25, when a newspaper article about a paper which you wrote was discussed. When I read the transcript, I found that the discussion was not complete. Would you please submit this article for the record and give your comments on it?*

Answer. The article (attached herewith) is substantially accurate. The only points on which I would take exception are as follows:

(1) In my paper (which has already been included in the record*), I did not charge that sabotage was occurring.

(2) I did not imply any blame to Secretary Finch.

(3) My statement that the current situation is the same as if Mr. Cohen were still Secretary meant only that the Social Security Administration is continuing to function in the policy planning and research areas in the same manner as before. It does not mean that this is true for the Department as a whole, or for any Social Security legislation proposals that the Department has made.

My primary concern is that I believe that the top leadership of the Social Security Administration strongly believes in what I have defined as the expansionist philosophy, whereas the Nixon Administration—judging from various speeches by the President and other top officials—adheres to the moderate philosophy.

Despite what has been said in some earlier testimony, the Commissioner of Social Security is not in the career civil service, but rather he is a political appointee, confirmed by the Senate. As such, he is responsible for directing research and program evaluation and for making policy recommendations directly to the Secretary. On several occasions, I have heard former Secretary Cohen make statements to the effect that those who control the collection of data and its analysis control the future course of a program. It seems fair and reasonable to deduce that a political appointee selected by an Administration that had an expansionist philosophy holds the same beliefs—how else could he have served it well and faithfully?

In addition, I am convinced that the leadership of the Social Security Administration cannot, with its strong philosophical views, serve the present Administration effectively. It is true that such leadership may support all proposed recommendations made by the Administration (as being "a step in the right direction"), but will it strongly defend such recommendations against those who want much greater changes to be made in the program?

In my opinion, the top Social Security position is political in nature—and it should be. If the functions of the Social Security Administration were purely administrative in nature, all its top staff could properly be under Civil Service.

There is no one single "correct" answer as to what should be the nature of the Social Security program (whose overall importance in the economy is indicated by the fact that its expenditures involve about $40 billion per year currently). It is desirable, in this democracy of ours, for different political Administrations to be able to express their philosophy and views as strongly as possible. This can be done only if each Administration has complete control over the formulation of program policies, as well as over research and program evaluation and planning. It is well known that the statistics and the research analyzing

*See p. 37.

the program have a strong effect on the policy recommendations for that program, and thus on its future course.

During the years when Mr. Cohen was in office, and when the expansionist philosophy prevailed, I served—in good conscience and with professional satisfaction—and made the best cost estimates possible, regardless of my feelings about the proposals. The top Social Security Administration staff then quite properly concentrated on research and studies aimed to expand the program, since this was the prevailing philosophy of that Administration.

Now, however, I believe that an injustice is being done by the top Social Security Administration staff in continuing their research and program planning activities along expansionist lines, contrary to the Nixon Administraton's policies. Thus, I believe that, in all good conscience, I must speak up on this subject, and so I have written several papers on the subject of the moderate and expansionist approaches in Social Security.

[From the Evening Star]

SABOTAGE CHARGED ON SOCIAL SECURITY

The chief actuary of the Social Security Administration charges that Democratic holdovers and career employees are sabotaging the Nixon administration's "moderate" policies and substituting their own "expansionist" policies.

Robert J. Myers, a GS–18 career employe who entered civil service in 1934 and has been social security's chief actuary since 1947, appears to place the blame for the situation on Health, Education, and Welfare Secretary Robert H. Finch who, he implies, is trying too hard to please the Democratic Congress. Myers earns $33,000 a year.

"Wilbur Cohen (HEW Secretary under former President Lyndon B. Johnson) might just as well still be secretary as far as any change in attitude is concerned," Myers said.

SABOTAGE CHARGED

Myers made his "moderates vs. expansionists" views known in a speech before the American Pension Conference and later expanded on them in an interview.

Myers charged that Social Security career employes twisted policy and sabotaged Social Security programs during the Eisenhower administration.

He said some of the top career people would write the testimony for the various HEW secretaries to present to Congress, then would slip questions to Democratic congressmen on the House Ways and Means Committee designed to "rip holes" in the testimony.

DRASTIC EFFECT SEEN

Regarding the present situation under Finch, Myers noted that both the commissioner and deputy commissioner of Social Security are holdovers from the Johnson administration.

He said the Nixon administration's policy of moderation in Social Security—that the Social Security System be kept up to date with changes in economic conditions and that any weaknesses or deficiencies which show up be remedied—is being shunted aside by careerists and political holdovers who he said embrace the "expansionist" philosophy.

PLANS OF EXPANSIONISTS

Myers said the "expansionists" want to provide full economic protection when an earning loss occurs. They also advocate that the government should provide a level of income for retirees and disabled persons which is virtually as high as income before retirement, Myers charged.

If the expansionists have their way, Myers asserted, it would have a drastic effect on the nation's economy, greatly reducing private savings and pension plans, reducing investments funds for private industry to expand economic-productivity activities, and would ultimately result in increased government regulation and control "and even ownership of productive activities."

Myers said civil service career employes should be limited to carrying out impartially the policies of the administration in power.

"In the policy-planning field, however, the top policy officials should have staff members working for them who are fully sympathetic to their views and approaches," Myers said. "Too much civil service and too little flexibility in filling top personnel posts can easily hamstring any administration in a particular area."

"For example, if the high-ranking civil service technical employe is of the same conviction as a public advocate of the 'out' party, how can it be expected that he will produce a vigorous, air-tight rebuttal for his political superior to an attack on administration proposals by such an advocate?" Myers asked.

There have been a lot of rumblings among some top Nixon appointees in recent months that career government employes in their departments and agencies have been thwarting their programs.

But none have been willing to be quoted until now when, ironically, Myers, a career official, made the charge against his colleagues.

*Question. Mr. Myers, you mentioned in your testimony that the concept of bankruptcy as it applies in private health insurance does not apply to Medicare. Please give me more details on your views.*

Answer. The financial solvency of an insurance company is determined by whether or not its assets at the valuation date are adequate to meet the liabilities outstanding. Let us first consider a health insurance company which sells only annual term insurance policies, with the premium rates being subject to change each year. The Supplementary Medical Insurance system operates on a somewhat similar basis to this. For simplicity, let us assume that the company sells all its policies on a January to December basis. Then, its financial solvency at the end of the year depends not on whether it has funds on hand, but rather whether such funds are at least as large as the unpaid claims costs incurred to that date, whether already filed for but not yet paid or whether not yet filed for. Such a company could have a sizeable cash balance, and yet it could be insolvent and be placed in bankruptcy by the regulatory authorities.

The Supplementary Medical Insurance system differs from such an insurance company in several important respects. It has a monopoly, in that no similar insurance protection is available elsewhere—primarily because the Federal Government subsidizes half of the cost. When the premium rate is increased, relatively few enrollees will drop out because of the higher cost to them. Thus, if the rate is too low for a certain year (as it is now), an increase later will not cause many to disenroll, and accordingly past deficits (on an incurred basis) can be made up in the future.

Congress has established that the premiums paid by the enrollees plus the equal matching from the General Fund of the Treasury should finance the program adequately on an accrued basis. However, the program can continue operations as long as it has a positive cash balance in the trust fund, even though it is insolvent on a private-insurance basis and deficient as measured by the principles set forth by Congress. It is desirable that the SMI system should have a trust-fund balance which is at least as large as a private insurance company would have as a minimum—i.e. at the proper level on an "incurred cost" basis. This should be the case so as to have equity between different generations—and also so as to have a sufficient contingency reserve.

At the end of 1969, the fund on hand was about $200 million, but there were claims-cost liabilities outstanding of about $730 million. Thus, the trust-fund balance should have been at least $730 million, instead of only $200 million. It would, of course, be undesirable—and also inequitable—to attempt to build the fund up to this level in a year, or even in a few years, by excessively increasing the premium rate for such purpose. But gradual progress towards this goal should be made.

It is not a simple matter to state categorically whether or not the Supplementary Medical Insurance program is insolvent or bankrupt. From a purely technical standpoint, there is no question that, on an incurred basis, it has been in such a condition almost from the very start—and the recent Trustees Reports have indicated this by showing the net actuarial deficit that has been present at the end of each calendar year from 1966 on (see, for example, Table 5 in the 1969 report). If this program were operated by a private insurance company, the regulatory authorities would undoubtedly require its financial condition to be recognized and appropriate financial safeguarding action to be taken.

But from a practical standpoint, there has always been a substantial balance present in the trust fund, and also it is estimated that this situation will con-

tinue in the immediate future (the duration of the currency applicable premium rate). Further, there has been no question, as to the ability of the program to meet its commitments as they arise, considering the ability to obtain additional income through changing the premium rate (with the virtual certainty that the vast majority of the enrollees will continue in the program).

Next, let us consider a private health insurance company that sells only guaranteed-rate, guaranteed-renewable policies, providing benefits of a specified nature that will be available during the policyholder's lifetime. The Hospital Insurance system provides benefits which are of this nature.

Solvency (or, conversely, bankruptcy) for such a company is not measured by whether the company has current assets in excess of current liabilities. Instead, solvency is measured by whether total current assets, plus future premium payments from present policyholders, are at least as large as total current and future liabilities, including (a) future benefit payments to such policyholders for claims that have already been incurred but not paid and for claims that will be incurred in the future and (b) future administrative expenses for such claims. Naturally, for solvency to be present for any type of insurance system, there must always be sufficient assets on hand to pay claims costs as they become due and payable to the beneficiaries.

Thus, if such an insurance company had more total liabilities (current and deferred) than assets (current and deferred), it could be declared bankrupt and then be forced to suspend operations by the regulatory authorities, even though it might have significant funds on hand.

The Hospital Insurance system differs from such an insurance company in several important ways. First, coverage is compulsory, so that there is always the assurance that there will be new policyholders. Second, the contribution rates and the benefit provisions can be changed at any time by Congress if necessary—i.e. there is no legal-contractual basis.

Accordingly, the terms "insolvent" or "bankrupt" are not applicable to the Hospital Insurance system, because changes in its financing (or in its benefits) can always be made by Congress to restore its financial soundness. What can be said is that the program is under-financed or that it has a lack of actuarial balance if the present fund plus the future income (according to the tax schedule in the law) cannot be expected to cover future outgo.

STAFF. In the staff report, the contention is made that the Blue Cross Association, as the prime medicare contractor, often functions as a duplicative and unnecessary layer of administration—this is the national organization—and that under that arrangement, the Government is required essentially to take the good Blue Cross plans with the poor ones. Do you agree with that?

Mr. TIERNEY. We agree. The contract is not clear about our right to choose subcontractors. We notified the Blue Cross Association a year ago, as we must under the contract, that we did not intend to renew the contract which is now in existence. I am not sure that the present contract absolutely binds us to accept any contracting plan. It is not perfectly clear under the contract just what our rights are in that regard and we intend to clarify it.

STAFF. You intend to assert your rights in July? Is that what you are saying?

Mr. TIERNEY. We intend to negotiate a whole new contract in July.

STAFF. In the report, it also is pointed out that social security regional personnel have complained to the staff that they were forced to go through the Chicago offices of the Blue Cross Association rather than the obvious route of dealing locally with local Blue Cross plans and that this causes delay and unnecessary redtape. Have you heard that complaint?

Mr. TIERNEY. We have found that complaint and I think we have learned to overcome that complaint. As you know, under part A, the Blue Cross Association was nominated as the prime contractor by 95

percent of the hospitals in the country. They then subcontract with the local plans. They took the position that they had to be the sole channel of communication between SSA and the plans. We now have onsite in many Blue Cross plans of our own staff representatives so that the problem of communication has largely been eliminated.

STAFF. Last August, you sent a letter to all intermediaries and carriers expressing your dissatisfaction that only one-third of a sample group of those intermediaries and carriers regularly verified that services paid for by medicare were actually supplied. What's the situation today on that?

Mr. TIERNEY. I am not totally familiar with the report you are referring to.

STAFF. It was an intermediary letter to all intermediaries and carriers, from the Bureau of Health Insurance, dated August 1, 1969. It is called "Claim Verification Procedures Development since July 1968." It says: "Responses received indicated that only one-third of a sample group of the contractors answered that they have regularly verified that services paid for by medicare were actually supplied." Is that familiar to you?

Mr. TIERNEY. Yes; that is familiar. This has been, as you well know from our many discussions, a problem inherent in this program since its inception. We have started out with, in many instances, very limited carrier capacity, certainly limited capacity to administer as complex an operation as medicare. It has been our job over a period of 3½ years of constantly improving those things, trying to intensify our surveillance of them, and bringing them up to par. I think we have been successful in those efforts, but there are still, certainly, indications that there are still deficiencies in some carrier operations.

I might say further that in addition to the Blue Cross contract, all of the carrier contracts come up for renewal in July and we are giving very careful analysis at this time as to whether or not there may be some new configuration of carriers.

The basic problem, I am sure you can understand, is that no matter how poor a carrier may have been in the beginning, they now have spent maybe 4 years developing the personnel, computer capacity, technique, and in improving their abilities. It becomes a very difficult judgmental question—shall you throw that full 4 years out of the window and start all over with the new carrier, even though the new carrier may have demonstrated a good capacity in another area, can it now come in and take over this area? We will be examining every one of them against the criteria we have established.

STAFF. As you know Mr. Tierney, in the staff report, we agreed with you on the poor performance of the carriers in the beginning. The staff contended that that created built-in difficulties—that inadequate performance and poor performance at the beginning of the program is responsible for many of the problems today.

For example, about 1 year ago, you sent a letter to all carriers directing them to develop customary charge screens if they had not done so. This presumably meant that a number of carriers did not know what customary charges were by physicians in their areas 2½ years after medicare became effective. How many carriers demonstrated that level of incompetence, and are they still carriers under medicare?

Mr. TIERNEY. I think at the time of that letter, if I am correct in my recollection, there were 14 carriers who had not fully implemented some kind of a customary charge screen. That does not mean that they did not have various mechanisms for determining the reasonableness of fee levels. But we did not feel they were in full compliance with our directive to have both the customary profile of the individual physician's fees and from a composite of that, the prevailing profiles of all the physicians in the area.

At the present time, I think there are perhaps five—and I might want to correct that figure—six carriers which still do not have full operative screens. Now, they have something. Some of them use relative value scale. Some of them use an appropriate fee schedule where it is appropriate

Again, it is a case of are you going to keep trying to develop in that carrier the capacity to do so, or forego all the effort that you made and start over with somebody else who would have to start from scratch?

STAFF. I think in the staff report, the staff recommended, that you not be afraid to cut your losses.

Mr. TIERNEY. For the record, I might say that Mr. Wolkstein points out that I am right, there are four carriers not now using customary charge screens.

STAFF. Last year, in conjunction with the staff study, you had the carriers provide us with profile data on physicians paid $25,000 or more. Do you agree that that profile data, that breakdown of the payments, was essential and just minimal in terms of determination of what a physician's practice was?

Mr. TIERNEY. Yes; I do.

STAFF. The Public Health Service, in looking at the profile data—they looked at it at our request—has reported that their major problem in evaluation was that apparently the claims payment systems used by the carriers are all different. As a result, a vast majority could not provide all of the data requested on the physician profile questionnaire.

Isn't the lack of the capacity to develop evaluative data one of the reasons for the rise in part B costs?

Mr. TIERNEY. Oh, I would not know how to answer that question as a conclusion. I think it is fair to point out again that at the inception of this program, it was not a case of four carriers, it was a case of 50 carriers who did not have this capacity. There were very few insurance plans in the country that covered such things as home and office calls and much of the spectrum of services of medicare. So it has been an evolutionary approach. But I do not think I would conclude that the fact that they did not have individual customary profiles on individual physicians was a major contribution to the increasing expense of the program.

STAFF. Well, they didn't know who they were paying for what. In the report we have here, Mr. Tierney, from the Public Health Service, it says that of 16 physicians identified by carriers as cardiovascular disease specialists, two in fact were thoracic surgeons, who have a much different pattern of practice.

Mr. TIERNEY. That is always a problem with establishing an appropriate code for individual doctors. I think Senator Williams made it very clear during the hearings last July that he felt maybe the use of a social security number would be appropriate. We have certainly moved ahead on that.

It does not mean that simply because the doctor's specialty might have been miscoded, there was an appreciable difference in the amount of payment.

STAFF. How much are you spending in part A on a direct and indirect basis for cost finding and auditing, including SSA costs, provider costs, intermediaries, and anyone else you use? This is all accounting and cost-finding costs that hospitals charge to the program, that intermediaries charge to the program, and which you incur.

Mr. TIERNEY. I think I would have to develop that data. I have the provider auditing by intermediate carriers for fiscal year 1969. The figure is broken out from their other administrative expense. But how much the individual hospitals are spending on accounting and the total SSA audit review figure, I do not have for you. I can attempt to get it.

(The following information was received for the record:)

PART A EXPENDITURES FOR COST FINDING AND AUDITING, FISCAL 1969

In fiscal 1969, intermediaries spent $22,753,230 for provider auditing. The Bureau of Health Insurance estimates that its expenditures for cost finding functions with respect to providers dealing direct with the Government were $277,000 for the same period. HEW Audit Agency costs for cost finding and auditing in connection with direct dealing providers are estimated at $420,000.

We have not included expenditures for the cost finding functions of both providers and intermediaries which are a part of their administrative cost and cannot readily be segregated from the organizations' total administrative costs. For the same reason, costs incurred by the Blue Cross Association for audit review are not included. It would be time consuming and expensive to obtain this data.

Senator ANDERSON. We hate to do this, but would you mind if the staff continued to ask some questions if the members were not here?

Mr. TIERNEY. Not at all. The staff has been asking me questions for 2 years now, Senator.

Senator ANDERSON. If an objectionable question is asked you let us know.

Senator WILLIAMS. These are all friendly questions.

Senator ANDERSON. Thank you, Mr. Secretary, very, very much for what you have done today and your staff.

Mr. VENEMAN. With the Chair's permission, I would like to go back and make a 5 o'clock meeting at the building.

Senator ANDERSON. Yes. Your staff will stay. They are very fine, too.

Mr. TIERNEY. On the question of provider auditing, part A for all intermediaries carriers, in fiscal 1969 amounted to $22,753,230. That is the auditing cost of providers.

STAFF. Right.

Mr. TIERNEY. By auditing firms.

STAFF. That doesn't include the internal cost accounting of the individual hospitals or ECF's?

Mr. TIERNEY. No, sir.

STAFF. And your costs.

In your prospective reimbursement approach to hospitals, would you assume an inflationary factor? That is, when you developed your prospective rate, would you include an inflationary factor?

Mr. TIERNEY. I do not know whether you would call it an inflationary factor. I would think you would have to obviously base any prospective rate on a known postcost already established and then apply appropriate cost indexes to it to try to establish what would appear to be a reasonable rate for the future. This, as you know, is what they are attempting to do in New York City with their new plan. They establish a limitation by class of hospital, so that no hospital's costs can exceed, I believe it is 15 percent above the group average. But you have to build into the prospective rate some estimate of what cost increases are going to be during the prospective period.

STAFF. Mr. Tierney, Secretary Veneman and others have recommended prospective reimbursement and discussed the problems with retrospective reimbursement and so on. There seems to be a key question which the staff has, that in negotiating with hospitals or with anyone else, what assurances are there that the Government will receive strong, expert, public interest, arm's-length bargaining with the hospitals? Now, Blue Cross can't provide that.

Do you agree with that? They have a particular relationship with hospitals.

Mr. TIERNEY. I think I would want to say for the record, that as you well know, Blue Cross without a doubt is the child of the hospitals. I think over the years, they have recognized that they had a basic choice of either being a producer cooperative, if you will, or a consumer cooperative. In more recent years, they have recognized the greater responsibility of being a consumer cooperative. They have had a lot of experience in negotiating with hospitals, dealing with hospitals. In some areas, they do, as you well know, a much more expert job than others. But I would not want to say they should be precluded from participating in negotiating——

STAFF. No, but in all of this, who would you say can assure the Government that it is receiving arm's-length public interest bargaining when it negotiates these contracts prospectively or retrospectively?

Mr. TIERNEY. I think Mr. Veneman pointed out the potential for utilizing review committees comprised of representatives of the public including representatives of the Government, representatives of the providers, representatives of the third party payers. There are a number of mechanisms that would have to be employed.

I think one of the great advantages, frankly, of the prospective approach is that it gives visibility to the whole procedure. You known on a given date, December 31, that next year, you are going to pay St. Luke's Hospital so many bucks and you can put it in the paper and everybody can examine it. That in itself, I think, gives the greater visibility and the greater protection to all purchasers of care than does this thing of coming along 2 years later and finding out what it costs.

STAFF. Obviously, that is going to be looked into quite a bit more.

Our next series of questions is for Mr. Hess. In the staff report, we had some fairly strong comments about the determination of

reasonable charges under medicare. We would sort of like to go through this a little bit.

You were the director of medicare at that time and running the show.

Mr. HESS. Right.

STAFF. Did anybody suggest to you in 1965 and 1966 that Congress intended limiting reasonable charges to not more than a Blue Shield carrier, for example, paid for its own subscribers under its regular contracts?

Mr. HESS. There was a good deal of discussion, as you know, after the enactment among ourselves and with the General Counsel's office and with others as to what was intended. A study of the legislative history indicated not only the statutory definition but, as you point out in your committee report, the reference in the committee language that in some circumstances, a Blue Shield schedule might be useful. Certainly the whole matter was considered because of the problem of giving interpretation to the legislative history. As you know, the provision which passed the House did not have this in the language of the law itself, but had in the committee report the reference to the fact that in determining reasonable charges, consideration would be given to customary and prevailing. That was then added to the actual language of the law in the Senate and the final enactment presented us with a series of criteria which it was necessary to interpret and to discuss with the carriers in terms of how they would apply these criteria.

STAFF. How many Blue Shield plans had customary and prevailing contracts in wide use when medicare started?

Mr. HESS. I would think if you want to say in wide use, there were probably none, since it was not a substantial Blue Shield development at that point. However, Blue Shield was, in the period 1963, 1964, and 1965, rapidly moving into this area. And of course, all their Federal employee contracts were on this basis.

STAFF. I beg your pardon?

Mr. HESS. Their contracts for Federal employees.

STAFF. The Blue Shield contracts in 1966 for Federal employees were on a usual and customary basis?

Mr. HESS. The high option, yes.

STAFF. The major medical——

Mr. HESS. The major medical, yes. You have, of course, the basic medical, surgical, and then the high option.

STAFF. Dan Pettengill of Aetna told HIBAC in 1966 that most physicians do not actually use a consistent schedule of fees but vary fees from case to case. Under such circumstances, don't you think it natural for doctors to select their highest fee charged as customary for medicare?

Mr. HESS. Not necessarily. I think here again, historically, you have to recognize that in the period in the early 1960's and even previous to medicare, this was charging as you got more and more insurance coverage. Then with medicare coming in as a result of supplementary coverage and as a result of extension of large group plans, which were demanding to be written on a basis that provided reimbursement to cover the liability of the individual pretty much for what his physi-

cian would charge, there began to be less of fee variability on the part of physicians and many of them began to charge established customary fees. Of course, the determination of what is "customary" is not a physician's responsibility, but rather is determined by the carriers on the basis of guidelines contained in the SSA regulations.

STAFF. Who was the largest third-party insurer for physicians' fees, Mr. Hess?

Mr. HESS. Blue Shield. And as you recognize, Blue Shield fee schedules and coverage, again historically, quite typically were of two kinds: Some in which there was only a fixed liability and others in which there was a fee schedule which purported to have been developed in some relationship to customary and prevailing fees. The latter discounted fees for low-income individuals, that is, participating physicians would agree to the actual charge that the plan would recognize as its liability being the total liability of a low-income patient.

STAFF. What did you consider low income, Mr. Hess?

Mr. HESS. That varied with the plan. That was by plan definition. Whatever in a particular—I am talking about plan conditions. You asked who was the largest insurer. I was saying that it varied with the plan in terms of the circumstances under which they would provide a full service——

STAFF. You mean $5,000 to $7,500 would——

Mr. HESS. Not necessarily.

STAFF. Blue Shield testified in 1965 that they had extensive data on physicians' customary charges. Was that statement true?

Mr. HESS. I don't think it was. Let me qualify that simply by saying that I think all of the testimony of the insurance industry as to what they knew about physicians' charges was dependent on the circumstances under which they received claims in the coverages that they had. Now, most of the insurance carriers and the Blue Shield plans were developing major medical coverage and did have records that they might have considered representative, particularly of certain in-house surgical and medical charges. Many of the Blue Shield plans collected fee information even with respect to claims where the physician was obligated to take their allowance for a full-service benefit.

The question of what charge the physician put down varied considerably. He might put his regular charge down, notwithstanding, knowing that since it was a full-service benefit, the Blue Shield plan would simply send him the charge that was appropriate. I think they did not have the kind of data collection systems that could assure them that the charge that the physician sent in, especially with respect to, if I may call it, the low-income coverage, was a customary charge. In other words, the physician, knowing what the plan would pay, might have put that down as his fee.

STAFF. But those service income plans covered a very large percentage of the working population in many areas.

Mr. HESS. Yes.

STAFF. How many carriers had comprehensive and adequate data on physicians' customary charges when medicare began?

Mr. HESS. Well, many of them claimed to have. I think you will recall that when we announced in—was it the Commerce Business Daily, or whatever it is called—the requirements for the program, and when we subsequently selected carriers and entered into contracts with

them, it was clear all along that they were to have the capacity for doing a number of things. Those that applied stated to us that they had the capacity, among other things, to keep track of or develop or collect from their systems customary charges in the community. Now, again, this is relative.

Mr. HESS. It is a question of relative attainment of a goal which today looks like quite a different goal to the insurance industry from what it looked like at that time. The question of how comprehensive your data collection system has to be in order to make you feel you have confidence as to what customary charges are, goes all the way from someone who might feel that you have to have computer data on every customary charge of every physician, to the carriers who felt that on the basis of the surveys they did, they had fully adequate information. And many of the carriers that we dealt with—and the basis on which we accepted their assurances that they knew what customary charges were—had conducted various kinds of surveys and extracted from their claims processes various kinds of data.

STAFF. Blue Shield told this committee in 1965 that "even in indemnity plan areas, the Blue Shield schedules generally reflect the prevailing charges in the community and that including service benefit plans, an increasing percentage of claims are satisfied in full by the Blue Shield payment."

In implementing part B, did you find that claim valid?

Mr. HESS. Well, I think we might have differences of opinion between various people as to how valid that claim was, but I think you and I tend to agree that that was an overstatement of what the——

STAFF. Would you tend to agree that possibly the Congress relied on that sort of statement from the largest medical insurer in the country?

Mr. HESS. No, I don't think so. I don't think this was the primary assumption on which the Congress predicated this program at all.

STAFF. At the start of medicare, didn't some Blue Shield plans contend to you that their existing fee schedules reflected customary and prevailing charges in their areas?

Mr. HESS. Yes.

STAFF. Why were they then instructed to ignore the schedules?

Mr. HESS. Well, they weren't instructed to ignore the schedules. They were instructed to pursue the administration of the reasonable charge determination with a series of criteria which permitted several possibilities. If there were indeed schedules that were fairly representative of the liability of patients generally for the kinds of charges that physicians were making they could use those. But the mere fact that the plan exceeded the schedule did not ipso facto mean that they would be out of conformity with our efforts at administration. We knew that for some of them, that was the very best information they had. Some of them for some considerable period of time have used their schedules as indicative of customary and prevailing.

Now, they had to enrich the grid, because in some instances, the schedule didn't cover all kinds of procedures, so they would go to relative values.

STAFF. Dr. Ackerman, chairman of the National Association of Blue Shield Plans, told HIBAC that in some areas, 95 to 98 percent of the

fees charged were made under established Blue Shield fee schedules. In those cases, did the remaining 2 to 5 percent of fees constitute the doctor's customary charge for medicare purposes?

Mr. HESS. I don't know what Dr. Ackerman was referring to. I don't really know of any areas of the country, except perhaps around Rochester, N.Y., where you had the kind of depth of penetration where you could say 95 to 98 percent of the charges doctors were making to the entire population were coming under Blue Shield schedules.

Maybe Mr. Wolkstein can help on that. Do you have any objection if he assists me?

STAFF. No.

Mr. WOLKSTEIN. We were just mentioning to each other here that Blue Shield largely covers inhouse care, surgery and medicine, while outside of hospital care was largely not covered. That would be one defect in the use of the Blue Shield schedule.

The other issue was that they never, even in the highest penetration areas—that is, like Rochester—Rhode Island had very high coverage, also some large cities scattered around the country. But even in those areas, the aged had low coverage, and generally speaking, the highest you might get in a Blue Shield area might be as high as 80 percent. I don't believe there would be an area any place in the country that had something over 90 percent.

Now you get into an issue of the sort you are talking about in an area where there is very high coverage.

STAFF. Try New York City, where the New York City Blue Shield people told us that they had surveys in 1965 asking doctors about their customary charges and doctors came back with essentially the same allowances made under the $4,000–$6,000 Blue Shield service benefit schedule.

Mr. WOLKSTEIN. My recollection on New York City is that a study by Columbia University found the most widely held plan for many years there to have an outdated schedule and a very low-income service benefit arrangement. Now, I am not saying that there are not other areas where your point is better taken, where the schedule is higher and the income ceiling is higher so that the coverage is more complete.

STAFF. The schedules are changed, though, from time to time, as well as the premiums. They are not static.

Mr. WOLKSTEIN. That is right.

STAFF. Mr. Hess, on March 26, 1966, you told HIBAC that pressures had arisen to disregard fees accepted under Blue Shield schedules in determining customary charges on the grounds they are substandard. Where did those pressures come from?

Mr. HESS. Well, I do not recall the exact statement or the exact circumstances, but I think what I was undoubtedly referring to was that in the course of our many consultations as to what possible options we had open when we looked into this question to which you have alluded. The testimony of the Blue Shield people was to the effect that their schedule or experience was quite appropriate in relation to what doctors were generally charging and that it was fairly up to date. Then, there was pointed out to us by medical society people and by others that in fact, we could not rely on that assumption. And, of course, exceptionally high charges to wealthy people were excluded.

STAFF. Right after you pointed that out, that those pressures had arisen to disregard Blue Shield billings you then proceeded to say that, disregarding those Blue Shield billings however, might seriously distort the physician's actual fee pattern. Yet the Department then went ahead and proceeded to issue regulations or instructions which set up a situation where the staff concluded physicians' fee patterns were seriously distorted.

Mr. HESS. No, I think—I would certainly have to have the opportunity to review in context, and maybe I could have the privilege of reviewing it in context and either elaborating on this—but I do want to make this comment. I think what we were talking about at the time was what goes into the physician's profile. We certainly took the position that in the physician's profile, charges that he makes under a Blue Shield coverage are not to be eliminated from the profile, that results in the determination of customary and prevailing. It could affect his customary charge. I think the only fees that we ever indicated were not to be included by the carrier in the profiles that result in the determination of customary charges were those distinctly discounted fees that were presented, let us say, to a welfare program or under circumstances where it is perfectly clear that the physician either presented the fee or received the payment that was quite obviously in recognition of the inability of the welfare program to pay a customary fee.

STAFF. It says here in the HIBAC minutes:

> Commissioner Ball stated that he thought it would be reasonable to exclude charges made in welfare cases.
>
> "Then in this connection, Mr. Hess informed the Council that pressures had arisen to disregard fees accepted under Blue Shield schedules in determining customary charges on grounds that they are substandard. He stated that disregarding these might seriously distort the physician's actual fee pattern."

Precisely where and in what manner did you apply the Finance Committee 1965 medicare report language concerning service benefit plans that "use of the same agreed-upon fee schedules that are employed in their own programs may be helpful in avoiding the possibility of disputes regarding fees?"

Mr. HESS. As you know, the statute itself places the responsibility for determination of reasonable charge on the carriers. Both the statute and the contractual agreement with the carrier places upon them an obligation, working within the guidelines and then subsequently the surveillance that we provide, to make appropriate determinations of reasonable charge and in doing so, to take into account both the statutory and other considerations. We conferred, as I said before, with the carriers at length, certainly over the early years. And I think Mr. Tierney and his staff can speak for the later years, in which there has been more intensive contract performance review. Whenever there is a contract performance review in which there is a specialist along from our reimbursement team—a part B reimbursement specialist—we go into the whole question of the nature of the adherence to the guidelines.

STAFF. How many of your carriers did not have customary charges data as of January 1968—based upon doctors' charges to all their patients, not just medicare?

Mr. HESS. I would have to supply that for the record.

STAFF. Would you supply that?

Would you say that a majority of them did not use all their charges in calculating customary and prevailing physicians' charges in January 1968?

Mr. HESS. Didn't use all their charges?

STAFF. Yes, sir.

Mr. HESS. Yes; I would have to say subject to—I would have to check on what the Blue Shield carrier did.

STAFF. We would want the commercials, too.

Mr. HESS. Of course, the Blue Shield carriers were the majority. If the Blue Shield carriers were using, as many of them did, a combination, a grid of reasonable charge screens, which included in some instances information from their fee schedules and adjusted by relative value and other techniques, that would, as I say, be something that we would have to look at.

(The following information was received for the record):

CARRIERS NOT HAVING CUSTOMARY CHARGE DATA

The information in our records on the number of carriers who did not have customary charge data based on doctors' charges to all their patients reflects the situation as of February 1968, rather than January. At that time, 15 part B carriers with medicare service areas in 25 States were using customary charge data. Five of these carriers had used data on charges under their private programs in establishing and validating their medicare customary charge screens. The remaining 45 carriers in the country had not done so. However, five of these did use data from their private programs to establish and validate medicare prevailing charge screens. In addition, there were a number of other carriers who were processing medicare claims using fee schedules or relative value scales with conversion factors (a) taken from their private programs, (b) based on studies of their private program experience, or (c) based on information obtained through surveys of physicians.

At the present time, there are only four carriers not using customary charge data in determining reasonable charges under medicare, and two of these are on the verge of doing so in computerized operations. Three of these four carriers have, however, used data from their private programs in establishing and validating their medicare screens. In addition, among the remaining carriers that are using customary charges, there are 36 which have used data derived from other programs than medicare, including their private insurance plans, to establish and validate their customary and prevailing charge screens.

STAFF. That is a more sophisticated approach than was generally reported. One of your carriers wrote the staff when asked "What customary charges did you have when you applied as a medicare carrier?" and said "None."

Then when asked "What data did you have when you started as a medicare carrier?" again, the answer was "None."

Mr. HESS. Right. One said that.

STAFF. As we have discussed here, the carriers in general did not have valid data within the context of your instructions and regulations on customary and prevailing charges when medicare started. Most of them did not. Without such data and in view of your instructions to disregard payments made under service income contracts, what effective gages and controls with respect to physician charges did medicare have in July 1966, when it began?

Mr. HESS. You have been pointing out, and I think I have been agreeing, that many of the carriers had quite incomplete information with respect to the customary charge. Now, the customary charge for a particular physician is a very good thing when it cuts below the

prevailing. But it is not the only cutting edge for his claims. The carriers had prevailing, their own prevailings which they used, or appropriate prevailings which they put into effect, which were quite effective cost controls in terms of what they were going to pay on a particular bill.

STAFF. Another carrier wrote the staff that their prevailing determinations were based upon personal knowledge in the local claims office of some claims adjuster because he was familiar with the billing habits of doctors in the area.

Mr. HESS. I don't think that is a fair characterization.

STAFF. They are still in the program.

Mr. HESS. I don't think that is a proper characterization of the extent to which, or the method by which, carriers establish prevailing screens.

STAFF. No, but it does indicate the extent to which some of them established prevailing screens.

Mr. HESS. No, many of them used relative values, taking off from appropriate fees in their own business. The whole technique of using relative values gives a good deal of substance and body to a fee grid.

STAFF. How much of the substance and body is present? How many carriers are using that, because there is material here indicating that you are having a great deal of problems—still having problems getting your carriers straightened out on customary charge determinations.

Mr. HESS. The question is what?

STAFF. In other words, all these things sound very fine.

Mr. HESS. I would certainly agree with you that from the point at which we started in 1966 to the present, we have worked diligently and not overcome many of the technical and other problems which are inherent in this complex concept of determining reasonable charges. But the point I was making is that I think a lot of headway has been made and I think the statistics that Mr. Tierney gave earlier in the afternoon indicate that gradually, we have gotten down to the point where their computer capacity, their systems capacity, and the information that the carriers have given us, provide a good deal more assurance -this is the point that I think we are making—a good deal more assurance than we had in 1966 and 1967.

STAFF. I think our point is that really, we started off with an inflated, uncontrollable base. That is the staff's contention. And that any efforts today are helpful, but the horse got out of the barn in 1966.

Mr. HESS. I think our point is that what we started off with was a reasonable charge determination process that was required by the statute and that we did the very best we could with what the statutory language and the committee report language, read together, indicated was the congressional intent. I do not want to prolong this if you are not disposed to. But I would like to refer at this point, simply refer in cross-reference to a statement that we asked to put in the record earlier in the afternoon.

STAFF. We have not had a chance to read them.

Mr. HESS. Right. I am simply cross referencing to that, because it bears directly on this subject.

STAFF. In May of 1969, you indicated that the Maryland, Rhode Island and Colorado Blue Shield plans were notified that they must fully implement the guidelines for determining reasonable charges or risk cancellation of their contracts. Are they fully implementing those guidelines now?

Mr. TIERNEY. No; as I pointed out, I think, Colorado is not.

Would you mind reading the three?

STAFF. Maryland, Rhode Island, anad Colorado Blue Shield.

Mr. TIERNEY. I think Rhode Island, to the best of my knowledge, is fully implementing the program. They put in a new EDS system. I might say the Colorado Blue Shield is scheduled around the end of February to complete the installation of a model system which will give them this capacity. I would have to give you the present status of Maryland.

(The information referred to follows:)

STATUS OF MARYLAND BLUE SHIELD WITH RESPECT TO IMPLEMENTATION OF MEDICARE REASONABLE CHARGE GUIDELINES

Maryland Blue Shield now is using customary charge screens, based on the median of the charges made for a service by the physician or other person rendering the service during 1968, for all services except radiology and pathology.

Under our instructions of February 25, 1969, it was required to continue using the same prevailing charge limits that were in effect at the end of 1968 until at least June 30, 1970 and at the end of 1968 the plan had not implemented all guidelines. However, Maryland Blue Shield has developed the necessary data and systems capacity, and will be able in July 1970 to revise its prevailing charge screens to further improve them. These reasonable charge screens for physicians' services have been fully computerized.

For out of hospital radiology and pathology, the carrier is using a fee schedule which it uses under its own private programs. The carrier has advised us it is prepared to revise this screen also, in accord with BHI instructions.

A contract performance review of Maryland Blue Shield is scheduled for the week of March 16, 1970, and all aspects of the carrier's reasonable charge methodology will again be thoroughly reviewed at that time.

STAFF. We wanted to correct one misinterpretation which appeared in Secretary Veneman's statement and in a statement by Commissioner Ball: The staff did not recommend in its report that medicare make payments to physicians on the basis of Blue Shield fee schedules. The report indicated our belief that it should have been related to those schedules in the beginning, but that it was too late to do that now. Now, we just wanted to point out that we do have two proposals on pages 10 and 11 which do not tie into Blue Shield schedules.

Mr. TIERNEY. I think it is clear in the paper that Mr. Hess referred to that we understand this now.

Mr. HESS. Yes; as a matter of fact, we refer quite specifically to the staff's so-called stopgap recommendations. It would be worthwhile your reviewing that when you have an opportunity to and then we can talk further about that. There is no misunderstanding.

STAFF. Mr. Tierney, in Colorado, what proportion of the 65-and-over population in that State, would consist of individuals having incomes of $4,000 or couples with $6,000?

Mr. TIERNEY. I have been away from Colorado for some time. I would hesitate to say. I would assume on a $6,000 level, a relatively high proportion of people over 65 would be below that.

STAFF. How about $5,000 and $7,500 in New Jersey?

Mr. TIERNEY. I have only passed through New Jersey on the train.

STAFF. How about $4,000 and $6,000 in New York City for the aged?

Mr. TIERNEY. I would assume, from all the information that I know about the aged, $6,000 income would include a very large proportion of the aged.

STAFF. The only point we are making is that some of the Blue Shield plans have been somewhat critical of the comparative table shown in the staff report where Blue Shield's most widely held contracts were compared with medicare's average payments. Many of those Blue Shield allowances are service income benefits, where the older person would have qualified for full payment under the Blue Shield contract.

Mr. TIERNEY. I think in reference to those minutes in which you were referring to, Dr. Akerman's statements that you were making, perhaps for purposes of the record and to clarify Dr. Akerman's understanding of the congressional intent, the minutes reflect that he was asked if the use of a fixed fee schedule developed, was being proposed by him or by the carriers. He said that while it would be easier for them to administer such a fixed fee schedule, he realized they could not ignore the congressional intent or discontinue the staff for the purposes of easing the problems of administration. I think it is clear that Dr. Akerman was not advocating a fee schedule.

STAFF. That took place after medicare went into effect. It was December of 1966, where he got into that.

We are interested in the supervisory physician. Do you think you can get Mr. Blumenthal up there?

Precisely how does each medicare beneficiary in a teaching hospital recognize, acknowledge, and contract with a supervisory physician?

Mr. HESS. To whom is that question addressed?

STAFF. You might as well handle it, Mr. Hess.

Mr. HESS. Obviously, we know that precisely each medicare beneficiary at a teaching hospital does not recognize the circumstances of his relationship with every teaching physician he may come across, because the circumstances vary greatly under which physicians serve in a supervisory or teaching capacity. For example, some beneficiaries may see "teaching physicians" and think they are their attending physicians. Yet the circumstances of the service on "grand rounds" or otherwise, may be such that there is no personal service to that patient cognizable on a fee basis. And that teacher may be on a salary, or he may be a voluntary teacher. If there is any medicare responsibility at all, it would be to meet the share of the teaching cost.

STAFF. Where does the beneficiary assume the responsibility?

Mr. HESS. On the other hand, there are many circumstances under which a physician performs a very personal, intense, lifegiving service to a patient under the same circumstances that he would have to any private patient, had the patient come to his office on the outside. But this particular patient happened to be referred to him in a teaching hospital setting. The mere fact that the referral took place there may cause the patient to feel that he has a different relationship to the physician yet, in fact, that physician is actually performing all the services warranting a change.

STAFF. Does the medicare beneficiary know that an attending physician is submitting bills with regard to him and that he is liable for that charge? How many medicare beneficiaries are aware that doctors are submitting bills for services to them for $500, $600, or $700? In one case we heard about yesterday, involving payments of more than $6,000, the patient was fortunate enough to have four attending physicians simultaneously at a certain teaching hospital.

Mr. HESS. Again, you have the tremendous variety of circumstances that are involved. The mere fact that the doctor submits that bill does not necessarily mean that it is a valid bill which either the beneficiary or the program should recognize.

STAFF. But are those bills submitted to the beneficiaries for payment and then assigned?

Mr. HESS. They may very well be, but whether they are submitted to the beneficiary or whether the beneficiary has given an assignment and they are submitted by the physician on an assignment, the beneficiary gets an explanation from us. In other words, every charge which a carrier recognizes and pays, irrespective of whether the payment is on assignment or otherwise, generates an "explanation of benefits" to the beneficiary, so he knows that charge has been paid. Even in the case of hospital-based physicians who charge for radiology or pathology, the patient may otherwise never know that a particular pathologist or radiologist read his plates or furnished diagnostic information.

STAFF. Have you had any beneficiaries complain or write in saying, "What's this," when they receive an explanation?

Mr. HESS. On occasion; yes. I think you might recognize that anybody who is involved in a large claims process gets a tremendous range, if not always a tremendous volume, of inquiries. Some may be characterized as complaints. They come from all kinds of circumstances—confusion, lack of information, or in some instances, legitimate complaints.

STAFF. You put out a question-and-answer letter on payments to supervisory physicians a few weeks ago. In effect, it seemed that in question 11, you were instructing hospitals how to create a legal liability on the part of the beneficiary to the hospital. Would you look that over and see if we are wrong on that?

Mr. TIERNEY. I think I can say you are wrong before I look it over.

STAFF. Well, please read the third part of that answer, then.

Mr. TIERNEY. The question is one of the requirements of intermediary letter HL372, that the attending physician must be recognized by his patient as an attending physician. How can the fulfillment of these requirements be met and the——

STAFF. Why don't you read it?

Mr. TIERNEY. The answer is: "This requirement is obviously met if the doctor-patient relationship is established prior to admission and continues throughout the patient's stay; that is, as evidenced by the meeting of other requirements. It is clearly not met if the patient is seen by residents or interns—or other physicians—and never saw the physician in question. In the less clear-cut situation, where neither of these circumstances exists, this requirement may be assumed to meet the requirement if the practice of the hospital—or a department—is

for the physician to be identified to the patient as his attending physician for, at least, the period in which he satisfied items A.1.a. through A.1.e of IL372."

I can get three things here. In IL372, one of the things that we said should be taken into consideration by a carrier as to whether or not an actual personal physician-patient relationship existed was whether or not the patient identified with this particular individual. Well, the carriers, in my opinion, quite correctly said to us, "How in the world can we look at a claim or 9 million claims and know whether a 85-year-old woman identified with this guy or that guy or the five other guys around."

Now, you cannot impose that on a claims process. So all we were trying to say here is that the purpose of that was that there be an identification to the patient of the attendance of a physician.

STAFF. Excuse me. When the teaching physician identifies himself as an attending physician to this 85-year-old lady flat on her back, does he also identify that she is liable to him for an unspecified amount?

Mr. TIERNEY. No; I do not think he does at all. What we are talking about here is how does a carrier going into an institution—and as you know, they have gone into 241 major teachings institutions in the Nation—determine the pattern of practice in that institution and whether or not actual personal professional services are being rendered. You and I have talked at length about eminent institutions in this Nation which believe in an educational approach involving a team of medical-paramedical personnel. No question about the quality of care, no question about the reasonableness of charge, no question about the personal rendering of care by the team leader. But the little old lady, 85 years old, that you are talking about, on her back, she doesn't identify with this man, maybe, and certainly he doesn't sit down and talk with her about their billing relationship. I agree with you.

STAFF. We just wanted to get that on the record.

Mr. HESS. May I say something on this general subject. I think the comment I want to make here is pertinent. I think the searching questioning that the committee staff has done, as well as the much more intensive work that we have done in the past year in trying to identify the great variety of situations under which it is necessary for the program to be able to say yes or no, the great efforts that have been made not only to prevent abuse in situations where there has been unconscionable abuse, but also in situations where there has been inadvertent activity that none of us would have intended—all of these things have pointed out that the present law is quite difficult to apply in every case. From an administrative point of view it is hard to document, in terms of totally satisfactory claims documentation, some types of teaching situations. We are quite responsive to the suggestions of the staff report, and in terms of our own experience, we are quite responsive to the idea that we probably ought to be seeking, through amendment, for a better variety of options than we now have. For example, in the health cost effective amendments under the broadening of the incentive reimbursement and demonstration authority, we are seeking authority to work with certain types of teaching

situations to try to get an ability to respond on a cost-related basis to a bona fide liability. And, of course, not to respond to where there is no bona fide liability. This would make a lot more sense.

STAFF. Then you are saying essentially the same thing the staff did, if you are relating it to the cost.

Mr. HESS. For some situations I think you will find in our document that the analysis of this begins to narrow down to the fact that the law was not written with the clear intention of these teaching situations in mind, and we have been struggling for 3 or 4 years, within the context of the part B fee for service situation and the part A administrative and teaching cost situation, to try to sort these cases out. An amendment or consideration of amendment or series of amendments to provide us some options here would make a lot of sense.

STAFF. Isn't it true that the same work group which recommended these methods of paying teaching physicians—and which essentially consisted of teaching physicians, who determined how supervisory physicians were going to be paid—also tried to recommend to HIBAC and SSA at that time that you accept fee-for-service billings by residents, salaried residents in institutions? However it was pointed out to them that that was expressly prohibited by the law.

Mr. HESS. That is correct that the group which you call the work group that recommended this—and it was simply a group of teaching physician representatives with whom we consulted to find out what the practices were and what the problems were that we were up against—this group contained some individuals, teaching surgeons, who felt passionately today that a fee for service charge is warranted even where there is a lesser degree of personal and identifiable service in relation to the patient than what we have prescribed. In other words, they feel that our prescribed documentation in some circumstances created situations which are not conducive to the best conduct of a teaching program. But we did not accede to that, I think the report shows.

STAFF. I think that about ends the questions the staff have. The Senators apparently will be unable to return this afternoon.

(Whereupon, at 5:30 p.m., the hearing was recessed, subject to the call of the Chair.)

(By direction of the chairman, the following article was made a part of the printed record:)

[From the Nation's Business, March 1970]

RUNAWAY EXPANSION OF SOCIAL SECURITY?

(Robert J. Myers)

(A long-time top official in the Social Security Administration warns that a big push is coming for raising payments to a point where drawbacks far outweigh the benefits)

Congress is taking another look at the Social Security program, along with the Administration's welfare proposals.

Robert J. Myers, a career civil servant in that program for more than 35 years and the Social Security Administration's long-time chief actuary, is a vigorous supporter of the program's role in economic security.

But, in this interview with NATION'S BUSINESS, he warns that mounting pressures for a huge enlargement of the program could radically transform the whole concept of the system, producing a federal near-monopoly in the pension field.

He is concerned that the possible consequences of any such change be fully understood—in terms of cost, greater dependency of the individual on the federal government and undue government expansion.

Dr. Myers also warns there's another side of the bigger benefits coin: higher taxes.

*You have expressed concern over the future direction of the Social Security program. What is the basis of your concern?*

Too many people believe there is only one possible course for Social Security, namely, to expand the benefits until they take care of the entire economic security needs of the vast majority of the population. I do not believe other possible routes for the development of the program have been adequately put forth to the American people. I am expressing my views now so as to bring the discussion on both sides out into the open, so there can be orderly consideration of the matter.

*Would you describe what's involved as a runaway expansion of Social Security?*

To date, I would say there has not been any runaway expansion, but I believe that in the next few years those who advocate great expansion of the program—even runaway expansion—will be pressing their views more and more strongly, particularly if additional federal funds become available through the cessation of the war in Viet Nam.

*How would you describe the ultimate goals of those who would expand the program?*

They want a cash benefit level sufficient to replace virtually the entire take-home earnings of 90 to 95 per cent of the workers in the event the person retires because of old age or becomes disabled, or, in the event he dies, for his family.

The expansionists also would like to see all medical services paid for or furnished directly by the government, which you might say is socialized medicine, or else they would want a system of nationalized health insurance very much as is the case in Britain.

*What would the government's role be then in the area of economic security?*

It would be to take over the entire field. There would be virtually no role for the private sector, other than for the few very-highest-income people, and there would be no need for any forms of private insurance, private pension plans or private savings.

*Through what steps would the expansionists' goals be achieved?*

From a legislative standpoint, through the ratchet approach. Every step would be irreversible, and they would keep moving further and further.

Specifically, the real first step is to increase the maximum taxable earnings base under Social Security from the present level of $7,800 per year up to something like $15,000, $18,000 or even $20,000 in the near future, so as to cover the total earnings of practically all persons under Social Security. Then they would push toward raising the benefit level so that a person's benefits would be 60 to 80 per cent of his gross pay, and thus about equal to his take-home pay.

The painful question of financing would be largely hidden, so that people—particularly the younger and middle-aged workers, who might want to spend their money some other way—would not realize how costly it was. Specifically, the expansionists would finance a large portion of these changes through government subsidy, from general revenues.

It has also been suggested by one prominent expansionist, Wilbur J. Cohen, the last Secretary of Health, Education and Welfare in the Johnson Administration, that employers should pay twice the rate that the employee pays, instead of on the equal matching basis that has been in effect since the program started.

*Would federal subsidizing from general revenues be started all in one stroke?*

No. The expansionists would follow the approach of gradualism because their real intent is to have a government subsidy of at least 50 per cent of the total taxes that the employers and employees pay.

If this were done all at one time, it would mean an additional $15 to $20 billion a year, currently, which would be quite difficult to achieve. Instead, many expansionists propose to take a little bite at a time.

The first year they would have a government subsidy of 5 per cent of total taxes and the next year 10 per cent, building up eventually to 50 per cent or more. That way they think it would be painless.

*Would the biggest single step be establishment of the principle of general revenue contribution?*

Yes, I think that is very well put. You first establish a principle that does not seem to have much cost and then you say: "Well, now that the principle has been established, let's really build on it."

*Is there any likelihood that this would endanger the economic system?*

I am more concerned that the issue is not clearly put forth before the American public, that people understand that expansion of the Social Security system does not mean just more benefits but also, on the other side of the coin, more taxes. I think it also can produce very serious effects upon our national economy and our national psychology.

*What would these effects be?*

In the long run, people would feel more and more dependent on the government and less and less really free and individually responsible.

There also are some very serious side effects. If all private forms of savings and insurance were diminished, this would have a great effect on the general investment market. The private pension plans have over $100 billion in assets; insurance companies have large amounts of assets, too.

If industry needed money to expand and there were not this source of financing, there would be only one source, the government; and when the government grants loans, the element of control naturally enters.

*More concretely, what would a sharp increase in the tax base mean to individual companies, say in terms of costs?*

The tax burden would fall quite differently on different types of businesses. Obviously, it would not increase very much for a business that employed workers in the intermediate range of $6,000 or $7,000 per year and had only a few high-paid people; but in another type of industry, where the workers all were skilled and getting $10,000 to $14,000 a year, then it would increase very much. On the average, to go up to $15,000 as the taxable base would increase the tax burden of the workers and the employers by about 10 per cent.

Of course, the expansionists would solve this problem of unequal treatment of different employers very simply. They say tax the employer on his entire payroll; just put a maximum ceiling on the employee's tax.

Secretary Cohen left a pile of documents just as he was going out of office in which he said, among many other expansions, he would eliminate the maximum tax base on the employer so he'd pay on the full salary of each employee; second, he would double the employer tax rate relative to the employee rate, and third, he would introduce government subsidies.

The subsidy would have to be financed somehow, and undoubtedly much of it would come from taxes on employers, although in the end these come down to the individual citizens. Employers cannot manufacture tax money out of thin air; they have to get it from sales of products.

*What is this likely to mean in terms of rigidity of the federal budget? Every time they try to reduce spending, we hear about the high level of "uncontrollable" expenses.*

This, of course, would be a very significant move much further in this direction, because certainly Social Security benefits are a cost that nobody in the Executive branch can put any control on.

*What are the objections to private pension plans?*

The expansionists believe that the government should take care of people and there should not be any inequities, which really means everybody should get the same. They say that some people get private pensions and others do not and that this is unfair, and they imply that, therefore, government should be the great equalizer.

*Weren't there similar complaints about health insurance?*

Yes, in the mid-Forties, when there was a big push for a national health insurance program administered by the government, the expansionists of those days were saying that private health insurance could never really take care of a very large proportion of the population. Yet we all know now that well over 80 percent of the persons under age 65 are covered under some sort of private hospital insurance, and in almost all cases by quite an adequate plan.

In the same way, many people have been saying private pension plans just can't do the job. Actually, these plans are now doing a good job, and as the years go by they will probably do much more successfully the job they are intended to do. So it is entirely a matter of philosophy, and I think the expansionists will be proved factually wrong again as more people qualify for private pension plans and as those plans are improved and extended.

*In your view, what is the proper long-range role of Social Security?*

I want to make it very clear that I do not believe the program should stand absolutely still. It must recognize changing economic conditions, changing price levels and so forth. If new problems come up, Social Security must be flexible. But my point is that Social Security should provide a basic floor of economic

protection, as it has, and there should be plenty of room for people to build on, either individually or collectively, to provide additional economic security.

*"Floor of protection." What does that mean?*

That means that if the vast majority of people can get along economically with what they have saved, with their home ownership, with private pensions and with Social Security benefits as the base on which all the rest has been built, then the system is performing adequately. Similarly, this means that if only a small proportion—say, 10 percent—need supplementary public assistance, then the Social Security benefit level is adequate. And this is what the situation actually is now!

*What currently is the ratio between the average monthly benefit and take-home pay?*

The average benefit for a retired worker is about $115 per month, which may seem very low compared to the average wage of workers currently. However, this average is pulled down by quite a number of factors, such as that many people have qualified for relatively low benefits because of having been only part-time in the labor force, and that persons who retired before 65 have actuarially reduced benefits.

I think the best comparison is to take a worker who is currently retiring at age 65 and who has been a more or less full-time worker. His benefit will be somewhere around one third of his average wage, and if he has a wife he would get up to about one half.

*How about the proper principle of financing?*

The principle that has been followed in the past, namely, that the system should be financed completely from the taxes of the employers and employees, is very desirable because it makes the cost quite apparent to everybody concerned. If government subsidy is introduced, then the system appears much less costly, with money—in a sense—coming out of the sky. It really is essential that the people know what government is costing them, what they can expect from government, and what are their responsibilities as well as their rights.

*Once you drop this financing principle, what happens?*

I am afraid that the system would deteriorate in many ways. Beneficiaries would always want more benefits, and workers would not realize what they were paying. I think the expansionists see this, and they realize that at the moment many young and middle-aged workers are rebelling against increased tax rates. So the only way to reach their goal is to inject hidden money into the system.

*Aside from Wilbur Cohen—and he's out of office—where is the big expansionist push coming from?*

Well, outside of government, the pressure comes from the labor movement, such as the AFL-CIO and the United Auto Workers. It also comes from many of the social welfare groups and from certain lobbying organizations set up for senior citizen groups.

Another place where there are expansionists is in the government itself. There are, I think, many among Social Security Administration officials and staff members, and in some ways this is quite natural. Whatever activity you are engaged in, you always want it to be bigger and better. Then, too, the top staff was largely employed during the early days of the program and has grown up with it and tends to have this expansionist philosophy.

The political appointees who formulate Social Security policy by directing research and program evaluation have been retained by the present Administration.

I do not think that most such Social Security Administration employees take the balanced view that they are also working for the contributors. Of course, I believe in Social Security myself, but I believe it has a single role and not an all-encompassing one.

In my opinion, the vast majority of the people over 65 are quite satisfied with their Social Security benefits. Like the rest of us, they would like more money but I believe they feel that Social Security has been quite a good deal. Of course, the ones you always hear about are the ones who say: "We want more so as to have all the luxuries of life," without realizing that this is not the purpose of the program.

*Your perspective is slightly different, isn't it, in that you are an actuary?*

Well, that's true. An actuary has to look at both sides of the situation. Some people will just look at the benefits side and say this is a good, noble cause—which it is—and say: "If it is good, let us have more of it," without realizing it has to be paid for.

I would not want to say that everybody in the Social Security Administration

feels this way, or that those who do are the only ones in the federal government; but I think many of them always have had this personal philosophy. I do not say it is evil; I just say it is wrong. And this tends to be self-perpetuating, through the selection for promotion or hiring at the highest grades of people of like philosophy.

An inter-agency group was formed during the Johnson Administration to consider private pension plans, and most people on it were, I think, really opposed to private pension plans or, at best, lukewarm about them, because they had the philosophy of the government providing full economic security for the vast majority of people. So it was a case of the fox guarding the henhouse.

*How about Capitol Hill?*

Over the years, Congress has, on the whole, been very responsible, largely due to the committees involved, namely House Ways and Means and Senate Finance. Both are tax-writing committees, so they are quite cognizant of the who-pays aspect as well as the who-gets aspect.

Of course, some people in Congress believe very strongly that the program ought to be greatly expanded and, without explaining quite why, that the government ought to provide all people with full economic protection.

*Isn't a lot of this embodied in a bill pending before Ways and Means?*

There are a number of such bills, but I suppose you are referring to the one introduced by Congressman Gilbert of New York, who, when he introduced it, announced he was doing so with the support of the AFL-CIO and the National Council of Senior Citizens, which is an organization of persons over 65, that has been sponsored by the AFL-CIO.

This bill would be a very big step in the direction of expansionism because, among other things, it would increase the earnings base to $15,000, introduce a gradual government subsidy and increase benefits about 50 percent. But it would leave out some proposals I mentioned, such as eliminating the maximum earnings base for the employers so they'd pay on their entire payroll, and it would not double the employer tax rate.

*When Congress passed the 15 per cent benefit increase, as against the President's recommended 10 per cent, did that strike you as a sign of things to come?*

I would not say so, necessarily. It was a bit more than the President recommended, and expansionists are trying for more in this session of Congress. But the real push is coming in the next few years. When the war ends, there will apparently be excess money available unless taxes are reduced. The expansionists will say: "Keep up the tax level and give us some of the money for a government subsidy to the Social Security program."

*How would you summarize the Nixon Administration's position?*

In my opinion, its proposals are definitely of the moderate school. Its views are, "Let's take this out of politics. Let's make the benefits automatically adjusted, according to changes in the cost of living, according to economic conditions, so that we do not get into a bargaining position every time legislation is considered."

You recall, when the President signed the bill with the 15 per cent increase, he pointed out that it would have been much better to have what he had originally proposed, a 10 per cent benefit increase now plus a guarantee to keep benefits up to date with the cost of living by future automatic adjustments.

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# APPENDIX A

## Manpower and Facility Shortages in the Health Care Field



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## MANPOWER

Physicians—At the end of 1969, the number of active physicians in the United States was estimated to be 318,000 out of a total of 339,350.

Over the past two decades the number of graduates of schools of medicine, (now numbering 107), has expanded from 6,562 in 1950–51, to 7,500 in 1960–61 to 8,486 in 1968–69. Additional graduates will be provided by the recent increase in first-year places, the new medical schools yet to graduate their first classes, and the five additional ones now being planned.

While the shortage of physicians has been estimated to be on the order of 50,000, the number has been derived either by computing the number of additional physicians needed to meet the national average in proportion to population, and anticipated population increases, or by extrapolating from existing patterns of care in, say, a large pre-paid multispecialty organization. Neither of these estimating procedures are satisfactory. Moreover, they are not responsive to a matter of national urgency—the use of physicians assistants and other allied health manpower to substitute, where feasible, for the physician. It is difficult to estimate the gains in productivity from this kind of substitution, but it would decrease the 50,000 estimate significantly.

This is not to say that there isn't a shortage: using net increases of physicians, the large-scale importation and use of foreign trained physicians; and the general rise in medical prices reflect a rise in demand for services outpacing the supply.

The estimating procedure is not simple under any circumstances, especially since the use of allied health manpower on a broader scale will require changes in licensing and certification practices in the States. Also involved are: policies on the importation and use of foreign medical graduates, changes in the effective demand for health care; non-medical alternatives (such as family planning, public information programs, improved nutrition, multiphasic screening and so forth) which may reduce the need for services, and the redistribution of services—a major determinant.

The supply of physicians is currently distributed very unevenly among the States and the regions. With improvements in transportation and communication, conventional indices of distribution of physicians in relation to State boundaries are becoming increasingly difficult to interpret. In 1967 in the United States, the average number of non-Federal physicians providing patient care was 132 per 100,000 Civilian population. The extremes among the nine geographic divisions of the country show that at the time the ratio ranged from a high of 171 (M.D. and D.O.) per 100,000 in the Middle Atlantic States to a low of 86 per 100,000 in the East South Central States. The disparity in the distribution of physicians within metropolitan areas is also very great, e.g., as between ghetto and suburb.

Major urban areas having 200 or more physicians per 100,000 persons are Baltimore, Maryland; Boston, Massachusetts; Denver, Colorado; Miami, Florida; New Haven, Connecticut; New York, New York; Richmond, Virginia; San Francisco, California; and San Jose, California. Major urban areas having fewer than 100 physicians per 100,000 population are Beaumont and El Paso, Texas; Johnstown, Lancaster, and York, Pennsylvania; Davenport, Iowa; Gary, Indiana; Lansing, Michigan; Mobile, Alabama; and Norfolk, Virginia.[1] State distribution follows:

[1] Statistical Abstracts of the United States, 1969, pp. 866 and 882.



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## LOCATION OF NON-FEDERAL PHYSICIANS IN RELATION TO POPULATION: DEC. 31, 1967

| Location | Civilian population in thousands July 1 | All non-Federal physicians [1] | | | | M.D.'s and D.O.'s providing patient care [2] | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | Number | | | Rate per 100,000 civilians | Number | | | Rate per 100,000 civilians |
| | | M.D. and D.O. | M.D. only | D.O. only | | M.D. and D.O. | M.D. only | D.O. only | |
| All locations | 198,649 | 292,661 | 279,418 | 13,243 | 147 | 260,296 | 249,273 | [3] 11,023 | 131 |
| United States | 195,669 | 290,420 | 277,177 | 13,243 | 148 | 258,279 | 247,256 | 11,023 | 132 |
| Alabama | 3,505 | 2,871 | 2,867 | 4 | 82 | 2,621 | 2,619 | 2 | 75 |
| Alaska | 238 | 177 | 173 | 4 | 74 | 164 | 162 | 2 | 69 |
| Arizona | 1,606 | 2,347 | 2,068 | 279 | 146 | 2,020 | 1,790 | 230 | 126 |
| Arkansas | 1,958 | 1,710 | 1,688 | 22 | 87 | 1,520 | 1,505 | 15 | 78 |
| California | 18,793 | 34,555 | 34,135 | 420 | 184 | 30,345 | 30,204 | 141 | 161 |
| Colorado | 1,927 | 3,685 | 3,425 | 260 | 191 | 3,237 | 3,013 | 224 | 168 |
| Connecticut | 2,912 | 5,422 | 5,367 | 55 | 186 | 4,776 | 4,735 | 41 | 164 |
| Delaware | 515 | 727 | 686 | 41 | 141 | 671 | 635 | 36 | 130 |
| District of Columbia | 793 | 3,023 | 3,007 | 16 | 381 | 2,521 | 2,509 | 12 | 318 |
| Florida | 5,902 | 9,447 | 8,841 | 606 | 160 | 7,450 | 7,006 | 444 | 126 |
| Georgia | 4,389 | 4,558 | 4,478 | 80 | 104 | 4,097 | 4,034 | 63 | 93 |
| Hawaii | 684 | 1,002 | 982 | 20 | 146 | 913 | 898 | 15 | 133 |
| Idaho | 695 | 676 | 639 | 37 | 97 | 622 | 598 | 24 | 89 |
| Illinois | 10,825 | 14,996 | 14,652 | 344 | 139 | 13,534 | 13,313 | 221 | 125 |
| Indiana | 4,989 | 5,158 | 4,960 | 198 | 103 | 4,686 | 4,516 | 170 | 94 |
| Iowa | 2,752 | 3,298 | 2,889 | 409 | 120 | 2,896 | 2,566 | 330 | 105 |
| Kansas | 2,255 | 2,680 | 2,483 | 197 | 119 | 2,388 | 2,228 | 160 | 106 |
| Kentucky | 3,142 | 3,168 | 3,129 | 39 | 101 | 2,825 | 2,795 | 30 | 90 |
| Louisiana | 3,622 | 4,095 | 4,083 | 12 | 113 | 3,715 | 3,704 | 11 | 103 |
| Maine | 958 | 1,238 | 1,031 | 207 | 129 | 1,091 | 935 | 156 | 114 |
| Maryland | 3,606 | 6,374 | 6,351 | 23 | 177 | 5,481 | 5,466 | 15 | 152 |
| Massachusetts | 5,387 | 11,195 | 10,913 | 282 | 208 | 9,763 | 9,534 | 179 | 181 |
| Michigan | 8,564 | 12,643 | 10,541 | 2,102 | 148 | 11,232 | 9,590 | 1,642 | 131 |
| Minnesota | 3,577 | 5,414 | 5,351 | 63 | 151 | 4,851 | 4,802 | 49 | 136 |
| Mississippi | 2,320 | 1,768 | 1,767 | 1 | 76 | 1,604 | 1,603 | 1 | 69 |
| Missouri | 4,565 | 6,832 | 5,677 | 1,155 | 150 | 5,883 | 5,030 | 853 | 129 |
| Montana | 691 | 726 | 686 | 40 | 105 | 673 | 645 | 28 | 97 |
| Nebraska | 1,423 | 1,717 | 1,670 | 47 | 121 | 1,511 | 1,479 | 32 | 106 |
| Nevada | 437 | 477 | 449 | 38 | 109 | 437 | 415 | 22 | 100 |
| New Hampshire | 681 | 964 | 938 | 26 | 142 | 813 | 797 | 16 | 119 |
| New Jersey | 6,947 | 10,041 | 9,398 | 643 | 145 | 9,211 | 8,688 | 523 | 133 |
| New Mexico | 985 | 1,050 | 928 | 122 | 107 | 895 | 788 | 107 | 91 |
| New York | 18,303 | 40,646 | 40,082 | 564 | 222 | 36,500 | 36,044 | 456 | 199 |
| North Carolina | 4,913 | 5,168 | 5,136 | 32 | 105 | 4,505 | 4,484 | 21 | 92 |
| North Dakota | 627 | 585 | 575 | 10 | 93 | 544 | 535 | 9 | 87 |
| Ohio | 10,437 | 14,760 | 13,682 | 1,078 | 141 | 13,415 | 12,539 | 876 | 129 |
| Oklahoma | 2,447 | 2,904 | 2,483 | 421 | 119 | 2,593 | 2,240 | 353 | 106 |
| Oregon | 1,994 | 2,935 | 2,766 | 169 | 147 | 2,555 | 2,422 | 133 | 128 |
| Pennsylvania | 11,612 | 18,728 | 17,163 | 1,565 | 161 | 16,628 | 15,380 | 1,248 | 143 |
| Rhode Island | 875 | 1,433 | 1,349 | 84 | 164 | 1,327 | 1,255 | 72 | 152 |
| South Carolina | 2,526 | 2,111 | 2,105 | 6 | 84 | 1,910 | 1,906 | 4 | 76 |
| South Dakota | 667 | 575 | 538 | 37 | 86 | 533 | 503 | 30 | 80 |
| Tennessee | 3,858 | 4,497 | 4,431 | 66 | 117 | 3,997 | 3,946 | 51 | 104 |
| Texas | 10,657 | 12,571 | 11,760 | 811 | [3] 18 | 11,342 | 10,644 | 698 | 106 |
| Utah | 1,020 | 1,365 | 1,346 | 19 | 134 | 1,205 | 1,188 | 17 | 118 |
| Vermont | 416 | 790 | 745 | 45 | 190 | 621 | 590 | 31 | 149 |
| Virginia | 4,349 | 5,183 | 5,147 | 36 | 119 | 4,566 | 4,538 | 28 | 105 |
| Washington | 3,029 | 4,725 | 4,515 | 210 | 156 | 4,133 | 3,973 | 160 | 136 |
| West Virginia | 1,797 | 1,870 | 1,756 | 114 | 104 | 1,690 | 1,590 | 100 | 94 |
| Wisconsin | 4,185 | 5,218 | 5,037 | 181 | 125 | 4,697 | 4,539 | 158 | 112 |
| Wyoming | 311 | 322 | 309 | 13 | 104 | 297 | 288 | 9 | 95 |
| Puerto Rico | 2,684 | 2,038 | 2,038 | ..... | 76 | 1,836 | 1,836 | ..... | 68 |
| U.S. outlying areas | 296 | 203 | 203 | ..... | 69 | 181 | 181 | ..... | 61 |

[1] Excludes 27,724 Federal physicians (27,552 M.D.'s and 172 D.O.'s) and 1,660 with addresses temporarily unknown to the AMA. Includes 14,198 inactive physicians (12,898 M.D.'s and 1,300 D.O.'s).

[2] M.D.'s include those in solo, partnership, group or other practice and those in training programs and in hospital-based practice; D.O.'s include those in private practice and those in training programs and professional full-time hospital positions. Excludes 30,145 non-Federal M.D.'s (11,166 on medical school faculties; 2,729 in administration; 3,352 in research; and 12,898 in inactive status), and 1,600 with addresses temporarily unknown to the AMA; and 1,486 non-Federal DO.'s (17 in full-time administrative hospital positions; 127 on college faculties; 42 in miscellaneous activities; and 1,300 in inactive status) and 734 whose status was not reported to the AOA.

[3] Total includes 775 D.O.'s in training programs for whom distribution by State is unavailable.

Sources: AMA Department of Survey Research: Distribution of Physicians, Hospitals, and Hospital Beds in the United States, 1967: Regional, State, County, Metropolitan Area. J. N. Haug and G. A. Roback, Chicago. American Medical Association, 1968. Membership and Statistics Department: A statistical Study of the Osteopathic Profession, Dec. 31, 1967. Chicago. American Osteopathic Association (June 1968.) U.S. Bureau of the Census: Population Estimates. Current Population Reports. Series P-25, No. 380, Nov.ember 1967 and No. 392, May 1968.

Incentives to redistribute health care services—in the form of economic incentives, social incentives—could alter this characteristic of "shortages."

There appears to be considerable variation in the degree of shortage in individual specialties. While general surgeons, for example, now are in relatively good supply, shortages exist in such fields of practice as pediatrics, obstetrics, physical medicine, anesthesiology, radiology, preventive medicine, pathology, and psychiatry. But these shortages, again, are based on traditional uses of manpower.

What has been said of physicians in the foregoing can also be applied to other members of the health care industry—dentists, nurses, technicians, and the like. Shortages are projected for all of these occupations, but the projections generally fail to take into account large potential increaess in their productivity, if changes were made in their education, use, and income rewards, or there was increasing use of labor saving equipment, reorganization of facilities and services.

## FACILITIES

As with the problem of health manpower, estimates of the need for facilities are affected by developing patterns of medical care, changes in the use of facilities, breakthroughs in technology and the organization and delivery of services. There are also distribution problems with some areas showing an adequate supply of facilities and other areas with serious shortages of outpatient and long-term care facilities, and a need for modernization of facilities.

Following is a table of the number of hospital and nursing home beds per thousand by State in 1967 and information from the Hill Burton State plans.

BEDS, AVERAGE DAILY PATIENTS AND ADMISSIONS IN SHORT-STAY HOSPITALS BY STATE: 1967

| Location | Number | | | Number per 1,000 population [1] | | |
|---|---|---|---|---|---|---|
| | Beds | Average daily patients | Admissions | Beds | Average daily patients | Admissions |
| United States | 901,738 | 676,719 | 29,642,544 | 4.6 | 3.4 | 149.8 |
| Alabama | 14,271 | 10,615 | 500,742 | 4.0 | 3.0 | 141.5 |
| Alaska | 1,028 | 611 | 29,111 | 3.8 | 2.2 | 107.0 |
| Arizona | 7,368 | 5,257 | 243,284 | 4.5 | 3.2 | 148.9 |
| Arkansas | 8,133 | 5,603 | 296,694 | 4.1 | 2.8 | 150.8 |
| California | 80,186 | 57,624 | 2,618,967 | 4.2 | 3.0 | 136.7 |
| Colorado | 12,269 | 8,862 | 828,073 | 6.2 | 4.5 | 419.3 |
| Connecticut | 9,961 | 8,082 | 368,495 | 3.4 | 2.8 | 126.0 |
| Delaware | 1,791 | 1,353 | 61,623 | 3.4 | 2.6 | 117.8 |
| District of Columbia | 5,619 | 4,406 | 179,547 | 6.9 | 5.4 | 221.9 |
| Florida | 27,820 | 20,247 | 911,143 | 4.6 | 3.4 | 152.0 |
| Georgia | 18,808 | 13,437 | 698,506 | 4.2 | 3.0 | 154.9 |
| Hawaii | 2,055 | 1,346 | 70,217 | 2.8 | 1.8 | 95.0 |
| Idaho | 2,908 | 1,869 | 100,997 | 4.2 | 2.7 | 144.5 |
| Illinois | 55,249 | 43,260 | 1,644,824 | 5.1 | 4.0 | 151.0 |
| Indiana | 19,448 | 15,740 | 685,568 | 3.9 | 3.1 | 137.1 |
| Iowa | 15,893 | 11,421 | 472,426 | 5.8 | 4.1 | 171.6 |
| Kansas | 12,014 | 8,442 | 359,563 | 5.3 | 3.7 | 158.0 |
| Kentucky | 13,979 | 10,143 | 488,247 | 4.4 | 3.2 | 153.1 |
| Louisiana | 16,700 | 11,736 | 590,816 | 4.6 | 3.2 | 161.3 |
| Maine | 4,491 | 3,139 | 151,065 | 4.6 | 3.2 | 155.3 |
| Maryland | 13,071 | 10,105 | 378,335 | 3.5 | 2.7 | 102.8 |
| Massachusetts | 27,947 | 21,628 | 828,674 | 5.2 | 4.0 | 152.9 |
| Michigan | 37,933 | 29,915 | 1,281,092 | 4.4 | 3.5 | 149.2 |
| Minnesota | 20,713 | 14,824 | 628,519 | 5.8 | 4.1 | 175.5 |
| Mississippi | 9,009 | 6,167 | 335,646 | 3.8 | 2.6 | 142.9 |
| Missouri | 23,901 | 18,406 | 746,940 | 5.2 | 4.0 | 161.3 |
| Montana | 4,283 | 2,768 | 140,969 | 6.1 | 3.9 | 201.1 |
| Nebraska | 9,179 | 6,544 | 249,501 | 6.4 | 4.6 | 173.9 |
| Nevada | 2,190 | 1,501 | 69,247 | 4.9 | 3.4 | 156.0 |
| New Hampshire | 3,213 | 2,236 | 104,332 | 4.7 | 3.3 | 152.1 |
| New Jersey | 27,626 | 21,911 | 856,981 | 3.9 | 3.1 | 122.4 |
| New Mexico | 4,431 | 2,971 | 158,235 | 4.4 | 3.0 | 157.8 |
| New York | 84,399 | 66,900 | 2,405,532 | 4.6 | 3.6 | 131.2 |
| North Carolina | 19,413 | 14,779 | 709,184 | 3.9 | 2.9 | 141.0 |
| North Dakota | 4,238 | 3,039 | 129,029 | 6.6 | 4.8 | 201.9 |
| Ohio | 42,449 | 34,977 | 1,456,426 | 4.1 | 3.3 | 139.3 |
| Oklahoma | 14,777 | 10,842 | 407,289 | 5.9 | 4.3 | 163.2 |
| Oregon | 8,983 | 5,959 | 488,363 | 4.5 | 3.0 | 244.3 |
| Pennsylvania | 56,904 | 45,100 | 1,692,071 | 4.9 | 3.9 | 145.5 |
| Rhode Island | 4,189 | 3,071 | 122,556 | 4.7 | 3.4 | 136.2 |
| South Carolina | 11,420 | 8,324 | 372,505 | 4.4 | 3.2 | 143.3 |

BEDS, AVERAGE DAILY PATIENTS AND ADMISSIONS IN SHORT-STAY HOSPITALS BY STATE: 1967—Continued

| Location | Number | | | Number per 1,000 population [1] | | |
|---|---|---|---|---|---|---|
| | Beds | Average daily patients | Admissions | Beds | Average daily patients | Admissions |
| South Dakota | 3,898 | 2,555 | 124,594 | 5.8 | 3.8 | 184.9 |
| Tennessee | 17,202 | 13,339 | 634,320 | 4.4 | 3.4 | 163.0 |
| Texas | 52,510 | 36,718 | 1,804,094 | 4.8 | 3.4 | 166.0 |
| Utah | 4,064 | 2,835 | 147,675 | 4.0 | 2.8 | 144.2 |
| Vermont | 2,164 | 1,584 | 69,611 | 5.2 | 3.8 | 166.9 |
| Virginia | 17,963 | 14,057 | 566,521 | 4.0 | 3.1 | 124.9 |
| Washington | 10,435 | 6,780 | 353,592 | 3.4 | 2.2 | 114.5 |
| West Virginia | 9,610 | 7,244 | 331,003 | 5.3 | 4.0 | 184.1 |
| Wisconsin | 21,623 | 15,296 | 691,138 | 5.2 | 3.7 | 165.0 |
| Wyoming | 2,010 | 1,151 | 58,758 | 6.4 | 3.7 | 186.5 |

BEDS, AVERAGE DAILY PATIENTS AND ADMISSIONS IN LONG-STAY HOSPITALS, BY STATE: 1967

| | | | | | | |
|---|---|---|---|---|---|---|
| United States | 729,363 | 664,210 | 1,101,084 | 3.7 | 3.4 | 5.6 |
| Alabama | 12,037 | 11,341 | 11,084 | 3.4 | 3.2 | 3.1 |
| Alaska | 865 | 722 | 3,912 | 3.2 | 2.7 | 14.4 |
| Arizona | 2,472 | 2,663 | 9,801 | 1.5 | 1.6 | 6.0 |
| Arkansas | 6,567 | 5,672 | 15,647 | 3.3 | 2.9 | 8.0 |
| California | 55,501 | 51,114 | 109,610 | 2.9 | 2.7 | 5.7 |
| Colorado | 5,309 | 5,490 | 9,113 | 2.7 | 2.8 | 4.6 |
| Connecticut | 13,073 | 10,598 | 20,807 | 4.5 | 3.6 | 7.1 |
| Delaware | 4,173 | 3,999 | 6,596 | 8.0 | 7.6 | 12.6 |
| District of Columbia | 10,002 | 10,916 | 28,151 | 12.4 | 13.5 | 34.8 |
| Florida | 13,693 | 12,291 | 21,232 | 2.3 | 2.1 | 3.5 |
| Georgia | 16,931 | 15,422 | 20,492 | 3.8 | 3.4 | 4.5 |
| Hawaii | 2,439 | 2,089 | 7,646 | 3.3 | 2.8 | 10.3 |
| Idaho | 892 | 790 | 1,276 | 1.3 | 1.1 | 1.8 |
| Illinois | 41,507 | 38,267 | 58,652 | 3.8 | 3.5 | 5.4 |
| Indiana | 15,335 | 13,691 | 10,989 | 3.1 | 2.7 | 2.2 |
| Iowa | 4,433 | 3,826 | 9,053 | 1.6 | 1.4 | 3.3 |
| Kansas | 5,664 | 4,858 | 13,319 | 2.5 | 2.1 | 5.9 |
| Kentucky | 8,525 | 7,599 | 21,588 | 2.7 | 2.4 | 6.8 |
| Louisiana | 9,450 | 8,163 | 19,410 | 2.6 | 2.2 | 5.3 |
| Maine | 4,331 | 3,915 | 6,571 | 4.5 | 4.0 | 6.8 |
| Maryland | 15,838 | 14,142 | 41,364 | 4.3 | 3.8 | 11.2 |
| Massachusetts | 31,085 | 27,155 | 38,233 | 5.7 | 5.0 | 7.1 |
| Michigan | 32,009 | 29,677 | 39,723 | 3.7 | 3.5 | 4.6 |
| Minnesota | 9,504 | 8,749 | 23,070 | 2.7 | 2.4 | 6.4 |
| Mississippi | 8,212 | 6,890 | 12,951 | 3.5 | 2.9 | 5.5 |
| Missouri | 14,664 | 13,244 | 13,633 | 3.2 | 2.9 | 3.0 |
| Montana | 1,721 | 1,595 | 2,382 | 2.5 | 2.3 | 3.4 |
| Nebraska | 4,510 | 3,900 | 4,923 | 3.1 | 2.7 | 3.4 |
| Nevada | 606 | 554 | 1,313 | 1.4 | 1.2 | 3.0 |
| New Hampshire | 3,667 | 3,140 | 3,806 | 5.3 | 4.6 | 5.5 |
| New Jersey | 26,292 | 23,653 | 26,843 | 3.8 | 3.4 | 3.8 |
| New Mexico | 1,498 | 1,307 | 7,774 | 1.5 | 1.3 | 7.8 |
| New York | 118,525 | 112,266 | 121,400 | 6.5 | 6.1 | 6.9 |
| North Carolina | 14,016 | 12,495 | 40,638 | 2.8 | 2.5 | 8.1 |
| North Dakota | 1,712 | 1,530 | 4,172 | 2.7 | 2.4 | 6.5 |
| Ohio | 34,962 | 29,616 | 47,561 | 3.3 | 2.8 | 4.5 |
| Oklahoma | 3,691 | 3,170 | 7,126 | 1.5 | 1.3 | 2.9 |
| Oregon | 5,446 | 4,083 | 9,325 | 2.7 | 2.0 | 4.7 |
| Pennsylvania | 55,233 | 50,445 | 56,635 | 4.7 | 4.3 | 4.9 |
| Rhode Island | 4,656 | 4,417 | 8,578 | 5.2 | 4.9 | 9.5 |
| South Carolina | 7,988 | 7,555 | 12,897 | 3.1 | 2.9 | 5.0 |
| South Dakota | 2,581 | 2,343 | 6,572 | 3.8 | 3.5 | 9.8 |
| Tennessee | 13,957 | 12,917 | 30,397 | 3.6 | 3.3 | 7.8 |
| Texas | 26,433 | 24,171 | 49,866 | 2.4 | 2.2 | 4.6 |
| Utah | 2,065 | 1,792 | 2,314 | 2.0 | 1.8 | 2.3 |
| Vermont | 1,894 | 1,597 | 1,224 | 4.5 | 3.8 | 2.9 |
| Virginia | 18,601 | 16,891 | 29,305 | 4.1 | 3.7 | 6.5 |
| Washington | 6,405 | 5,688 | 10,434 | 2.1 | 1.8 | 3.4 |
| West Virginia | 6,457 | 6,019 | 9,832 | 3.6 | 3.3 | 5.5 |
| Wisconsin | 20,513 | 18,619 | 30,541 | 4.9 | 4.4 | 7.3 |
| Wyoming | 1,423 | 1,164 | 1,297 | 4.5 | 3.7 | 4.1 |

[1] U.S. Bureau of the Census: Population estimates. Current Population Reports. Series P-25, No. 380. November 1967.

BEDS, RESIDENTS, AND FULL-TIME EMPLOYEES IN NURSING CARE AND RELATED HOMES BY STATE, 1967

| Location | Number | | | Number per 1,000 [1] population 65 and over | | Full-time employees per 1,000 residents |
|---|---|---|---|---|---|---|
| | Beds | Residents | Employees (full time) | Beds | Residents | |
| United States | 846,554 | 756,239 | 383,158 | 45.0 | 40.2 | 507 |
| Alabama | 8,806 | 8,231 | 5,373 | 30.0 | 28.0 | 653 |
| Alaska | 139 | 123 | 60 | 19.9 | 17.6 | 488 |
| Arizona | 3,998 | 3,780 | 1,992 | 31.5 | 29.8 | 527 |
| Arkansas | 10,478 | 9,762 | 4,613 | 49.0 | 45.6 | 473 |
| California | 85,105 | 77,234 | 38,566 | 51.8 | 47.0 | 499 |
| Colorado | 10,918 | 10,192 | 5,554 | 62.7 | 58.6 | 545 |
| Connecticut | 15,924 | 14,216 | 7,214 | 58.5 | 52.3 | 507 |
| Delaware | 1,429 | 1,283 | 765 | 35.7 | 32.1 | 596 |
| District of Columbia | 2,071 | 1,910 | 1,123 | 29.2 | 26.9 | 588 |
| Florida | 22,139 | 19,318 | 11,228 | 28.5 | 24.9 | 581 |
| Georgia | 11,236 | 10,419 | 5,872 | 33.6 | 31.2 | 564 |
| Hawaii | 1,327 | 1,223 | 628 | 33.2 | 30 6 | 513 |
| Idaho | 2,978 | 2,754 | 1,620 | 45.8 | 42.4 | 588 |
| Illinois | 49,478 | 44,623 | 21,931 | 45.1 | 40.6 | 491 |
| Indiana | 21,929 | 19,266 | 10,255 | 46.1 | 40.5 | 532 |
| Iowa | 27,998 | 25,071 | 10,057 | 80.9 | 72.5 | 401 |
| Kansas | 17,372 | 15,692 | 7,180 | 67.1 | 60.6 | 458 |
| Kentucky | 11,841 | 10,689 | 4,706 | 37.5 | 33.8 | 440 |
| Louisiana | 10,313 | 9,167 | 5,238 | 37.1 | 33.0 | 571 |
| Maine | 5,704 | 5,222 | 2,638 | 51.4 | 47.0 | 505 |
| Maryland | 10,409 | 9,474 | 5,454 | 38.8 | 35.4 | 576 |
| Massachusetts | 38,604 | 35,566 | 16,291 | 64.0 | 59.0 | 458 |
| Michigan | 28,739 | 26,599 | 15,685 | 38.6 | 35.8 | 590 |
| Minnesota | 28,337 | 27,009 | 11,111 | 78.2 | 08.0 | 411 |
| Mississippi | 3,766 | 3,153 | 1,742 | 18.3 | 15.3 | 552 |
| Missouri | 22,860 | 20,680 | 10,189 | 41.6 | 37.7 | 493 |
| Montana | 3,170 | 2,838 | 1,380 | 47.3 | 42.4 | 486 |
| Nebraska | 11,560 | 10,174 | 4,164 | 65.3 | 57.5 | 409 |
| Nevada | 749 | 684 | 310 | 30.0 | 27.4 | 453 |
| New Hampshire | 4,021 | 3,541 | 1,741 | 54.3 | 47.9 | 492 |
| New Jersey | 22,888 | 20,392 | 11,074 | 35.2 | 31.4 | 543 |
| New Mexico | 1,964 | 1,699 | 1,140 | 30.7 | 26.5 | 671 |
| New York | 60,341 | 54,844 | 31,054 | 31.5 | 28.7 | 566 |
| North Carolina | 14,181 | 13,014 | 5,814 | 38.3 | 35.2 | 447 |
| North Dakota | 4,909 | 4,562 | 2,041 | 77.9 | 72.4 | 447 |
| Ohio | 43 059 | 42 650 | 20,521 | 49.4 | 43.8 | 481 |
| Oklahoma | 19,374 | 17,213 | 8,315 | 70.5 | 62.6 | 483 |
| Oregon | 13,518 | 12,279 | 5,238 | 64.4 | 58.5 | 427 |
| Pennsylvania | 47,331 | 42,986 | 24,398 | 39.2 | 35.6 | 568 |
| Rhode Island | 4,876 | 4,569 | 1,961 | 50.3 | 47.1 | 429 |
| South Carolina | 4,720 | 4,383 | 2,720 | 26.8 | 24.9 | 621 |
| South Dakota | 5,198 | 4,780 | 2,022 | 66.6 | 61.3 | 423 |
| Tennessee | 18,449 | 7,677 | 4,300 | 53.0 | 22.1 | 560 |
| Texas | 43,988 | 37,778 | 20,688 | 48.7 | 41.8 | 548 |
| Utah | 3,777 | 3,414 | 1,439 | 52.5 | 47.4 | 421 |
| Vermont | 2,682 | 2,488 | 1,332 | 59.6 | 55.3 | 535 |
| Virginia | 10,062 | 9,130 | 5,143 | 30.2 | 27.4 | 563 |
| Washington | 17,378 | 16,016 | 7,031 | 57.0 | 52.5 | 439 |
| West Virginia | 2,186 | 1,992 | 1,169 | 11.9 | 10.8 | 587 |
| Wisconsin | 25,793 | 23,675 | 10,713 | 57.4 | 52.7 | 453 |
| Wyoming | 982 | 804 | 365 | 32.7 | 26.8 | 454 |

[1] U.S. Bureau of the Census: Population estimates. Current Population Reports. Series P-25, No. 380. November 1967.

NATIONAL FIGURES, FISCAL YEAR 1968, IN TERMS OF FACILITIES—SUMMARY OF ALL STATE PLANS

| | Number of facilities to be added | Per 100,000 population | Number of facilities to be modernized | Per 100,000 population |
|---|---|---|---|---|
| A. Facilities: | | | | |
| 1. General hospitals | 103 | ..... | 3,101 | ..... |
| 2. Long-term-care facilities | 1,906 | ..... | 4,541 | ..... |
| 3. Public health centers (primary) | 883 | ..... | 1,236 | ..... |
| 4. Diagnostic or treatment centers (outpatient section of hospital) | 1,060 | ..... | 1,436 | ..... |
| 5. Rehabilitation facilities | 388 | ..... | 177 | ..... |
| B. Beds: | | | | |
| 1. General hospital | 85,007 | 39 | 240,624 | 123 |
| 2. Long term (geriatric, nursing home, medicare, chronic disease) | 165,430 | 77 | 214,506 | 109 |

Note: The State having the greatest need for modernized beds is New York, 26,629; followed by Pennsylvania, 21,805. Approximately 47 percent of all primary public health care facilities are in Southeastern region.

PRIMARY HEALTH CARE FACILITIES

| Total estimating | Number | Per 1,000,000 population |
|---|---|---|
| United States | 1,886 | 9.7 |
| New England | 46 | 4.1 |
| Mideastern | 112 | 2.7 |
| Great Lakes | 385 | 10.0 |
| Plains | 92 | 5.8 |
| Southeastern | 880 | 21.0 |
| Southwestern | 168 | 10.8 |
| Rocky Mountain | 29 | 6.2 |
| Far Western | 174 | 7.0 |

# APPENDIX B

## Department of Health, Education, and Welfare Comments on the Senate Finance Committee Staff Recommendations for Changes in Medicare and Medicaid



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DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
COMMENTS ON THE SENATE FINANCE COMMITTEE
STAFF RECOMMENDATIONS FOR CHANGES IN MEDICARE AND MEDICAID

In this document the Department of Health, Education, and Welfare presents general comments on the major recommendations made by the Staff in its Report, Medicare and Medicaid, Problems, Issues and Alternatives.

## Reimbursement of Institutions Providing Medical Care

The Staff suggests changing the law so as to limit Medicare reimbursement to an institution's customary charges to the general public (as in S. 1195) when such charges are less than cost.

We agree. This proposal is similar to one of the proposals in the Administration's cost effectiveness amendments submitted last July. There are a few situations in which heavily endowed institutions actually charge the general public considerably less than their cost and in such circumstances we believe that the Government should not pay full cost but should limit reimbursement to charges.

The Staff suggests that depreciation and interest on loans not be allowed in the case of major expenditures where the expenditure was specifically disapproved by the appropriate planning agency (as provided in S. 1195).

We agree. This recommendation for a change in the law is the same as one of the Administration's cost effectiveness proposals submitted last July. This is approximately the same provision that passed in the Senate in the 1967 amendments but was dropped in conference.

We believe that this change in law is necessary to support the planning efforts of States and localities where under present law reimbursement of cost may on occasion undermine such efforts.

The Staff suggests that except in unusual situations the law should be changed to limit Medicare recognition of increases in hospital costs in any area of the country to the annual percentage increase in the Medical Care Price Index for that geographic or metropolitan area (as provided in S. 1195).

We believe that a much more fundamental change is needed in the law so that the reimbursement of institutions can be shifted from retroactive reimbursement on a cost basis to an incentive formula based upon a target rate for the coming year. Under this new approach institutions would share in savings they make as a result of more economical and

effective management. In designing such prospective rates one would naturally consider the past actual cost of the institution as well as what could be expected in the way of medical care price increases in general in that particular geographic or metropolitan area. However, we do not believe that any method of payment based on cost reimbursement limited by a price index would enlist fully the ingenuity of institutional managers and policymakers toward more effective and efficient management. As long as they stay under the average increases as reflected by the Medical Care Price Index, further improvement in operations would merely reduce their reimbursement. We believe they need an economic incentive providing that reductions in cost will result in greater income to the institutions. It should be noted that the Staff Report also indicates that the Staff is searching for an incentive system for institutional reimbursement such as we are proposing.

The Staff also suggests that payment for care provided in one institution be limited to not more than a reasonable difference above cost for comparable care and services in a similar but less expensive institution in the same area. This would be an important factor to consider in setting prospective rates and we would agree that such additional legislative authority would be desirable under the present retroactive cost provisions.

To encourage prompt final settlement of accounts with institutions the Staff recommends that blame be assessed for delay and that institutions be charged interest where the delay is their fault and the Government pay interest if it is determined that the delay is the Government's fault.

The process of reimbursement involves paying the institution currently on an estimated basis, the submission of cost reports at the end of an accounting period by the institution to its intermediary (a private insurance company or Blue Cross), a desk review of the cost report by the intermediary with tentative adjustments from the previous reimbursement based on the interim rate, and finally, adjustment if necessary based upon actual audit performed by the intermediary.

Under present policy, if an institution fails to submit its cost report more than 90 days after the close of its accounting period (for good cause 30 days more may be granted), its interim payment is reduced by 20 percent. This has been an effective device for speeding up the submission of the cost reports which can then be reviewed by the intermediaries and tentative adjustments made. Overall differences between the reimbursement figures following the review of the cost reports and final settlements based upon formal audit are not large.

Frequently the delay in the final settlement is the result of an appeal by the institution of a relatively small item of difference on which the institution disagrees with the auditors. Assessing blame in these situations would seem to be a nearly impossible and a complicating part of the process and perhaps one which would undermine the right of the institution to question an audit. We believe that this process has been substantially improved and that the suggestion ot the Staff would not lead to additional improvement but, on the contrary, would create problems.

We are currently experimenting with the possibility of using audits provided by the institutions rather than requiring separate audits by the intermediaries. This procedure will result in quicker action in some instances. As the Staff Report suggests we are developing common cost reports with other programs to avoid duplicate work on the part of the provider.

The Staff suggests that where approved capital needs cannot otherwise be met the existing reimbursement formula might be modified to allow capital assets to be depreciated in one-half the time ordinarily accepted where the expenditure can be expected to contribute substantially to efficiency.

We will give further study to the practicality of this suggestion. At the present time we have issued notice of a regulation change (asking for comment from interested parties) which would remove in all cases the opportunity to take accelerated depreciation. Our action in this respect was prompted by some ot the same considerations which led the staff in other parts of the Report to show concern about the effect of accelerated depreciation on reimbursement practices and to recommend that the opportunity for accelerated depreciation be removed. However, if accelerated depreciation could be retained in limited circumstances it might be desirable to do so. The reservation that we have on the specific suggestion of the staff is the difficulty of making the kind of determination they propose that the expenditure would "substantially contribute to efficiency," since the expenditure may be part of a large total of many capital expenditures adding to the services ot the institution. For example, the proposal might mean that any new construction that included labor saving elements would be subject in some part to accelerated depreciation. Another possibility for granting accelerated depreciation is that this advantage might be tied to approval by a planning agency.

The Staff suggests that the intent of the law be clarified by the Congress as to whether Medicaid should follow the same hospital reimbursement formula as Medicare.

We agree. Since present law requires in the same statute that both programs reimburse hospitals for the cost of providing services to the beneficiaries of the respective programs, we have thought the words of

the statute ought to be given the same meaning in each program. If any change is made, it should be kept in mind that if States are allowed to define "reasonable costs" within only general guidelines established by the Federal Government, the result in many instances will be that the reimbursement for Medicaid patients would be less than cost. A case can be made for different treatment between the two programs because of the tradition of medical care being furnished at less than cost to people who meet a test of need as in the Medicaid program or to allow for experiments by States with a variety of approaches. If differences are allowed, but within regulated limits, some approaches could be barred by regulations should they turn out to have unsatisfactory results. However, in considering this issue one needs to recognize that most hospitals would have to shift cost to other patients if the Medicaid programs are going to pay less than cost for their patients. With Medicare paying only cost for its own patients and Medicaid paying less than cost for its patients, the result could well be a considerable escalation in charges to people protected by private commercial insurance and Blue Cross as well as to those patients who pay their own way.

The Staff proposes that Medicare reimbursement have an overriding limitation related to the proportion of average actual Medicare occupancy to total beds available in the institution.

Intermediaries are required to eliminate from cost determinations any excess of nursing or staffing costs that arises from having standby personnel greater than are needed to take care of patients on hand. Moreover, interim rates are not permitted to exceed published charges.

We believe that our proposal in the Health Cost Effectiveness Amendments that would limit reimbursement to published charges when lower than cost (and would thus govern the final settlements as well as the interim rates) together with a continuation of the present instruction would largely take care of the problem of excessive reimbursement for standby costs. The adoption of our broader proposal to provide authority to reimburse on the basis of a prospective rate would remedy the situation.

In any event, the situation pointed out in the Staff Report occurs infrequently and usually in connection with new institutions starting up. In our opinion the kind of limitation suggested by the Staff would be a considerable complication in the reimbursement process.

The Staff recommends that more refined accounting methods be used to eliminate the possibility that Medicare is paying part of the collection costs of non-Medicare bad debts.

Hospitals are required to attempt to collect Medicare bad debts. The collection process is generally only one part of the cost of total "front office administration" of a hospital that involves many other

types of administrative and recordkeeping activities applying to all patients. At present costs are apportioned among departments before allocating costs between Medicare and non-Medicare patients. The distribution between Medicare and non-Medicare patients of general administrative costs occurs as part of the distribution of costs of routine and ancillary patient services to which the administrative costs are allocated.

It would greatly complicate hospital recordkeeping to apportion subactivities in administration between Medicare and non-Medicare and possibly make similar distinctions for other nonincome producing departments. Doing this would require statistics related to degree of use by Medicare patients. Charges provide a basis for allocation only in income producing departments. The question, then, is whether the degree of refinement and recordkeeping required to make additional cost allocations would constitute accounting "overkill" or, in fact, be worth the additional cost and burden to the hospitals and to the auditing system. We are giving the matter further attention.

The Staff suggests that appraisal procedures when facilities change hands should be tightened, and that depreciation should be allowable only on a straight-line basis as is now the case under the tax law.

As intermediaries and their auditors have gotten more experience, they have become more skilled at identifying cost reports that claim excessive reimbursement based on attempts to establish unreasonably high asset values.

As indicated in our earlier comments, a notice of changed regulations, with opportunity for comment, has been issued to deal with several matters related to depreciation and the fixing of asset values, involving particularly profit-making health facilities which are involved in changes in ownership.

Specifically, the revised regulations would: (a) eliminate the use of accelerated methods of depreciation except with respect to assets currently being depreciated on that basis; (b) extend present provisions under which gains or losses on sales of depreciable assets are taken into account in determining provider costs to apply to sales that take place within a year after a provider terminates participation in the program, and (c) provide for recovery of any amount paid toward depreciation of provider assets in excess of what would have been paid on a straight-line basis when a provider terminates or substantially reduces participation in the program.

Under present regulations, the fair market value--that is, the price that would be set in bona fide bargaining between well-informed buyers and sellers at the time of acquisition--provides the upper limit for valuing depreciable assets in the hands of a new owner. Procedurally, it has been difficult in the case of some transfers to assure that the value placed on depreciable assets did not improperly

include elements of goodwill. The fair market concept also provides the upper limit for valuing the other assets--including land and goodwill--that form the base for the return on equity capital to be allowed the new owner, and the base for determining whether loans to finance acquisition give rise to allowable interest. This limit was set in expectation that the fair market value of facilities would be a reasonable valuation of the assets of the facility. We have had, however, a number of cases where it was questionable whether the nominal price paid for depreciable assets or the facility as a whole reflected a reasonable valuation of its assets. The price paid sometimes includes securities--stocks, bonds--in addition to cash. It seems clear that amounts paid for health care facilities and assets in excess of reproduction costs cannot be considered a cost that is necessary for the delivery of services. Hence, the regulations would limit the cost basis recognized in determining the allowable amount of depreciation to the lower of the fair market value of the depreciable assets at the time of purchase or the current reproduction cost of such assets depreciated in accordance with the age of the assets at the date of the sale using straight-line depreciation.

Also, the revisions in the regulations would exclude from equity capital and the base on which interest may be allowed, amounts paid for facilities in excess of the value of the tangible assets determined under the limits applicable to the depreciable assets. This would generally prevent amounts paid for "goodwill" from being recognized in determining the return on equity capital and allowable interest.

## Payments for Physicians' Services

The Staff believes that the present statute should have been interpreted to mean that Medicare reimbursement for physician fees be limited to what a Blue Shield plan pays under its own most widely held contract (or even the average payments actually made under all the plan's basic contracts) regardless of whether the Blue Shield schedules anticipate that a substantial portion of the physicians' fees be paid directly by the subscriber. The Staff has a very fundamental proposal for change (see section following this) but in the meantime it offers as a stopgap measure the recommendation that all Blue Shield plans serving as Medicare carriers be required to limit the physician's charge recognized as "reasonable" to not more than the average payment actually paid for a given service or procedure under all of its basic surgical-medical subscriber contracts.

We disagree with the idea that present law can be interpreted as the Staff suggests it could. We do not believe that it was the intent of Congress that a reimbursement policy be developed that would require Medicare patients typically to pay their physicians substantial amounts in excess of the deductible and coinsurance. An analysis of one example which the Staff has used in illustrating this issue makes the result quite clear. In the most widely held Blue Shield plan in Alabama a payment for a

cataract operation was limited to $75. However, there was no agreement by participating physicians to limit charges to $75 even for the lowest income subscribers of the Blue Shield plan. The physicians were generally expected to charge more. In practice, customary fees of physicians for this operation in Alabama are around $350. If the allowable charge under Medicare were limited to the fee allowed under the most widely held Alabama plan, physicians would on the average have submitted bills to their patients for $350 and Medicare would have paid, after the deductible, 80 percent of $75, or $60, and the patient would have had to pay the balance of $290. Thus, the beneficiary would have had less than 20 percent of his bill paid by Medicare and could hardly be expected to accept that result as fair or equitable.

On the other hand, in North Dakota where the most widely held Blue Shield plan is based on reimbursement of what physicians customarily charge, Medicare could have paid a full 80 percent of the maximum allowance of $375. Yet the older people in both Alabama and North Dakota would have each been paying the same $4 for their protection.

Under the Staff's "stopgap" recommendation it is stated that if, for example, Blue Shield in Massachusetts under all of its basic medical-surgical contracts actually paid an average of $250 for removal of cataract during 1968, Medicare would not recognize charges above $250 as reasonable for purposes of reimbursement. This proposal, too, could leave beneficiaries with substantial, additional liabilities to physicians in excess of the deductible and coinsurance although under this approach the gap would not usually be as great as in the Alabama illustration. Many Blue Shield basic medical-surgical plans are significantly below prevailing fees and Blue Shield plans that offer programs for group coverage in competition with prevailing fee plans generally provide a supplementary type of "major medical coverage." The problem about wide variation also remains. Thus, the Staff's "stopgap" measure involves the same basic objections though to a lesser degree.

It should be noted also that for another compelling reason the Staff recommendation could not be taken literally. If the cognizable charge for physicians' services for purposes of reimbursement under Medicare were not to exceed carrier payments actually made, as stated, the Medicare payment would be a reduced amount less than the average payment of the carrier for the reason that after the allowable charge has been determined the Medicare payment represents only 80 percent of the charge after the annual deductable has been taken into account. Such a result clearly would not be contemplated by the Congress. For the same reason, we do not think the Staff's construction of section 1842(b)(3)(B) of the Social Security Act can be sustained. This provision requires that the Medicare charge shall be both reasonable and

also "...not higher than the charge applicable for a comparable service and under comparable circumstances to the policyholders and subscribers of the carrier..." (underlining supplied). The statute does not set up as the test of Medicare's reasonable payment the schedule or other payment made by the carrier in its own business. It sets up the charge applicable, which is the charge which the physician would actually make to his patients irrespective of what the carrier's liability might be.

Since this short-run recommendation applies only to States in which a Blue Shield plan is a carrier for Medicare, the same anomalous results would not only occur on an inter-plan basis, but more particularly between those States in which Blue Shield is the carrier and those States having commercial carriers. There would not be a uniform national policy offering Medicare beneficiaries wherever they live approximately the same treatment in relation to their liabilities for medical costs and the premium they have paid.

Not only do we feel that the results of the Staff interpretation would have been unreasonable but we do not believe that such an interpretation would have resulted in significant control over the cost of Medicare, at least for very long. If Medicare ceilings were tied to Blue Shield rates, there would have been considerable added pressure for Blue Shield plans to raise their rates substantially.

But even if such an approach could be considered desirable, our reading of the legislative history would not allow it. We believe it is clear from the law and from the legislative history that reasonable charges under Medicare were not to be limited to amounts paid by private insurers under their own plans when such payments were unrelated to the total liability of the patient and, on the contrary, were only in partial indemnity for what the patient would have to pay. Such plans are not comparable to the Medicare program, which was, generally speaking, designed, except for deductibles and coinsurance, to relieve patients of what they would otherwise have had to pay the physician.

Contrary to what the Staff Report indicates, we have required the carriers to use the charges they recognize as a basis of what they pay in their own business as a limitation on what they can pay under Medicare when circumstances are comparable. For example, most of the commercial companies in their own business set up a prevailing rate which results in the reduction of reimbursement of physicians' fees that exceed these prevailing levels. They

are instructed to make sure that the prevailing levels in Medicare do not exceed the prevailing levels which they have established for their own business. Similarly, in Blue Shield plans, which are increasingly following the same approach, the same limitation is imposed and even in the fee-schedule approach of some Blue Shield plans when the schedules do in fact widely establish the upper-limit of patient liability for payment, as in the Rochester plan, the fee schedules have been used as a limitation on allowable charges in Medicare.

We agree that controls are needed over the recognition by Medicare of increases in physicians' fees. During fiscal year 1969, the program recognized only a 3 percent increase in the general level of physicians' fees although nationwide the actual increases in physician fees were between 6 and 7 percent. At the present time, about 30 percent of all requests for payment of physician and supplier bills submitted under Medicare are reduced before payment, with a savings to the program of $155 million a year. However, we believe that it is very important that what the program is willing to reimburse not be allowed to get too far out of line with what physicians are customarily charging, for the clear result would be a shift of program cost to the patient who would more frequently be charged the difference between the customary charge and the allowed charge. We are, therefore, watching very closely the rate of assignments under Medicare as we continue to apply a policy of limited recognition of fee increases.

Our present approach is what might be called a slowdown in the recognition of fee increases.

For the long run, we believe that it would be desirable for the law to be changed so that Medicare recognition of fee increases from year to year would be limited to an index made up of appropriate elements of wage and price indices. This would give us a much firmer base for control of fee escalation.

The Staff recommends a change in the law to provide for reimbursement for physicians' fees on the basis of a fee schedule which would limit payment to the amount estimated by regional advisory boards to be supportable by a $4 premium paid by the beneficiary and matched by the Government.

We do not agree. It is possible that at some time in the future it may be necessary to consider a fee schedule approach. However, any fee schedule established would need to be designed so that the

payments provided are not far below what most physicians are regularly charging other patients or the result will in many cases be the shifting of program costs to the patients as indicated earlier.

Under the plan proposed by the Staff, it is clear that even the initial fee schedule would mean the program would meet about one-fifth less of what physicians are now charging their patients. Since there would be no procedure to increase the premium rates other than by changing the law this gap between what the program was willing to base its reimbursement on and what physicians are actually charging would grow. The effects are quite predictable. A quite limited number of physicians, particularly those with the least successful practices, would agree to provide services to all patients at the rates provided by the program. (This, of course, has been the experience with medical care provided by the public assistance programs where fees have been set considerably below what the majority of physicians charge their regular patients.) Other physicians would normally charge their patients the regular fees and the patient in turn would be reimbursed for only a limited part of the bill, and, as time passed, a declining part. In other words, the proposal holds little promise of controlling what physicians charge and what the patient has to pay but rather controls only what the program's liabilities are.

The Staff recommends that uniform definition of medical procedures and services be applied in the payment of benefits under Part B.

Accurate reports of services and standardization of nomenclature are, of course, extremely important in the health insurance field and we have had extensive discussions and made considerable progress with the carriers and with medical societies. The attainment of general acceptance among all physicians, carriers and programs of uniform definitions of procedures and services is a highly desirable goal and is one of the recommendations made by the Health Insurance Benefits Advisory Council in its first annual report to the Secretary in May of 1969. This, however, is not as easy a matter as one might think from the discussion included in the report. The problem is, of course, complicated by the many possibilities for "packaging" services and charges and, of course, use of standard definitions would require a great deal of cooperation from the medical profession in completing bills and supplying information on charges. However, we will be working toward greater standardization in the classification of the services covered by physicians' charges so that more meaningful comparisons can be made in determining reasonable charges and would welcome legislative support in this area.

## Payments to Physicians in Teaching Hospitals

The Staff recommends that payments for physicians' services to "institutional" patients in a teaching setting be immediately terminated pending the development of new congressional policy.

Aside from the question of whether it would be desirable to stop such payments, we do not believe the law as it now stands would allow such an action. We see no basis for refusal to pay for physicians' services rendered to patients in an institution on the grounds that the patient is receiving his care in a teaching setting, that he was treated there by a salaried physician having a title such as assistant professor, or that he did not personally select a particular physician prior to entering the hospital.

A clear understanding of what is involved here must take account of the fact that services in the so-called teaching hospitals of the Nation are provided in a variety of ways. Many physicians who assist with intern or resident programs are in private practice and serve the hospital or a medical school part-time as a member of the teaching staff. When such a doctor treats a patient, whether he admitted the patient or not, and whether he uses interns to assist or not, he renders a personal professional service to the patient. The great number of people who are taken unconscious to the nearest physician's office or hospital following an accident are in no position to make a choice of physician, but if a physician, other than an intern or resident in a hospital, treats them, they may expect to pay for his services. And hospital patients very often do not "hire" (and in fact may never consciously see) the radiologist and pathologist who attends them, but this will not mean that they will not be billed for the services.

It goes without saying that there are problems in this area. The Social Security Administration instruction that reimbursement be paid only for identifiable and personal services rendered by attending physicians has not been followed consistently and even where followed has not always been appropriately documented as required by regulations. However, particularly in the last six months, administration in this area has greatly improved. In any event, the immediate cessation of all payments does not seem justifiable.

The present provisions of the Medicare law were not specifically designed to meet all the types of situations that can arise. It is worth reviewing in some detail the current situation. The medical insurance provisions (Part B) of the Medicare program provide for

payment to be made on a fee-for-service basis for physicians' services without regard to whether the patient is a teaching patient and without regard to whether he is a "private" patient or an "institutional" patient. As is stated on page 24 of the Report of the Committee on Ways and Means on the original legislation: "Like other physicians' services, the services of radiologists, anesthesiologists, pathologists, and other physicians employed by the hospital or working through the hospital would be paid for under the voluntary supplementary plan; such services would not be covered under the hospital insurance plan." (Underscoring supplied.) However, hospitals may be reimbursed under the hospital insurance provisions for costs they incur in compensating physicians for their teaching and administrative activities.

There are many hospitals in which a teaching physician may be responsible for institutional patients, and the services the teaching physician renders to these patients may be the same, slightly different, or very different in character from the services he renders to private patients. Thus, a sharp distinction cannot necessarily be drawn between the institutional patient and the private patient. Over the past several years increasing numbers of private patients have received care in teaching programs as institutional patients, so that the physician-patient relationship is often essentially the same for the patient who elects to get services from a physician designated in the hospital, as for the patient who chooses his own physician. Payment for physicians' services under the medical insurance program is permitted only where such a private physician-patient relationship exists. The regulations that set forth this policy state, in part, that:

> "Payment on the basis of reasonable charges is applicable to the professional services rendered to a beneficiary by his attending physician where the attending physician provides personal and identifiable direction to interns or residents who are participating in the care of his patient. In the case of major surgical procedures and other complex and dangerous procedures or situations, such personal and identifiable direction must include supervision in person by the attending physician. A charge should be recognized under Part B for the services of an attending physician who involves residents and interns in the care of his patient only if his services to the patient are of the same character, in terms of the responsibilities to the patient that are assumed and fulfilled, as the services he renders to his other paying patients. The carrying out by the physician of these responsibilities would be demonstrated by such

> actions as: Reviewing the patient's history and physical examination and personally examining the patient within a reasonable period after admission; confirming or revising diagnosis; determining the course of treatment to be followed; assuring that any supervision needed by the interns and residents was furnished; and by making frequent reviews of the patient's progress." (Underscoring supplied)

The regulations go on to note that there will be situations where a patient will receive medical services from residents and interns and the benefit of physician supervision for which charge reimbursement cannot be made by Medicare; payment for these services may only be provided by reimbursing the hospital under the hospital insurance program for its costs in providing the services.

As noted in the Staff Report, it has been difficult to achieve effective and uniform application of the program's policies to the large number of widely varying teaching settings. In some cases, charges have been paid for services rendered in hospitals--especially charity hospitals--which clearly did not involve the degree of physician participation envisioned by the regulations. Bills from the teaching physicians of a number of institutions have been suspended in order to permit a review to determine whether their billing practices are consistent with the Medicare coverage criteria and, where necessary, to provide full assurance that future billings are correct and that past overpayments are liquidated. However, it may well also be appropriate to modify the Medicare reimbursement provisions so that they are more responsive to the unique practices and policies of some of the teaching institutions.

We do not concur in the view that there is generally no obligation on the part of the patient to pay the supervisory physician for medical services in the teaching setting if the services are personal to him. Not only are such payments required by the Medicare law but other third parties generally recognize an obligation to pay for physicians' services furnished to institutional patients although, as in the case of the services of other hospital-based physicians, payment is sometimes made by a hospital benefit plan such as Blue Cross and related to costs rather than, as in the case of Medicare, by a medical insurance plan.

Nor do we believe that an insured person's obligation to pay for the services he receives should be determined solely on the basis of whether he can pay that portion of the charge that is not met by his insurance or on whether uninsured, indigent patients in the

same institution are expected to pay. It seems clear from the Medicare program's legislative history that Congress intended to provide protection for eligible aged persons requiring health services they cannot pay for except through insurance benefits. For example, section 1862(a)(3) of the law stipulates that services to indigents who are eligible under State-Federal public assistance programs should be paid for under Medicare. Obligation to pay a fee, we believe, should be determined by whether patients who are not indigent are required to pay for services they receive. We do not believe it was the intent of Congress that other patients or programs bear what are indeed undeniable costs of a service just because the physician happens to be a teacher.

The heaviest concentrations of "institutional patients" are, of course, found in public hospitals. As already noted, if payment for physicians' services were to be barred on the basis that they are furnished "free" to institutional patients, a strong incentive would be provided for Medicare patients to be sent to non-Government hospitals, where Medicare rather than the State or local government would pay the bill, even though the patient may prefer to go to the public hospital. The cost to Medicare of care in the voluntary or private hospital is generally higher than in the public hospital.

This is not to say that it might not be desirable to make some legislative modifications in the present provisions. For example, there is the question of whether it is appropriate to pay a volunteer physician from the community his customary fee for services he donates to a hospital even where the services he renders to a teaching patient are essentially of the same character as his services to his other patients. Also, the present law may be too restrictive in not providing reimbursement for the teaching and supervisory activities of physicians who are compensated by some source other than the hospital--e.g., an affiliated medical school or medical group.

## Large Payments to Health Care Practitioners

The Staff recommends that carriers and State Medicaid administrators be required to regularly compile and evaluate basic payments profile information with respect to each health practitioner.

We agree and have required Medicare carriers to institute postpayment controls that depict individual physician patterns and consist, at a minimum, of the following:

1. Ratios of total number of services (line items) provided to total number of beneficiaries served.

2. Ratios of lab services, x-rays, PT treatments, and injections to number of beneficiaries served.

3. Ratios of office, home, hospital, ECF, and nursing home visits to number of beneficiaries served.

4. Total payments on assignment to physician.

5. Total payments to beneficiaries per physician.

Standards for a post-payment surveillance system for Medicaid administrative agencies have been developed and steps for implementation are under way. In some States and with respect to some fiscal agents dealing with the Medicaid program for the State, the implementation of these changes will involve considerable cost and time, because it requires either basic systems changes or additions to the capability of the present systems to maintain provider profiles and to conduct surveillance by computer methods.

The staff suggests that it would be helpful to enlist the support of professional organizations in dealing with problems of possible program abuse.

We agree. This is a requirement that was part of the original contract with carriers, and from the very start, carriers, medical societies, and the Medicare program have been working to assure effective identification and resolution of situations of possible abuse.

The Staff recommends that each State Medicaid administrator be regularly provided Medicare payments profile data with respect to physicians practicing in that State.

We agree. We have been furnishing such information to State Medicaid administrators on basis of ad hoc decisions on its release. Our regulations on confidentiality have now been revised to permit release of such information to all State Medicaid administrators on a regular basis.

Incentive Reimbursement Methods for Hospitals, Extended Care Facilities, and Physicians under Medicare

We are recommending a change in the law which goes in the same direction as this recommendation as discussed on page 2.

Certification of Extended Care Facilities

The Staff recommends that certification of facilities with deficiencies--other than those of an insignificant and minor nature--be prohibited.

Much depends on what is meant by deficiencies of an insignificant and minor nature in the above recommendation.

It is correct, as the report points out, that a temporary conditional certification was granted to 250 ECF's that were not initially able to meet the charge nurse requirement. This certification was granted, however, only after the Secretary was given assurance by the State Health Department that no hazard was involved and efforts were being made to correct the deficiency. These certifications were terminated in April 1968.

At the present time it is possible to certify for participation in Medicare an institution that is in substantial compliance and is making progress toward full compliance. This means that all statutory conditions for compliance must be met and that the deficiencies in failing to meet the regulatory requirements established by the Secretary must not be of a type that would endanger the health and safety of the patient, e.g., the facility does not have available to it the periodic services of a qualified dietitian, but its food service personnel are experienced, effectively trained and supervised, and are performing in a satisfactory manner. We believe it is quite essential, particularly in rural areas and particularly in the beginning of the program, that institutions be allowed to come into full compliance gradually as long as they substantially meet the conditions of participation. Out of some 20,000 nursing homes in the country, only some 6,000 have applied for extended care participation, and only 5,600 have been approved. Eight hundred have dropped out or have been dropped involuntarily. The same certification concept is applied to hospitals. If one had applied all the details of full compliance at the very beginning of the program, many areas of the country, particularly rural areas, would have been left without participating institutions. The problem was one of establishing high standards, certifying participation for those who substantially met the standards, and exerting pressure for improvement as compared with leaving large parts of the country without coverage of the services that the program was proposed to cover.

If the Department were to adopt the suggestion of the staff, it would face the following alternatives: (a) deny facilities any time frame within which they can be moving towards the goals embodied in the standards, and require them, in a single step, to come into full, rather than substantial, compliance with essentially all of the demanding standards and factors now embodied in the conditions of participation and deny coverage of extended care services for beneficiaries in many parts of the country; or (b) relax the conditions of participation to the extent

necessary to assure the availability of services to beneficiaries. We do not believe that either alternative is acceptable. We believe that both availability of approved extended care services and pressure toward the highest health and safety standards must be maintained.

The Staff recommends that the law concerning a distinct part of an institution certified as an extended care facility be interpreted to limit a distinct part somewhat more than at present.

We agree. The development of policies along the lines suggested by the staff is under way. Extended care facilities that are participating or wish to participate have now had time to become acquainted with the Medicare requirements and to make plans for adjustments of this type.

## Institutional Utilization Review Mechanism

The report recommends that we require the staff of the utilization review committee of a participating hospital to be drawn from physicians associated with other hospitals and require utilization review plans for extended care facilities to be organized outside the institution.

Utilization review conducted by responsible committees of the organized medical staffs of hospitals is still a relatively new concept but has made great progress in recent years, particularly in the larger hospitals of the Nation. Medicare provided a substantial impetus and turned what was essentially an educational concept into a review device. It is important to encourage and further perfect the mechanisms of peer review within institutions, and we believe that the experience to date, at least in the larger institutions, warrants building on patterns consistent with the requirement of present law, rather than to institute a dramatic change of the kind recommended by the Staff. Indeed, adoption of the recommendation across the board would present formidable conceptual and procedural difficulties which could offset the hoped-for increase in objectivity. The extra drain on scarce physician time, a lack of institutionally-based discipline around which to carry out the activities in the hospital, and confusion regarding scope of responsibility are some of the more basic problems in organizing a committee of physicians not immediately associated with the institution.

The formation of utilization review committees is particularly difficult for small institutions or institutions not having an organized medical staff willing to assume the duties. It can readily be seen, for example, that, in rural areas where only a few physicians are available, requiring them to travel considerable distances regularly and to work on the review of utilization in other hospitals than the ones they use would have severe drawbacks. Nonetheless, there is room for additional experimentation with variations on utilization review and some changes that are desirable could possibly be worked out, especially with respect to very

small hospitals and with respect to extended care facilities generally. Changes of this type, which would provide for medical society participation, or State health department assistance to institute reviews on a community-wide basis, as the Staff Report proposes for extended care facilities, would be desirable. We would recommend here an approach which provides sufficient leeway to permit various types of demonstrations of the general principle so that further experience may be gained with respect to utilization review in the types of facilities where, because of ownership or for other reasons, the adequacy of present review may be doubted.

The Staff recommends that we require intermediaries to employ local, regional, and possibly national utilization criteria in evaluating the provision of institutional services.

The Staff Report comments upon the considerable experience which is emerging that results in more successful application by the intermediaries of length of stay criteria. We have made good progress in communicating to intermediaries agreed-upon concepts and better methodology for their claims screening. We are now studying the possibility of utilizing, nationally or on an area-by-area basis, length of stay criteria as one means of making it possible to screen out claims potentially involving noncovered days of institutional stay. Claims screening of this nature may be related more to claims review by intermediaries than to utilization review in facilities, the latter having an objective more of improving services than of rejecting claims. However, it is possible that with the development and communication of fairly objective clinical criteria, the utilization review committees at least at the larger institutions could also be involved in the selection of certain types of cases that would be presumptively covered or noncovered for certain lengths of stay.

The Staff recommends that we consider the use of diagnostic and length-of-stay criteria to identify cases which can, upon transfer from a hospital, be given automatic eligibility for some days of extended care.

This recommendation touches on an area which we have been exploring and on which we hope to be able to make recommendations for legislative modifications.

The Staff recommends that homemaker benefits be provided, on a demonstration basis, as an alternative to more costly institutional care.

Medicare now pays for the services of home health aides under certain circumstances. However, the provision of homemaker benefits involves serious problems. For one thing, it would be very difficult to draw the line between the

benefits intended and other kinds of domestic help. This would make it very difficult to estimate or control the cost of such a benefit. However, we support the recommendation to cover homemaker benefits on a demonstration basis. We also believe it would be preferable to make these benefits more widely available on a test basis to persons whose health, in the absence of the service at home, would require them to be institutionalized.

## Medicare Fiscal Intermediaries

The Staff recommends that the law be changed so that institutions no longer nominate intermediaries but rather that they be designated by the Secretary as he now selects carriers under Part B.

We have been mindful from the outset of the program of the possibility of certain providers using this right of nomination as a device for obtaining more favorable treatment from the intermediary. We have informed intermediaries that offering such inducements would not be tolerated and we have taken appropriate and prompt administrative action whenever we have had any indication of such action. We have also established the policy that a provider may not change intermediaries without good and sufficient reasons that are directly related to the efficient and effective administration of the Medicare program. On the other hand, there are advantages to allowing the provider the right to nominate the intermediary that it feels it is best able to work with and disadvantages to disturbing existing effective provider-intermediary relationships without clear evidence that such a change is necessary.

The Staff recommends that the Social Security Administration in its contract with Blue Cross Association reserve the right to select as local intermediaries only the Blue Cross plans which are capable of proper and efficient performance.

We agree. One of our proposed contract modifications would clarify the Secretary's right not to concur in the renewal of the subcontracts with Blue Cross plans. It would be made clear that individual plans could be excluded from program participation at the beginning of each contract term even when the prime contract with BCA remained intact.

The Staff recommends more direct dealing between the Social Security Administration regional offices and local Blue Cross plans as compared with routing matters through the national Blue Cross Association.

The need to provide BHI regional offices direct access to individual plans on significant issues is being met under the present contract. Moreover, clarification of regional office-plan liaison will be an objective of the SSA in renegotiating the BCA contract.

## Medicare Carriers

The Staff recommends that there ought to be fewer carriers and changes made that would foster genuine competition for appointment to the job of Medicare agent.

The Bureau of Health Insurance has worked diligently throughout the first difficult years of Medicare implementation to advise and assist carriers in handling the tremendous impact of initial workloads, to establish the procedures and policies necessary to assure sound operations for the long run and to establish clear standards of performance which would make it possible to evaluate carrier operations. There was little basis in the initial period to "weed out" inefficient carriers, but over time, as contracts have been renewed or modified, we have begun a selection process that is intended to move in the direction of a gradual reduction in the number of carriers and the enlargement of their areas. However, there are serious problems involved in making these shifts. A carrier that has performed well in a given area may not have the capability or inclination to serve in the area to be vacated by a poorer performer; a carrier that is efficient at its present level of Medicare operations may not have the capacity to perform efficiently at the higher level of Medicare operations that would result from its assuming the areas of poorer performers; and, of course, any major realignment of carrier areas would involve a substantial loss of operating efficiency during the transition period. In addition, the working relationships that have been established with providers, physicians, medical suppliers and health care organizations that would have to be severed and reestablished represent an investment and a resulting replacement cost of considerable magnitude.

## The Quality of Administration of Medicare

The Staff suggests the need for improvement in the quality of information supplied to and requested of carriers and intermediaries.

It is always possible to improve almost any operation. However, we were quite pleased actually at the reaction of the intermediaries and carriers to the questionnaire sent out by the Staff asking them to evaluate the quality of instruction and other material they receive. The results are that 76 of the organizations said the material was good and 36 said it was fair and only 6 said it was poor.

The Staff suggests that data necessary to evaluate program administration be given highest priority and be placed under control of BHI and that data useful for cost estimation be given only a slightly lower priority and be placed under control of the Actuary.

We have been reexamining our system for collecting and providing the program data required for administrative and cost estimation purposes. We will bear in mind the suggestions of the Staff in this reexamination. However, the highest priority is presently given to the production of program evaluation and cost data and close liaison is presently maintained between the Bureau of Health Insurance, the Actuary, and the Office of Research and Statistics to assure that the data produced is geared to administrative and cost estimating needs.

The Staff suggests that research related to the impact of the program on beneficiaries and the health industry should have a lower priority than data for administrative evaluation and cost estimation and should be carried out by the Office of Research and Statistics.

We have been operating in this fashion since the start of the program.

The Staff suggests that contractors be relieved of as much data gathering and reporting as possible.

We have been mindful of the need to avoid placing unnecessary data gathering and reporting burdens on Medicare contractors. At the same time, it must be recognized that our responsibility to secure the information needed for monitoring administration, estimating costs and evaluating the impact of the program must be fulfilled. The problem is to gather the necessary data while minimizing the administrative cost of doing so. We have been working hard to attain this result and will continue our efforts in the future.

In this connection, it should be noted that much of the data that contractors are required to report are byproducts of contractor operations which are often computerized. It should also be noted that much of the data requested by the Staff in preparation of its report would have been unavailable if extensive data and reporting requirements had not been imposed from the outset of the program.

## Medicare Financing

The Staff recommends that future increases in the earnings base be reserved for program improvements and not used to meet increasing program costs.

The costs of benefits now provided by the law in the hospital program,

of course, increase as wages rise. There seems to be no very good reason why one wouldn't use the income from increasing payrolls to meet these increasing costs. It does not seem wise for the Congress to commit itself to not using the money that becomes available from a rising base to meet present costs because the Congress might wish to broaden benefits when the cost of such a broadening is unpredictable. Rather, it would seem more prudent to take this increase in the base into account in considering the financing of the program.

It seems certain that the earnings base will rise under conditions of rising earnings. The maximum earnings base has been kept up to date since 1950 with regular ad hoc increases. Unless this practice continues in the future, the cash benefit side of the program deteriorates in relative protection. If earnings increased without earnings base adjustments over the 25-year period used in the hospital insurance cost estimates, the cash benefits would offer largely flat rate protection with little relationship to earnings.

It is true that from 1965 on the cost estimates have assumed a level earnings base but we do not believe that this is a desirable procedure and will be furnishing estimates on both bases in the next Trustees Report. We will recommend that the estimates based on a rising earnings base be used to set the contribution rates for the program.

## Medicaid Administration

The Staff recommends that appropriate legislative, or administrative action by the Department of Health, Education, and Welfare, be taken to prevent payments to intermediate care facilities at the same or higher rates than those made to skilled nursing homes in the same area.

We agree. A legislative proposal is being developed by the Department to achieve the objective stated in this recommendation.

The Staff recommends that the Medical Services Administration must provide dynamic, concerned, and qualified leadership and staff if a complex, costly, and important program such as Medicaid is to be soundly administered.

We agree. The Department has already recognized that the Medical Services Administration has been suffering from severe staff malnutrition and has begun to correct the situation. We have just appointed a new Commissioner for Medicaid, Howard N. Newman, an able medical care administrator. We are confident that he will provide dynamic and innovative leadership. We are also adding to MSA's staff a considerable number of highly qualified people who will bring the necessary expertise to bear on Medicaid's complex problems.

The Staff recommends that consideration be given to mandating use of fee schedules for payment of health care practitioners under Medicaid.

We believe that policies with respect to fee schedules under Medicaid should be worked out in the context of the possible changes in Medicare reimbursement of physicians discussed earlier under the heading, "Payments for Physicians' Services."

The Staff recommends that drugs be provided on substantially the same basis which would have been established under the provisions of the Medicaid amendment adopted by the Senate in 1967.

We agree. It is our belief that adoption of this recommendation will indeed save substantial sums of money.

The Staff recommends that the States be required to adopt procedures for prior independent professional approval of elective surgery, dental care (except for minor procedures), eye care, and hearing aids.

We agree that prior authorization is a useful adjunct to the control of utilization. The Ad Hoc Advisory Committee on Payments to Individual Practitioners Under Title XIX recommended to the Secretary (The Haughton

Report) that "prior authorization requirements should be made a part of the utilization review mechanism," and apply to certain nonemergency services, dental services, hearing aids, eyeglasses, psychiatric care, and nursing home placements.

To the extent that prior authorization procedures do not inhibit and needlessly interfere with needed medical services they may serve to curtail unnecessary services.

One should not overlook the administrative burden that prior authorization places on the title XIX agency and guard against a too rigid or a too lenient application.

Ideally, as the Haughton recommendation concludes, prior authorization should be a spin-off of a successful utilization review mechanism.

The Staff recommends that the States require the designation of a "primary physician" by recipients in areas or cases where abuse of physician services by recipients is detected or where that type of costly overutilization is widespread.

We agree that patient designation of a "primary physician" may deter costly "Doctor-Shopping" by recipients of public assistance. In the California Cannery Workers Program of Automated Multiphasic Health Testing, such a designation is reported to have worked well. However, the State agency must establish a way of designating a physician for a patient if the patient is unable to find one for himself.

Basic to the concept of the "primary physician" is the ability of the title XIX agency to identify recipient overutilization patterns. This is particularly difficult in a constantly changing recipient universe.

As pointed out in the Committee's report, accommodation is required to the "free choice" principle.

It should be pointed out, also, that the same problem exists in outpatient clinics of large hospitals. In the clinic setting a remedy has been found in the form of a skeleton health record which the patient is required to carry with him. A similar device can be used outside a hospital.

The Staff recommends that the States be required to furnish each recipient with a notice and explanation of health care paid in his behalf by the program.

A policy regulation dealing with information reporting requirements has been drafted. Now being cleared, the policy requires that States establish a basis for verifying with recipients whether services billed by providers were actually received. The Staff's recommendation will be considered in this connection.

The Staff recommends that the making of vendor payments under Medicaid to independent collection and bill discount agencies be prohibited.

We agree that there is a need for streamlining administration and processing of title XIX claims so that providers can be paid promptly. Assuming that independent collection and bill discount agencies now operate legally, legislation will be required to prohibit States from making vendor payments to such agencies from title XIX program funds.

The Staff recommends that the claims control system used by a State Medicaid system (or by its fiscal agent) should be specifically approved by the Department of Health, Education, and Welfare and if not approved, specific fiscal penalties should be invoked.

We are fully in favor of establishing Federal standards and requiring Departmental approval of State Medicaid claims control systems to assure program integrity.

However, the proposed imposition of specific penalties for unacceptable procedures will create numerous administrative problems.

Rather than imposing penalties on States which in most instances are doing their best under the constraints of inadequate administrative funds and insufficient technical and professional staff, we prefer to offer them technical consultation and financial incentive as the Department has proposed. We are considering the recommendations of the Department's Task Force on Medicaid and Related Programs for increased Federal matching for administration to be made available to States whose management information system and claims processing procedures meet prescribed criteria. Upgrading existing claims control systems will require appreciable State effort in both manpower and funds.

In addition, a model State claims payment system that places special emphasis on provider surveillance and review of recipient utilization has been designed by a management consultant firm under contract to the Department.

Aimed at preventing and curbing fraud, abuse and overutilization, this model will be made available to States along with appropriate Federal technical and consultant staff needed to help them implement it. The Department has also contracted for an improved Federal reporting system capable of providing MSA with critical data on a more timely basis.

The Department's initiatives should vastly improve the claims control systems. Adding legislative authority to provide States with financial incentives to adopt the model systems developed would facilitate all these efforts.

The Staff recommends that Federal administration and supervision of the Medicaid program be strengthened in the following ways:

1. Consultants with expertise in the fields of claims review and fiscal and professional controls should be made available by the Federal Government to assist any State which requests such assistance. Such personnel could function as a team to assist States in establishing basic operating control programs.

2. Regulations and guidelines should be reviewed and issued on a timely basis.

3. Expanded activity to assure that States are fully complying with the congressional intent respecting the provisions of the Medicaid statute.

4. Special efforts to establish a system of routine and expeditious exchange of information and experience on a formal and informal basis among State Medicaid agencies.

We agree. The items listed in this recommendation are among MSA's top priorities for action as the organization is strengthened and reorganized.

The proposed organization structure includes a Division of Technical Assistance which will employ experts qualified to assist States with specific aspects of the program, or will contract with management consultant firms to provide assistance beyond its capability.

The writing and dissemination of policy, regulations, and guidelines has top priority and will be expedited as additional staff is employed.

Efforts already under way in SRS regional offices to monitor compliance with Federal regulations on a quarterly basis will be intensified. Regional offices will also assume greater responsibility for on-site reviews of State programs thereby increasing our ability to review them more frequently.

We have recently completed studies for a "ready to go" surveillance and utilization review system for State agency use. The design is now ready to be tested in selected States on a demonstration basis. We are also redesigning the system used for State reporting to allow better program control at the Federal level. Both these efforts should lead to systems that will enable one State to learn from the experiences of another. As our information resource grows, we will develop technical assistance techniques and communications channels to assure nationwide dissemination of effective and innovational activities.

The Staff recommends that Medicaid fraud and abuse unit should be established in the Department of Health, Education, and Welfare.

We agree with the objectives of the recommendation and will make every effort to coordinate the activities of the Medical Services Administration with those of the Social Security Administration in the detection of fraud and abuse.

The Medical Services Administration has published an interim regulation in the Federal Register and is preparing final policy on the subject. The regulation requires all provider claims forms to contain a statement indicating that State and Federal funds are involved and that false claims or statements can be prosecuted under State and Federal law. The regulation also requires the State Medicaid agency to report to the Social and Rehabilitation Service every case of suspected fraud that has been referred to law enforcement officials and the ultimate outcome of the referral.

The Staff recommends that all States be required to maintain specific organizational units for the prevention, detection, and investigation of abuse and fraud in their health care programs.

We agree. The policy on fraud published as an interim regulation requires that a State plan "(1) Provide that the State agency will establish and maintain (i) methods and criteria for identifying situations in which a question of fraud in the program may exist, and (ii) procedures developed in cooperation with State legal authorities for referring to law enforcement officials situations in which there is valid reason to suspect that fraud has been practiced. The definition of fraud for purposes of this section will be determined in accordance with State law; (2) Provide for methods of investigation of situations in which there is a question of fraud that do not infringe on the legal rights of persons involved and are consistent with principles recognized as affording due process of law; (3) Provide that the State agency will designate positions that are responsible for referring situations involving suspected fraud to the proper authorities."

Federal financial participation in the claims-payment process is now at the rate of 50 percent. The rate of such participation in the utilization review activities is at 50 percent or 75 percent depending upon the level of professional participation. We see no reason for the detection of fraud being reimbursed at a higher level and therefore do not concur with the recommendation that matching be at 90 percent for personnel engaged in such activities.

The Staff recommends that the Medical Assistance Council be terminated and its functions combined with those of the Health Insurance Benefits Advisory Council.

We do not agree with this recommendation although we agree that many of the comments made about areas of commonality between the two programs. There are, however, basic and fundamental differences in the programs that would make a single, combined council less effective for each program.

We recognize the need for coordination of program activity and program regulations wherever possible and are achieving it by closer staff coordination within the Department. There has just been established in the Office of the Assistant Secretary for Health and Scientific Affairs a post of Deputy Assistant Secretary for Health Services, one of whose functions it is to provide guidance and program coordination for all Department programs concerned with financing, organizing, and delivering of health and medical care services

In conclusion, the services each of the separate councils offers the two programs are extremely valuable; we believe their help would be diluted rather than strengthened if the two groups were combined.