

S. HRG. 108-273

**FAIR DEAL FOR RURAL AMERICA: FIXING  
MEDICARE REIMBURSEMENT**

---

---

**HEARING**

BEFORE THE

**COMMITTEE ON FINANCE**

**UNITED STATES SENATE**

**ONE HUNDRED EIGHTH CONGRESS**

FIRST SESSION

—————  
(DES MOINES, IA)

—————  
APRIL 14, 2003  
—————



Printed for the use of the Committee on Finance

—————  
U.S. GOVERNMENT PRINTING OFFICE

WASHINGTON : 2004

89-955—PDF

---

For sale by the Superintendent of Documents, U.S. Government Printing Office  
Internet: bookstore.gpo.gov Phone: toll free (866) 512-1800; DC area (202) 512-1800  
Fax: (202) 512-2250 Mail: Stop SSOP, Washington, DC 20402-0001

COMMITTEE ON FINANCE

CHARLES E. GRASSLEY, Iowa, *Chairman*

ORRIN G. HATCH, Utah	MAX BAUCUS, Montana
DON NICKLES, Oklahoma	JOHN D. ROCKEFELLER IV, West Virginia
TRENT LOTT, Mississippi	TOM DASCHLE, South Dakota
OLYMPIA J. SNOWE, Maine	JOHN BREAUX, Louisiana
JON KYL, Arizona	KENT CONRAD, North Dakota
CRAIG THOMAS, Wyoming	BOB GRAHAM, Florida
RICK SANTORUM, Pennsylvania	JAMES M. JEFFORDS (I), Vermont
BILL FRIST, Tennessee	JEFF BINGAMAN, New Mexico
GORDON SMITH, Oregon	JOHN F. KERRY, Massachusetts
JIM BUNNING, Kentucky	BLANCHE L. LINCOLN, Arkansas

KOLAN DAVIS, *Staff Director and Chief Counsel*  
JEFF FORBES, *Democratic Staff Director*

# CONTENTS

## OPENING STATEMENTS

	Page
Grassley, Hon. Charles E., a U.S. Senator from Iowa, chairman, Committee on Finance .....	1

## WITNESSES

Wilensky, Dr. Gail R., John M. Olin Senior Fellow and Co-Chair of the President's Task Force To Improve Health Care Delivery for Our Nation's Veterans Project Hope, Bethesda, MD .....	4
DeParle, Nancy-Ann, Senior Advisor, JP Morgan Partners and Commissioner, Medicare Payment Advisory Commission, Washington, DC .....	6
Holcomb, David M., president and CEO, Jennie Edmundson Hospital, Council Bluffs, IA .....	12
Kitchell, Dr. Michael, McFarland Clinic PC, Ames, IA .....	14
Earley, J. Michael, President and Chief Executive Officer, Bankers Trust Company, Des Moines, IA .....	17
Forsyth, John D., Chairman and Chief Executive Officer, Wellmark, Inc., Des Moines, IA .....	19

## ALPHABETICAL LISTING AND APPENDIX MATERIAL

DeParle, Nancy-Ann:	
Testimony .....	6
Prepared statement .....	35
Earley, J. Michael:	
Testimony .....	17
Prepared statement .....	41
Forsyth, John D.:	
Testimony .....	19
Prepared statement .....	45
Grassley, Hon. Charles E.:	
Opening statement .....	1
Holcomb, David M.:	
Testimony .....	12
Prepared statement .....	49
Kitchell, Dr. Michael:	
Testimony .....	14
Prepared statement .....	50
Wilensky, Dr. Gail R.:	
Testimony .....	4
Prepared statement .....	54

## COMMUNICATIONS

American Benefits Council .....	57
Fisher, Elliott, MD, and Jonathan Skinner, Ph.D. ....	63
Covenant Health System .....	65
Deere & Company/John Deere Health .....	66
Ellsworth Municipal Hospital .....	68
Grinnell Regional Medical Center .....	68, 69
Hamilton County Public Hospital .....	71
Hancock County Memorial Hospital .....	72
Health Policy Corporation of Iowa (HPCI) .....	74
Kossuth Regional Health Center .....	80

IV

	Page
Madison County Health Care System .....	81
Marengo Memorial Hospital .....	82
Mary Greeley Medical Center .....	83
Mercy Medical Center, Cedar Rapids, IA .....	84
Mercy Medical Center, Clinton, IA .....	85
Mercy Medical Center, Des Moines, IA .....	86
Merrill Pioneer Community Hospital .....	88
Northwest Iowa Health Center .....	89
Palmer Lutheran Health Center .....	90
Trinity Regional Medical Center .....	91

**FAIR DEAL FOR RURAL AMERICA: FIXING  
MEDICARE REIMBURSEMENT**

MONDAY, APRIL 4, 2003

U.S. SENATE,  
COMMITTEE ON FINANCE,  
*Des Moines, IA*

**OPENING STATEMENT OF HON. CHARLES E. GRASSLEY, A U.S.  
SENATOR FROM IOWA, CHAIRMAN, COMMITTEE ON FINANCE**

The CHAIRMAN. I thank everybody for coming, particularly for the promptness of people being here. And more importantly, I have to thank you, the people that have worked so hard to put testimony together.

Before I forget it, there are people who need to be thanked for helping us set this meeting up, and one is Marty Weise of the historical society for helping us put together the building, the facilities and all of that. And then we have here on my right Terri Orrante, who is with Cassidy Reporting, because this is an official meeting of the Senate Finance Committee, and everything is taken down.

And in a few months, I don't know how long, but if any of you are interested in a complete transcript of what evolves at this hearing, you can get that by contacting me or the Senate Finance Committee staff in Washington, DC, once the final transcription is put together.

Let me also say that it's a real privilege for me to have the opportunity to chair the Senate Finance Committee, a committee that has jurisdiction over taxes, trade, Social Security, Medicare/Medicaid, welfare, and some other things. And it gives me a wonderful opportunity to help set the agenda in Washington. I wish it also gave me the opportunity to guarantee that anything I wanted to get done could get passed. I have one vote like everybody else has and, obviously, leadership and building from one vote up to 51 votes to get a bill passed. In some cases, as you know with the filibuster in the U.S. Senate, it's a case of building up to 60 voters if you want to ever get to finality.

So as chairman, I feel I have an opportunity to keep this Medicare equity issue on the senate agenda, and I intend to do just that. I would hope that there are interests in other States that are interested in the Medicare equity issue as well that will help us along to influence their respective senator to get to the necessary 51 votes.

Sometimes, as chairman of the committee, you think, well, you can get anything done you want to get done. I thought I brought some reality to the U.S. Senate Thursday night when I promised

some of my colleagues, because we needed two more votes in the U.S. Senate to get the budget passed, that I would make sure that we didn't have tax cuts of more than \$350 billion. Without that we wouldn't have a budget. When you have a vote of 50/50 and you have to bring the vice president in to cast a tie-breaking vote, you know things are tight.

So I made that agreement not just because of the tax cut issue, but because the budget set aside \$400 billion for Medicare improvement/prescription drugs for senior. And in that pot of money was the direction to work on the Medicare equity issue. So for a lot of reasons, I think the Congress ought to have a budget. Some of my colleagues maybe thought we'd be better off without a budget, but I don't know how you have fiscal responsibility in Congress without a budget.

But after that decision I made on the tax issue, and you sometimes think as chairman of the committee you can really get things done, the speaker of the house said Senator Grassley's irrelevant as far as taxes are concerned. Well, I hope I was relevant enough to get the necessary votes so that the republicans can do what we promised in the last election, to provide a budget. Put the point of the matter is, we need the prescription drugs issue, the Medicare issue as a locomotive to move along with what we're talking about here today.

So I thank all of you for coming to this official hearing of the U.S. Senate Committee on Finance. The purpose of our hearing today is to discuss one of the most pressing issues in Medicare today, particularly in rural America, Medicare equity. We want to better understand how and why Medicare underpays health care providers in rural America, and we want to better understand what we can do about it.

Our testimony today will focus on the situation here in Iowa, but it's not unique just to Iowa because there's 30 States, most of them rural, that are below the national average. But I'm sure everyone here knows unfair Medicare reimbursements not only affect Iowa, but it has an impact on our Medicare beneficiaries through potentially reducing access to health care services. It also affects our businesses through higher health insurance costs for employees.

Many of our hospitals lose money on every Medicare patient. Our physician's clinics are having difficulty recruiting young physicians because they can't afford the level of compensation these physicians are offered in other parts of the country.

Our businesses find that the cost of health insurance they provide for their employees is higher because health care providers must charge non-Medicare patients more because—to make up for the shortfall of Medicare. Businesses end up spending more in benefits and less on improving their businesses, hampering their ability to compete nationally and now even globally.

To help us understand these issues and what to do about them, we've convened two panels of very knowledgeable, experienced people. The first witness, Gail Wilensky, who serves as the John M. Olin Senior Fellow at Project HOPE, she analyzes and develops policy relating to health reform—health care reform. But particularly, I wanted Dr. Wilensky here because she served as Medicare director under the first president, George Bush. Secondly, we have

Nancy-Ann DeParle, who serves as senior advisor for JP Morgan Partners and as commissioner for the Medicare Payment Advisory Commission, which also advises Congress on Medicare payments. Ms. DeParle did serve as Medicare administrator under President Bill Clinton. And in that particular capacity I had the honor of working with her as we tried to bring about changes and enforcement of nursing home laws in the United States to make sure that we had safe places for people in nursing homes. Maybe not a problem in Iowa, but we sure found it at that time a problem, for instance, in the State of California, where 29 percent of the people had situations of jeopardy. And she has moved that along a long place, and I thank you for that, Nancy.

Both Ms. Wilensky and Ms. DeParle will provide history and context for Medicare's payment policies in rural areas and, more specifically, in Iowa.

Now, our second panel is Dave Holcomb, who serves as president/CEO of Jennie Edmundson Hospital in Council Bluffs and is chair of the Iowa Hospital Association. Mr. Holcomb will discuss how Medicare's reimbursement policies affect the ability of hospitals to provide high-quality care.

Dr. Michael Kitchell, neurologist, McFarland Clinic, Ames, currently serving as board member and president of the clinic. Dr. Kitchell will discuss how Medicare payment policies shortchange physicians.

Our next witness, Mike Earley, who serves as president/CEO of Bankers Trust in Des Moines. Bankers Trust is the largest independent bank in the State of Iowa, and he will discuss how Medicare payment policies affect business development.

Finally, our last witness, John Forsyth, serving as chairman and CEO of Wellmark Blue Cross and Blue Shield of Iowa and is CEO of its subsidiary, Wellmark Blue Cross and Blue Shield of South Dakota. Mr. Forsyth will discuss how insurance carriers deal with the impact of low Medicare payments.

At the end of the hearing, as we indicated in press releases, if time permits, I'd like to take a few questions in writing from the audience. If you have questions that you would like me or other panelists to respond to, please write them as legibly as you can on the index cards that we've distributed. And if you would like an answer—and if you would like an answer to your question and we don't get to it orally, I will try to respond in writing, if you'll leave your name and address on the card.

We're ready to start with Ms. Wilensky. And everybody will have their full testimony because we expect everybody to put reams of testimony for us for the record. We've asked each to summarize 5 minutes. And the red light would indicate, as you folks know from Congress, to please summarize. For those of you that are new to the process, I just ask you not to necessarily stop but to summarize as quickly as you can the last thoughts that you have so that we can keep on time. Ms. Wilensky?

**STATEMENT OF GAIL R. WILENSKY, JOHN M. OLIN SENIOR  
FELLOW AND CO-CHAIR OF THE PRESIDENT'S TASK FORCE  
TO IMPROVE HEALTH CARE DELIVERY FOR OUR NATION'S  
VETERANS PROJECT HOPE, BETHESDA, MD**

Dr. WILENSKY. Thank you, Mr. Chairman, for inviting me to appear before you. As indicated, I'm currently at Project HOPE. I'm going to be drawing on my experiences as the administrator of the Health Care Financing Administration in the first Bush Administration and also my 4 years of chair of the Medicare Payment Advisory Commission.

I'm going to focus on issues of geographic variations and talk about variations in Medicare payments per seniors. I want to talk a little bit about Medicare payments to physicians and institutional providers, what the lower spending in Iowa means for Iowa seniors, what it means for business. And I'll try to reward a higher quality of providers in the 5 minutes you've asked us to.

First let me say a few words about geographic variations in spending by Medicare. I know Nancy DeParle will also cover some of these issues. There are two type of geographic variations in Medicare payments that are frequently discussed. The first is the variation in Medicare payments per senior, and the second is a variation for Medicare payments to physicians and institutional providers. These are related to each other because the payments to physicians and other providers is a part of what makes up the variations in spending per senior. It's not the only thing, but it is part of the variation.

So let me go back and start talking about the variation in Medicare payments per seniors. There's been a lot of attention in Iowa on this issue. Unfortunately, the most attention has been to a measure that does not, in fact, show what it purports to show. The measure that has been most commonly cited is cash receipts to Iowa providers divided by the number of Iowans who are on Medicare in somehow trying to claim that this shows what Medicare is spending per Iowa senior, approximately per Iowa senior, plus the other people on Medicare.

The reason it's not a good measure is that some people leave a state to go get their services, and other people come in. And you need to make adjustments for that out-migration and in-migration. In Iowa it's particularly important both because the number of seniors leave during the winter and receive health care outside the state, and some people go to some of the health centers nearby, particularly the Mayo Clinic. Others comes in, but in balance, more people leave than come in.

And so in looking at cash receipts to the Medicare to the Iowan providers per Medicare beneficiary, rather than looking at Medicare spending per beneficiary gives you a distorted notion of what's going on. And, in fact, when you look at the more proper measure of Medicare spending per beneficiary in Iowa, what you find out is that Iowa is about 35th and not this 50th that has been banning about.

Now, that is a serious issue, but it's important for people to get off this measure of cash receipts. It's unhelpful to have any discussion. The question that people in Iowa might ask and it's one the people in Utah might ask, and one the people in Oregon might ask,



is why do we spend less per beneficiary in our state than other people. And the answer really to two-fold. Part of it has to do with the cost of providing services. It's about percent. And the majority 54 percent has to do with the number of services that are used.

So what is it that is going on in terms of use of services? Well, what we know is that people in Iowa use fewer services. Physicians have a more conservative practice style. People in Iowa are healthier. It may be that people in Iowa also seek care somewhat less than people in other States. It's harder to tell. We know for sure that the practice style and the healthier status causes lower use. And so part of what happens is, understanding that there is lower use, this is going to have repercussions for business community. And I'll get to that in a minute.

What has become more controversial for hospitals and physicians has to do with the lower payments that are received. And it happens because there is an adjustment made for wages and for other costs of providing services. Now, this has been a controversial area, and there have been attempts to try to help rural physicians and hospitals. The resource-based relative value scale, which was introduced when I was the administrator, was a distinct strategy to try to help these primary care physicians and rural physicians relative to specialty physicians and urban physicians. And, in fact, if you look at the data, there was relatively larger increases to those two groups than to the specialist than to the urban areas. And there's been a number of attempts to try to help rural hospitals. Nancy-Ann DeParle will talk about some of the MedPAC recommendations. I'd like to say that I support the four recommendations that MedPAC has made with regard to helping rural hospitals such as low-volume adjustment.

Two quick points. I see my light is on. I'd like to mention for business that although the concern has been raised as to whether they're spending more, actually the same reasons that Medicare spends less in terms of fewer services ought to help, not hurt business. Conservative practice styles by physician will help business, and the healthier status of Iowans will help business. The question has to be with cost shifting. That is less than half the reason for lower spending. And it's under dispute as to whether this really goes on. It depends very much about the competitive nature of the various marketplaces and the relative power between the provider groups and the institutions that are providing care.

With regard to the Iowan seniors themselves, there's a lot of reason for saying that because there is lower spending, they can lower cost sharing. The MedPAC policies tend to be lower, and the actual paid dollars into the HI trust fund tends to be lower because wages are lower here as well.

So finally the question is, is there a way to try to reward States like Iowa that traditionally have not only lowered spending but, in the studies that have been done, suggest Iowa is higher quality both in terms of the studies of quality improvement indicators that CMS has done, and in some other studies showing that higher spending is not traditionally associated with higher quality care? And this is an idea that I've already bounced off some of you on the provider panel, that because Iowa historically has an extensive data collection system for at least the 20 years that I know about,

it might be possible to structure a demonstration with CMS to see whether or not there is a way for the reward places like Iowa that are low cost, that are high quality, and see whether or not the information systems might be used for this purpose.

Now, Medicare is a price-administered system. It seems to be quite rigid. It's spent the last 20 years trying to find the right price for physicians and hospital services. So it doesn't do this easily, but both the centers for Medicare and Medicaid services and MedPAC have shown an interest in trying to pay for quality, and maybe Iowa can help.

The CHAIRMAN. Thank you, Dr. Wilensky. Now Nancy-Ann DeParle.

[The prepared statement of Dr. Wilensky appears in the appendix.]

**STATEMENT OF NANCY-ANN DEPARLE, SENIOR ADVISOR, JP MORGAN PARTNERS, COMMISSIONER; MEDICARE PAYMENT ADVISORY COMMISSION, WASHINGTON, DC**

Ms. DEPARLE. Thank you, Mr. Chairman. It's a pleasure to be here today in Des Moines. As you know, I was the administrator of the agency that was formerly called the Health Care Financing Administration, now called CMS, from 1997 to 2000. And I want to tell you again it's good to see you and that I enjoyed very much working with you on the issues around Medicare and its beneficiaries.

I found you were always fair. You and your staff are always focused on the beneficiaries first. I still have on my desk now a poster that you presented to me when I met with you the first time. I don't know if you remember this, but you did a poster with all the things you were expecting me to do. I want to tell you, though, some people might do that and you never hear from them again. But, Senator Grassley, and I don't think you were chairman of anything at that point, well, Aging Committee, I guess, but certainly you weren't chairman of the Finance Committee, but you continued to take me to task on those issues on that chart. And as I said, I've sort of kept it as a reminder of what someone who's focused can accomplish, and we did get a lot done.

I'm now a member of the Medicare Advisory Commission which Gail Wilensky was the founding chair. I'm here speaking on my own behalf, MedPAC has a number of members who are in various areas, and we can only speak as a group. But I'm going to be drawing on the analysis that MedPAC has done to give you some more details, I guess, to drill down a little bit of some of the details about the variation in per capita expenditures.

MedPAC is interested in this issue, and I myself have been interested in it for some time coming from more of a rural state myself in Tennessee: Why are there differences in Medicare spending and whether those differences—if they are at the state level or at the county level, I'm going to suggest that that is an appropriate way to look at it as well—whether they raise concerns about Medicare beneficiaries in lower spending areas, whether they're getting the kind of care, quality of care, they need, and whether care is really being sufficiently provided in the higher payment areas. That's something on which Senator Grassley has been among the hardest-

working members of the Senate, whether we are doing things efficiently and with integrity. The issue raises a lot of questions that need to be raised. We're now looking at Medicare's future. It's almost 40 years old. And it has been a wonderful program, helped a lot of people. But if you look at things like variation in spending and quality, you have to ask some questions. And I'm going to be very interested in hearing from our colleagues on the provider panel to take back some of their concerns to my fellow commissioners on MedPAC about what they've seen.

As I said, MedPAC staff has done a number of analyses to try to answer the questions that are raised here. And as Dr. Wilensky pointed out, one of the measures that's often used to look at this issue is really one that is very misleading. That's where you take the—basically the cash receipts that providers of the state receive and divide that among the number of beneficiaries and decide from that, well, Iowa is 50th and Tennessee is 40th or whatever the number might be.

That measure, as Dr. Wilensky pointed out, is flawed on several dimensions. One, it doesn't account for beneficiaries who might go, say, from Iowa to Omaha, Nebraska, or to the Mayo Clinic or the other places to receive care. That measure also can include some other things that probably should be included here, like payments to Medicare HMOs, and it doesn't account for payments that providers in a state receive in a year; rather, it should be accounting for the payments that result from services provided to beneficiaries in a year.

So MedPAC staff has developed an alternative way of looking at this, a different measure, which we think is better. And using that measure, MedPAC derived the national average expenditure per beneficiary of around \$5,360, using the most recent data available, which is 2000 data. For Iowa the average expenditure per beneficiary is about \$4,200. So there is a difference. So let's just spend a couple minutes talking about what that difference is. And it drills down to some of the details that Gail alluded to.

There's two sources of spending differences. The first is the cost of providing services as reflected in the prices that Medicare pays for services. Medicare is an administered-pricing system. They try to get prices right for a base price, and then there's adjustments made around that based on the local area. And the most important cost determiners are what are called input prices in a local area. That basically means things like the rent as charged in the local area, the salaries and wages paid to nurses and other allied health professionals. Those things reflect basically the cost of living in an area.

Another factor in the cost of providing services is the mix of the provider. There you're looking at, there are a lot of teaching hospitals, hospitals that train medical residents. Do the hospitals provide services to a large number of Medicaid beneficiaries? If those two factors are there, hospitals receive substantial additional Medicare payments. And if you add those two factors together, the local, sort, of cost and the additional payments, you can account for almost \$550 of that \$1,200 difference that I mentioned between the Iowa and the national average spending per beneficiaries.

The other big source of the spending difference is the quantity of services that beneficiaries use. And here, again, Iowa is different. There's about a \$650 difference between Iowa and the national average. And it stems from the fact that Iowa beneficiaries in general are healthier than the national average. And MedPac now estimates about \$200 in the difference comes from that.

I couldn't help noticing, Mr. Chairman, on the way from the airport yesterday all the folks out running, walking, exercising. And it was sort of evocative to me of this difference that statisticians are seeing in the data. The remaining \$450 of the difference MedPAC staff believes is probably attributable to other factors such as those as Dr. Wilensky alluded to; for example, a more conservative practice pattern among providers here in Iowa who furnish care to Iowa beneficiaries and/or a lower propensity to use those services by beneficiaries here.

MedPAC took its analysis one step further and weighted each state by its medical population so that beneficiaries in the less populous States would not count more than those in a more populous state with the idea being that it should be the beneficiary that we're really focusing on. And when you look at the beneficiary-weighted States, according to their relation to the national average spending per beneficiary, you still find a large variation. But on this measure Iowa is at 78 percent of the national average. It's about 8th lowest, and it's clustered with about 15 other States, States like Wisconsin, Minnesota, Maine, New Hampshire, which strikes me as being probably correct because those States seem to have some similar characteristics to Iowa in that they tend to have healthier population, and they tend to have a more conservative practice pattern.

Now, we're still at the very beginning of this analysis, but MedPAC staff has found that if you adjust for these factors I mentioned—the impact of input prices, health status, special hospital payments that some States receive quite a bit of and others like ours don't—you really can help to explain this variation. You get a distribution that shows much less variation. Iowa's still below the 100 percent of the average. Iowa's more like 90 percent of the national average.

I do think it's important—and I wanted to touch on this before finishing here—to also look at quality. MedPAC and the people who are studying this issue about the geographic variation, are also interested in whether Iowa beneficiaries are getting better or lower quality of care on average. And I suppose I should be congratulating the representatives of providers here in Iowa because, in fact, the evidence that CMS has shows that beneficiaries here are getting better quality services. It's interesting from what MedPAC staff has done so far, the quality tends to vary inversely with the amount of services that are provided. And that is really food for thought along the lines of what Dr. Wilensky was suggesting. Perhaps we should be rewarding the States where the providers are being more conservative, giving the people what they need, resulting in a better quality of care and better health status for quality Medicare beneficiaries.

There ought to be a way to reward that as opposed to rewarding people for providing more and more and not providing benefits to

the beneficiaries. And, as Dr. Wilensky pointed out, Iowa beneficiaries have one of the lowest levels of cost sharing in the nation. That, of course, also goes along with lower spending on providers who provide more conservative care. More conservative practice pattern means that beneficiaries will have lower cost sharing. They're also more likely in Iowa to have Medigap for supplemental insurance. Our data States about 97 percent of the Medicare beneficiaries in Iowa have that, and they pay less. They pay on average about \$1,300 for medical costs versus \$1,500 nationally.

So this is a very complicated issue. It has many aspects and many layers, like peeling off the layers of an onion. But what I can say to you, Mr. Chairman, is that MedPAC stands ready to continue working with you to try and address the concerns that you and others in Iowa have, and I personally will do everything I can to help with that. Thank you.

[The prepared statement of Ms. DeParle appears in the appendix.]

The CHAIRMAN. Well, thank you very much. Let me ask two or three questions of this panel before we go to the other one. This gives us a chance to hear this from the national perspective. Our second panel is going to have an opportunity not only to present their testimony to the Senate Finance Committee, but also we have two outstanding policymakers here on this issue, and we'll be able to address Iowa's concerns to them as well.

To both of you, you've made the point that low utilization and low intensity of services relative to other States accounts for a big part of the difference in Medicare reimbursements received by Iowa doctors and hospitals compared to other States. Basically, we do have a chicken-and-egg question here, and let me explain that. Is it the low reimbursement that prompts physicians and hospitals to treat Iowans less frequently and would lower intensity services than physicians and hospitals do in other States?

Dr. WILENSKY. There's a notion of practice style of physicians is an interesting long-observed phenomenon, basically started back with Jack Lindberg in the early 1970's. I don't know that we know exactly why, although those diagnoses that are less certain or symptoms that have less agreed-upon procedures associated with them tend to be associated with greater variations in how physicians treat them. So we know, particularly when you look at a county level, easier when you look at a state level, that there are variations in how individual physicians treat different kinds of medical conditions. Medicare since its inception has tried not to influence directly how physicians practice medicine prior to being incorporated to allow for local decision-making by physicians in terms of how to treat patients. It has a very big part as an explanatory factor as to why services are used so differently around the country. A very interesting study that I commented on is the analysis of internal medicine in February of this year, looked at three medical conditions, very carefully looked to see what happened in the high-spending versus low-spending States. And basically they found no better quality of life or quantity of life mostly increased discretionary expenditures that were going on in the high-spending areas.

The tough part is do we want Medicare to start telling physicians, other providers of a fair institutional right or other providers that it will only pay for certain types of services even though they may fall within the medically allowable variation. And that's the rope. It's why trying to reward the places that have high quality, low cost as opposed to telling physicians that they will not be reimbursed if they provide in certain circumstances or if they provide volumes of services, a lot of it is discretionary volume. It is an issue of how to stop it if you don't want to tell physicians what they can and cannot do, which starts to get very sensitive. I'm sure Dr. Kitchell will have his own views on that.

I think the very question is how do we reward the same effects that we know goes on as opposed—because the policy levers of how to stop aggressive practice style start getting very unsettling because of the pressure that will put on the senior or because it will start telling physicians how to practice medicine, which is something they tend to frown on.

The CHAIRMAN. One way is, of course, the quality factor in the formula.

Dr. WILENSKY. As that is, you know, as you know, my whole 4 years at MedPAC I was startled constantly how complicated these administrative price procedures were. I thought I understood them having been the head of HCFA, as it was then called, but I was always surprised at how complex these government set prices are. It is something that is being talked about. But because there's a lot of uncertainty about what exactly is quality, and if it means somebody else's money, people are going to start getting very aggressive about putting their kind of measure in as opposed to some other. But I do think that Iowa, because of its unusually rich data system, might be able to help CMS see whether or not there are ways to reward high-quality, low-cost States over others.

The CHAIRMAN. Let me ask Nancy-Ann another point. Your statement mentioned at several points that components of the Medicare formulas that are used for Iowa don't differ greatly from those used in neighboring States—I think you mentioned Nebraska, Missouri—and that Iowans on an average use the same amount of services than neighbors in other States. But doesn't that just beg the question which is whether the reimbursement formulas for all those States are adequate or fair at all?

Ms. DEPARLE. Well, I think what it suggests is that there do seem to be some similarities among those States both in the local cost of living sort of factors, the hospital factors that account for such a large proportion of the variation, as well as the propensity of the population to use services and the way that providers practice.

I think that if you look at the data—I didn't get a chance to get into this in my oral discussion, but my written statement does. If you look at the data across the country on a county level, what's interesting is that even within Iowa, for example, despite the difference, there's a pretty wide swing among counties in Iowa. And I provide some of the details of that in my written statement. So even if you dealt with the state level variation, you'd still probably have variation at the county level.

And I think I agree with Dr. Wilensky. When Medicare was begun, one of the big controversies was, was the Federal Government going to start telling physicians how to practice, was it going to tell Dr. Kitchell, yes, you can perform an MRI, or no, you can't? And in general, we've tried to avoid doing that. We've tried to allow more discretion to the individual physicians to make those kind of clinical judgments. So if there was some way to direct clinicians towards answers that we have clinical confidence in, would produce a better result for beneficiaries without getting into cookbook medicine or telling them what to do, that would be maybe the right direction to go in. And I think it would be wonderful if we could figure out a way to do a demonstration here in Iowa for that kind of thing, and it would speak for the other States that are similar.

The CHAIRMAN. Let me ask one more question before we go to our second panel. And you're going to hear, as I've heard from the last several months, from other people in Iowa. And I think you'll hear it from a couple people, particularly Mr. Forsyth and Mr. Earley, taking off on the point that Dr. Wilensky made, that Iowa businesses get a pretty good deal from Iowa providers because of our providers' conservative practice style and higher quality of services and thereby face lower costs than businesses do elsewhere. But it seems to me that we still have the question of whether or not non-Medicare payers pay more because Medicare pays relatively less.

Could you comment on this assertion that there's a substantial cost shift for Medicare underpayment to other payers in Iowa, which seems to me to be obvious since there's no free lunch.

Dr. WILENSKY. Well, being able to document cost shifting has been proven to be much more allusive than people would tend because you are left with one of the questions, if you could charge higher prices before, say, Medicare reduces payments, why weren't you? Why did you just respond when Medicare didn't if you had such complete control as to what you could charge the private sector? And why the first interest of a hospital might well be that if the increase in the Medicare reimbursement is less than what they thought it would be, to see whether or not they could up their rates to the private sector, the question is, is the private sector going to tolerate that or not, and why—whether or not this goes on at all, which is very hard to document, seems to depend on the relative power of the paired community versus the provider community and how competitive these various places are.

Let me make one other suggestion because it gets a little sensitive to places like Iowa, which has been very proactive in taking advantage of a program that I was around when it started. That was the so-called initially the MAP program in Montana. The demonstration then was called Reach and Peace, the outreach program, now it's critical access hospitals. It's a very important way to try to help small hospitals that were not viable as full-service hospitals become something else that they might be viable at so as to help rural communities.

I still think it's a very good idea in principle, although it seems to have expanded far beyond what was initially thought of in the late 980's when it started in Montana and when it was the essential access and primary access hospital program and even when it

was early on in the critical access program. It is possible that there are problems that Medicare can't fix. If you've got a very small hospital with a low occupancy, you really need to think hard about the trade-offs in terms of what it is you're trying to do. And the same way, unfortunately, for some areas which you're getting into recruiting physicians. There are some problems that Medicare can't respond to, and in an age of rapid communication and tele-medicine, other ways to try to—either add the service to the person or the person to the service to be sure we're taking the most sensitive strategy.

Again, I'm very supportive of the principle of the critical access hospital. But because there has been billing away some of the initial criteria as to what would determine if you were a critical access problem, I think we may have even created some of the problems now that we're facing. I urge people who are trying their best to get good quality care to think about this issue about whether this bill is a Medicare issue or whether it's a different issue that we're facing.

The CHAIRMAN. Now we have the opportunity to hear from our panelists of experts from Iowa, and we're just going to go from one right to the other. And then when all four are completed, we will have—I'll have questions of them, maybe some back and forth here before we take questions from the audience. I think it will be in the order of Mr. Holcomb, Dr. Kitchell, Mr. Earley, and then Mr. Forsyth. Go ahead.

**STATEMENT OF DAVID M. HOLCOMB, PRESIDENT AND CEO,  
JENNIE EDMUNDSON HOSPITAL, COUNCIL BLUFFS, IA**

Mr. HOLCOMB. Thank you. Good morning. I appreciate the opportunity to testify. I'd like to preface my remarks by saying you've just heard some very compelling testimony in the difficulty of measuring this on a per beneficiary basis; all true. Perhaps a more generally accepted way of looking at it, one which I'm equally comfortable with, is the whole concept of margins. What I'd like to point out is my remarks don't depend on that. Either way we're not going to save the boat.

I'm here as a representative for all 116 Iowa hospitals, about 70,000 who people make their living serving in hospitals and about 60,000 volunteers who show up every day and do the very best to serve their communities and their hospitals.

I want you to talk very plainly about the Medicare in Iowa. Medicare and its payment policies cheat Iowans. I say that because the program continues to utilize high-quality, efficient providers like Iowa. The system as it now stands flies in the face of common sense and is an affront to any reasonable concept of fairness. However, there's a lot more wrong with Medicare than that.

It's also wrong because low payments do, in fact, drive up the cost of providers and thus other insurance. It's wrong because hospitals and physicians are now having to decide when and how to curtail services and limit access. It's wrong because physicians have got very much of these same problems. It's wrong because we're at a tremendous recruiting disadvantage, particularly amongst neighboring States with considerably better reimbursement. It's wrong because we've got a health care system that's



known for its quality and cost-effectiveness, and we still find ourselves subsidizing States where that is not true.

Medicare has become an unfair burden on the Iowa economy. Our hospitals offer deep and constant wellspring of opportunity and service that attracts young, well-educated professionals and their families. A financially stable health care system is critical to supporting existing business and to attracting growth to Iowa. Good health care provided by well-supported hospitals and physicians is a large and irreplaceable block in the foundation that defines quality of life for Iowans.

The current unfair system is cracking and weakening that block the future creating instability and seriously threatening Iowa's future. Today my hospital loses about 20 cents on the dollar each time we treat a Medicare patient. In our skilled nursing unit we lose 74 cents on the dollar, and those issues—those numbers are from CMS. Unfortunately, it's very typical. All told, Iowa has the worst Medicare margin in the country and is losing approximately \$80 million a year to the program. Hospitals do, in fact, have to cover that cost. They can only increase private sector fees or increase taxes. Iowans end up taxed twice for Medicare and forced to subsidize the program elsewhere. Significant changes can be made to that payment, which would begin to make it fair to Iowa.

First, we need to authorize full inflationary updates of Medicare payments. That's only reasonable. Second, the base payment amount just got adjusted by 1.6 percent. That needs to be made permanent. Third, the wage index; major, major fault. It's applied to 71 percent of hospital payment, although it's unquestioned that only about half of hospital payment is related to wages and benefits. Every hospital in Iowa is cheated soundly by that lack of reality in the formula.

Finally, let's create a Medicare system that really does reward high-quality, cost-effective health care. It should seek and reward value, just as consumers do everywhere else in the American economy. Here's how such a system might work.

States can be ranked on both per-beneficiary cost, overall quality measures, substitute margin, if you want to. Hospitals and physicians in States that have the best combined scores, that is, the best quality at the most reasonable cost, would receive a 5 percent add-on as a reward for outstanding performance, entirely consistent with Congressional intent.

Members of Congress and people with DHS and CMS repeatedly have come to Iowa and told us how great the health care system is and how unfortunate it is that it's formulated in such a way that we're cheated rather than rewarded. That needs to change. It's time that Iowans, who've invested so much in their hospitals, who depend so completely on the jobs and services they provide, that our physicians provide, start seeing real equity to go with the kind words.

Iowa hospitals have illustrated a pathway to cost-effective quality. We need you to lead Congress toward a fair and equitable Medicare system, Senator, and you can do it. Your Iowa constituents greatly appreciate your leadership and your commitment on this. We're proud of your chairmanship of the Finance Committee

and your relationship with the president. Tell us know how we can help.

The CHAIRMAN. Well, that is very short and sweet. Thank you very much. Very seldom do we have witnesses before the Congress that finish within the 5 minutes. Dr. Kitchell?

[The prepared statement of Mr. Holcomb appears in the appendix.]

**STATEMENT OF DR. MICHAEL KITCHELL, MCFARLAND CLINIC  
PC, AMES, IA**

Dr. KITCHELL. Yes. Thank you, Senator Grassley, for allowing me this opportunity to address this critical issue to all Iowans, not just the 475,000 Medicare patients that we serve. We physicians take our responsibility for the health and lives of our patients very seriously, and this issue of the inadequate Medicare reimbursement has affected us greatly.

As you know, all physicians around the country have been burdened by paperwork, regulations, compliance issues, such as HIPPA. We see increasing cost overhead of our liability insurance. Our liability insurance has sky-rocketed all over the country.

One of the other issues, though, that I'd like to address today is the sustainable growth rate. This is a measure that was instituted to try to keep a lid on physician costs. Physician utilization is a significant part of the sustainable growth rate formula. The center for Medicare services that Congress has actually admitted that there have been major errors in the formula for this sustainable growth rate, this is strictly cuts in physician reimbursement all across the country. Fortunately, with Senator Grassley's help, we have avoided the 2003 cut.

But our physicians in Iowa feel that we are victims of two penalties: both the sustainable growth rate formula, which is flawed, and also the geographical price cost indexing. Believe it or not, just because physicians practice in Iowa, they're paid significantly less for the same services that we give to our patients compared to Chicago, San Francisco, or New York.

These penalties that Iowa physicians are suffering from affect our patient care. I'm part of McFarland Clinic, and there's a stereotype that the physicians of a small town, just out of small population that they serve—we at McFarland Clinic serve 300,000 patients. We have 300,000 charts of patients that we care for. Those patients are affected by the problems that we have in recruiting and retention of physicians.

In the last 2 years McFarland Clinic has had a significant downsize. We've had three cardiologists leave. We'd had two dermatologists leave. We've had an opening from a neurosurgeon leave. We've had an opening from an infectious disease specialist. We've had an opening from a nephrologist leave. I could go on, but I do think that the important issue here with regard to physician payment is recruitment. We have a significant problem in recruiting. We have 16 different physician's positions that are open right now, some of which have been open for four or five years because we cannot recruit physicians here.

The Medicare burden of our physicians is greater than in most areas of the country. We have a physician shortage here in Iowa.

We have not only fewer physicians, we have to take care of more Medicare patients. At McFarland Clinic we have 32 percent of our patients in Medicare coverage. We have problems with recruiting not only primary care but specialty care physicians. We have—in the State of Iowa we have one physician for every 622 people. In Washington, DC, they have 171 patients per physician. In Massachusetts they have 230 patients per physician. Our workload here in Iowa is three and a half times as many patients per physician than in Washington, DC.

This type of burden of Medicare and this shortage of physicians to care for those patients is critical now. For example, in our community if we have a patient with a spinal cord injury or a brain injury, they have to go to Des Moines for their care. That would be like in Washington, DC, if you don't have a neurosurgeon, you'd have to go to Baltimore for your care. In Ames we don't have a psychiatrist who takes Medicare patients. So if you have a chronic psychotic condition, you have to go to Des Moines. If you have a heart attack in Ames and you need intervention cardiology, you must be shipped to Des Moines 45 minutes away. Your heart in those 45 minutes may have quite a bit of damage.

These issues, therefore, not only affect physicians, they affect our patients, patients in our communities. So what is a second penalty that our physicians in Iowa face? We not only face the sustainable growth rate formula, which, as I said, is a national formula, we face these geographic price costs in those penalties.

Believe it or not, the physicians in Iowa get paid 30 percent less for most procedures, whether it's an office call, a surgical procedure, or some other procedure compared to San Francisco or New York. We get paid about 20 percent less than in Chicago. So when we have a recruit—and right now we are recruiting more second pulmonologists. We only have one pulmonologist. So we have our potential pulmonary candidates come to us and say, "We get paid 20 percent less than Chicago for the same procedures, for the same visits or consults for the patients. And by the way, what's on-call like?" You only have one pulmonologist, so in our McFarland Clinic system you'll be on call every other night. What is the cost of that lifestyle, that cost of the on-call burden. We are recruiting a third otolaryngologist. Our old otolaryngologist left. The cost to that otolaryngologist coming is not only a 20 percent lower reimbursement, lower fee schedule than Chicago, Delaware and Dallas, instead of joining a group of 10 otolaryngologists in Chicago and joining 2 otolaryngologists that is on call every third weekend and every third night.

You can see it's a little difficult to encourage physicians to come to that type of a situation. Recruiting is a clear-cut major issue. So why is there a 20 to 30 percent difference in our fees compared to Chicago or New York or San Francisco? The reason is our fee schedule is made up of what we call relative value units. And those relative value units are all adjusted by the geographical region that we serve.

There are three components to the relative value unit system, and two that I think if we get accurate data we can agree on. The cost of professional liability insurance, that's one adjuster. The second adjuster is the practice expense. Here in Iowa we not only have

the cost of being on call more often, we also serve our communities with outreach. We have significant expenses driving to smaller towns to serve the patients in those communities. But the most egregious penalty that physicians in Iowa face is quality work effort.

Work effort is the time the physical and mental energy spend treating patients and the training of our physicians. Our physicians here in Iowa have just exactly the same training, the same amount of time that they spend with patients, the same effort and time and in concentrating and remembering what the patients need. The effort for physicians here in Iowa is devalued. We are paid 4 percent less than New York City, for example, because of that relative value unit system adjustment of our fee schedule. I don't understand why we have a lower reimbursement for physician work effort. I can understand the differences in our malpractice and in our practice expenses. I can't understand the difference in the sustainable growth rate formula, but the sustainable growth rate formula is a national penalty, not a regional penalty. And that gets to my last point.

As Ms. Wilensky talked about, there are wide differences in physician practices around the country. This is the utilization that's quite different from region to region. There's been a research group that looked into the references for the difference in the cost. Why is the reimbursement in Louisiana so much higher than in Iowa? Why is the reimbursement so much higher in Washington, DC, than it is in Iowa? The researchers found that there were variations in high-spending areas and low-spending areas. There were greater than 60 percent differences in those costs, and they found—I'm happy to have you read my reference. They found that those differences in cost were entirely due to utilization.

Utilization is a physician and patient decision. What tests do the physicians do? What expensive or cheaper drugs do the physicians give? Should the patient have conservative or aggressive treatment? Should the patient be in the intensive care unit? Should they be in the hospital longer? How many visits does that patient with Alzheimer's disease or Parkinson's disease get? Those decisions on utilization affect health care cost, and they vary tremendously from state to state.

Here in Iowa we have the sixth highest quality by Centers for Medicare Services measurements. In Louisiana they are last in the country. In Washington DC, they are 37th in health care quality. The people in Iowa and the physicians in Iowa feel that these penalties of the sustainable growth rate formula and geographical adjustments for work effort are not fair, and we hope that you will be able to make some changes.

Thank you, Senator Grassley, for allowing me to speak today.

The CHAIRMAN. Yes. And you said you have some data. If you will give that to us, we'll be sure to include that in the record. Mr. Earley?

[The prepared statement of Dr. Kitchell appears in the appendix.]

**STATEMENT OF J. MICHAEL EARLEY, PRESIDENT AND CHIEF  
EXECUTIVE OFFICER, BANKERS TRUST COMPANY, DES  
MOINES, IA**

Mr. EARLEY. Thank you, Senator Grassley. I appreciate you bringing the field here to Des Moines, Iowa. I'm of the opinion that the issue of Medicare reimbursement is the single most important issue, Federal issue, facing Iowa.

It is widely understood by experts that we've heard today that the Medicare reimbursement scheme is unfair. Annual Medicare payments per beneficiary by state, Iowa is arguably at 3,200, give or take. The United States average is 70 percent higher than that. Louisiana is 137 percent higher than that. I should note that as background that Iowa hospitals rank extremely high in terms of quality. A recent American Journal of Medicine indicated that we are sixth in the nation in terms of quality.

I'm on the board of Mercy Medical Center here in Des Moines, Iowa, and I asked them to assist me with some information on how our hospital is affected by this unfair reimbursement plan. Their analysis showed that if Mercy of Des Moines were to receive the payment rate of any hospital outside of Iowa that they would receive more reimbursement for essentially the same effort and the same work.

Let me give you some examples. If Mercy were in Omaha, 140 miles away, in a community that we compete with daily on all forms of services, the reimbursement for Mercy would have been \$7.3 million higher; St. Cloud, Minnesota, \$6 million more; Sioux Falls, South Dakota, 2½ million more. Mercy is just one hospital in our state, and I've been told that it's estimated that difference statewide is approaching \$100 million.

As a consequence of this unfair scheme, Iowa hospitals find it extremely difficult to recruit and retain nursing professionals, and there's already a tremendous shortage in that area. Iowa hospitals are forced to rely more heavily on donor support to upkeep their equipment, maintain their equipment. Physicians in Iowa are taken advantage of by the Federal Government. Significant payment differentials have already been shared with you as high as 40 percent. Des Moines has lost and continues to lose key specialists; 14 in the last 12 months. Iowa is ranked 47th in physicians per capita.

It's becoming more widely understood in the business community that rates paid by non-Medicare individuals and businesses are being pushed higher in Iowa than in other States because Iowa hospitals are not even able to recoup the cost of providing Medicare to Medicare recipients. Other States enjoy as much as a 20 percent margin of Medicare reimbursement over their cost. In Iowa our reimbursement rate, as I understand it, falls far short of covering our cost. The difference in this shortfall is made up by charging more to Medicare—non-Medicare individuals such as myself and my employees.

I re-emphasize here, Senator Grassley, that the increase to non-Medicare individuals occurred in Iowa occurs in spite of the fact that we have an extremely high level of quality in our state. Iowa hospitals are also very efficient, as been evident by the American Hospital Association study that those—that our daily patient costs

are considerably less than the U.S. average. And as a result, Iowa's inpatient costs are sixth and outpatient costs are second.

Furthermore, I wanted to note that our insured, Wellmark Blue Cross/Blue Shield of Iowa, has worked very closely with employers and other health care providers in this state to address these costs. They've worked on us to develop a pilot project that will change the utilization of services that will drive our costs lower. They've created a unique Wellmark report which was a tremendous aid to employers and health care professionals in reducing costs.

So in spite of extraordinary efforts on behalf of our health care providers and our insured to provide quality and efficiency, Iowa falls farther and farther behind in terms of lower reimbursement. Our economic system was not designed to penalize top performance, but that's exactly what the medical reimbursement scheme is doing to Iowans, Iowa hospitals and Iowa health providers. I pay taxes with pride, but I'm alarmed to know that the payroll rate that I pay of 1.45 percent is paid by every other—the same rate is paid by every other recipient, but the recipients in Iowa receive on average \$500 less recipient nationwide. And I question why is that. My mother who lives in Cedar Rapids is 89 years old, and I wonder, aren't her health issues as critical and as important to her and her family as those recipients in Nebraska and Louisiana?

I become angry when I think how other States recruit our doctors, who are my neighbors and friends. I can just visualize how they use the medical reimbursement chart. First they use that chart to determine where the lowest payers are, Iowa, and then they use the American Medical Association Journal to find out the highest quality is from Iowa, so they're going to go to Iowa to recruit our doctors, my neighbors.

Second, they're going to recruit those doctors by showing them the reimbursement plan and saying, For doing the same amount of work, you'll be able to recover 47 percent more. You can reduce the time in your practice and spend more time with your family by moving across the river to Nebraska. You know, it's one thing to compete with the sunbelt, their climate, but it's disheartening to know that the taxes I pay are funding the cash incentive to recruit the doctors from our community and leave and go to Nebraska.

Finally, I can only imagine how the Iowa Economic Development Team feels when they call on Iowa employers and find out that a representative from Nebraska had been there and showed them that same chart and has encouraged them to build their next plant across the river in Nebraska and enjoy lower costs because that state has a higher reimbursement cost recovery rate.

I'm not a health care expert, but what I'm here about today is to ask for equity and fairness in this reimbursement system, Senator Grassley, and I ask it be done rapidly because it's most injurious to our economic and the health of our Medicare recipients in the State of Iowa. Thank you, Senator Grassley.

The CHAIRMAN. Thank you, Mr. Earley. Mr. Forsyth.

[The prepared statement of Mr. Earley appears in the appendix.]

**STATEMENT OF JOHN D. FORSYTH, CHAIRMAN AND CHIEF  
EXECUTIVE OFFICER, WELLMARK, INC., DES MOINES, IA**

Mr. FORSYTH. Thank you, Mr. Chairman, for scheduling this meeting here in Des Moines today. I appreciate the opportunity to share some of my thoughts on Iowa's outstanding health care system and the increasingly negative impact on Medicare payment on Iowa's hospitals and physicians.

I first would like to say a couple of things. I didn't write any of my colleagues' testimony. Second, when I saw you earlier today, I noted the first time in 20 some years I forgot my watch, but I will try not to borrow any Mr. Holcomb's time.

One thing that I think we can all agree on is Iowa's physicians and hospitals deliver outstanding value to Iowa seniors and the Medicare systems both in terms of quality and cost. We have two excellent ex-HCFA administrators here, and I think both of them testified to that fact. In fact, there was no question about the following: the level of quality of care that the Medicare recipients receive in Iowa. And two of the panelists did quote Medicare's own quality improvement report of 2000, 2001, which ranked Iowa number sixth in the country.

I also think that Medicare costs are among the lowest in the country. Now, we heard Dr. Wilensky say on her preferred measure, I think it was 35th. We know that we have seen things that have come out of the hospital association that are 50th or 49th, 46th. Ms. DeParle measures, I think she started saying that we were 75th—75 percent of national average, and then with every adjustment that MedPAC could think of, we became the 90th percentile of the national average. And she didn't comment about the standard deviation there because I am sure there was a huge standard of deviation.

My experience with smart people is they can do anything with data. So if you start all kinds of assumptions with data, you can prove it with data. But it's pretty clear that Iowa benefits from an outstanding group of physicians and hospitals that attract great value to Medicare recipients. A recent Dartmouth Medical School study—it was reported in the *Annals of Internal Medicine* in February of this year—confirmed the fact that neither quality of care nor access to services appear to be better for Medicare enrollees in higher-cost States, and Dr. Wilensky talks about that. I think she said 5 percent of the cost she'd seen had been driven by the services. And, again, that's attributable in terms of cost-effective providers who have practiced historically and currently in Iowa. One of the problems is the system is penalized for being efficient and effective, inconsistent with any system that you try to set up in the private sector, or I would hope in the public sector.

Now, the same health care system in Iowa that has demonstrated high value for Medicare recipients is also delivered on exceptional value for residents under age 65. So as both of you pointed out, Iowa is always in the top seven or eight, if not number one, in the country. My written testimony, I believe, shows about three studies where we're between first and seventh.

We've also done a great job as it relates to uninsured citizens. So if you look right now, IOM most recently reports that we have 8.7 percent uninsured, the lowest in the country. Other reports

have us at 7.4 percent, again, the lowest in the country. And if you look at that over any period of time, over the last 20 years, we have among the lowest uninsured rate in the country, anyplace in the country. And, again, I go back to that because of the effectiveness of the providers in hospitals and physicians in the State of Iowa.

And, as Dr. Wilensky pointed out, that should mean that our health insurance rates are more competitive. And I believe that's the case. We've looked at hospital rates, and recently Family USA reported the average premium for a 25-year-old in Iowa is 16 percent lower than the national average and for a 55-year-old is 16 percent lower than the national average. So we do have a competitive advantage as a state based on the efficiency and effectiveness of our doctors and our hospitals.

Again, this says that we have a high value of health system in Iowa. The concern that I and others have is the integrity of Iowa's health care system. It's building and continues to build in spite of these high-valued services. The services are being threatened with Medicare, the largest single purchaser of health care in the state, increasingly paying less than its fair share, as my colleagues from the provider community so appropriately testified to.

Historically Iowa doctors and hospitals have responded to Medicare payment equities by the only tools readily available to them. They could increase efficiency, and they've done that. And over time I think you look at the measures in Iowa and say that the efficiency and effectiveness of care is not only high, it's increased. Many of our rural hospitals are supported on a county tax base, and so the people in those areas are, in some sense, being double taxed because they have increased the tax support for their hospitals.

And the last available is shifting costs to the private side of their practices. Now, as a company, we estimate between 10 and 15 percent of our payments to Iowa hospitals and physicians are attributable to Medicare/Medicaid cost-shifting. We think the data is fairly good data because we used to use the cost report as a vehicle to Medicare costs. So we have some very good historical data.

Now, said another way, we could reduce our premiums by 10, 15 percent if Medicare paid hospitals and physicians fairly. And there was a judgment made to pass all those savings along to our customers. Now, business and individuals who purchase private insurance have seen their health care costs escalate dramatically to the point that coverage makes it seemingly not affordable to some Iowans.

In my written testimony you'll see that from an administrator's perspective our company has maintained relatively quite a discount over the last 7 years. And they're very competitive on a national basis. At the same time, for the last 5 years the cost in terms of medical costs have gone up by 45 percent. And we've heard a number of underlying drivers of cost expenses: technology, technological advances, drug treatment, medical devices, aging population, higher incident of chronic diseases, funding of the uncompensated area, which is the 8.74 percent without insurance, and last, but certainly not least, the cost shifts from Medicare shortfalls.

Now, providers have historically had the ability to cost shift to the private side, and this is becoming increasingly difficult because



payers, including my company, are seeking ways to limit their exposure to cost-shift. So where in the past one might pay a percentage of fees or charges, we now have fee schedules. And we update those on an annual basis.

So this is a deterrent, creating further stress on the hospitals and physicians and their financial situations. The long-term consequence for inadequate Medicare payments are clear. It's going to be an erosion of the quality of the health care system in Iowa, and on another level it's going to be a drag on the Iowa economy.

We're very interested in economic development in Iowa. We should have a major competitive advantage as it relates to our health care expenses. And because of the existing reimbursement from Medicare, that advantage has been significantly mitigated.

Now, I agree with our two ex-HCFA administrators that we ought to be thinking of a Medicare program as to how we purchase value. And to me, value is looking at cost and looking at quality. So value is cost-effective. That's certainly how we would do it in the private sector. We in the Midwest have seven Blue Cross plans and state hospitals associations. Iowa, Minnesota, Montana, Nebraska, North Dakota, and South Dakota, as well as Wisconsin, have gotten together over about the last 2 months to see if we can't come up with a measure that we could recommend, and Mr. Holcomb referenced part of our thinking. But the idea is that it sounds as though there's an agreement on how one measures quality. So we should be able to measure quality. It sounds like there's a bit of a disagreement yet on the best measure of cost, but we certainly ought to measure cost and cost effectiveness. You put together the low cost, the high quality, and you look at that in 25 percent of the States, and you would think it would behoove us to have some kind of an add-on. Mr. Holcomb recommended a 5 percent add-on for the most cost-effective States, those that provide the greatest value.

We've looked at a number of different ways to measure cost, though I'm not sure it's your way of measuring cost, and looked at value. Right now Iowa would become fourth in the nation as it relates to adding value to the Medicare program. Now, both of our ex-HCFA administrators suggested we go that direction but suggested it be a demonstration project, if I heard your testimony correctly.

And, Senator, I urge you not to go forward with a demonstration project. The experience of demonstration projects takes the pressure off the underlying issue, but it doesn't solve the issue for Iowans on a go-forward basis. So sometimes demonstration projects are appropriate. I would suggest to you at this time a demonstration project isn't appropriate.

The last thing I would say is, I'm sure at a point in time the system was probably in balance. If you have a system that gives percentage increases as opposed to the absolute dollar increases, the differential in payment over any period of time becomes very dramatic, so that standard deviation becomes fairly dramatic. So we ought to look at ways to reduce the standard deviation. I'm not saying that you take away dollars from the highest paid. And you and I in the past have talked about giving absolute dollar increases as opposed to percentage increases for some period of time.

So we're pleased that you've brought this hearing to Iowa. We're pleased we've been able to provide testimony. We look forward to working with you and others to help provide solutions.

[The prepared statement of Mr. Forsyth appears in the appendix.]

The CHAIRMAN. I thought about your comment about percentage increases and what that does. When I was chairman of the Appropriations Committee in the Iowa Legislature, I suggested dollar increases based on the average increase so that the high and the low would get the same dollar increase. And I was accused by all of my colleagues of being socialistic in my vote. However, I tend to agree with you. Once there's a certain differential set, it gets ridiculous after a while. So I agree with your suggestion. I don't know whether it's reasonable that we could get that done or not.

At this point I want the audience to think in terms of what I suggested previously, that if you have questions that you want to put on your three-by-five cards, now's the time to do it. And I would suggest you put your name and address so that if we don't get to any or—we, obviously, won't get to all of them. If you want an answer from my office—I can't speak for the participants here, but I can sure speak for myself—that I'd be glad to give you my opinion to your answer in writing.

I'm going to ask—before I ask you individuals questions, I think I ought to ask our panel from former CMS people if they could address the point made by this report, cite from other witnesses, the effect that there's a 6<sup>9</sup>/<sub>10</sub> percent difference between Iowa hospitals average Medicare margin and the national average, a minus 6.5 percent, 6.5 percent, to a positive point <sup>4</sup>/<sub>10</sub> of a percent clearly indicating an unfair and unsubstantially unfair reimbursement.

What are we to make of this differential, and what does it tell us about the fairness of the program?

Dr. WILENSKY. I'm going to do a broader response into the particular margin that you've looked. MedPAC has identified for some years now at least two of the recommendations that were issued before the recommendations when I was there in 2001, that there are four adjustments that would help rural hospitals and, therefore, help Iowa in balance with that, help Iowa uniformly.

One is a low-volume adjustment. We do know historically that hospitals with low volume have a higher cost. That's a recommendation that has been floating around for several years. That would help.

A second one is the so-called issue supporting the chair payment that has been in the past. There has been some adjustments that have already been made in the 2000 legislation—I think in the DRA 99—but there still needs to be an increase in the cap that is paid for the disproportion share. That would help Iowa. One of you raised the question about how much goes to labor. I'm not sure I'll buy 50 percent, but there is some agreement that 71 percent, which is the labor share that's used in the current hospital payment, is probably too high. It ought to be an imperial-based measure. And I have not seen 50, but I have seen in the 60's, and that would also help Iowa.

And finally, historically there been a differential between urban hospitals and all other hospitals, many urban and other urban

versus rural, and that would also help. So I think there are some suggestions that MedPAC has made some of them now for several years that it would be possible to include those adjustments. It would help the Iowa hospitals.

If you don't mind, the only comment—I have lots of comments, and maybe afterwards I'll have a chance to share one. But the notion that the Medicare, the current Medicare, is injurious to the Medicare beneficiary is something I can't let slide. Everything that we know says it is not injurious to the Medicare beneficiary. The quality is high, the payments are low because the cost-sharing is low, the Medigap is lower, and the dollars actually paid into the HI trust fund, the rate might be the same, but the wages are lower, so actually payments have gone in.

What you are rightly concerned about is whether over time something might happen to the provider system, institutional or physician, if we don't get some of these changes put in place. And I think both of us have indicated our sympathy that there are some changes; not all of the ones we've heard but differently some of the ones we've heard that we agree with, and that, in addition, it would be good to reward quality, which Iowa seems to provide.

But I do think it's important to not believe that the current system is injurious to the Medicare beneficiaries. There's absolutely no indication that that's the case. And I hate to have your audience walk away with that.

The CHAIRMAN. Do you want to add to that, or should I go on?

Ms. DEPARLE. If I can, just one point.

The CHAIRMAN. Please.

Ms. DEPARLE. Dr. Wilensky did outline the recommendations that MedPAC has made to the Congress that I think would help to deal with many of the issues that have been raised insofar as they deal with hospitals in particular; for example, the hospital margin issues you raised, Senator, adjusting the base rate so that there's no longer a difference in base rates for the urban areas and the small urban and rural would make a difference.

You know, changing the labor—the labor share used for the geographic adjustment, which I think Mr. Holcomb referred to and Dr. Wilensky just referred to, those are all things that have been recommended, and we hope to work with the Congress in the next year on doing some of those things. And I think that would help make a difference.

Also on physician payments—and I guess Dr. Kitchell talked a lot about that—MedPAC has said that the physician payment formula for the entire country needs to be relooked at. And it's a very expensive and difficult undertaking to go back into all that again, but that would perhaps help to deal with some of these issues as well.

The CHAIRMAN. Let me suggest the extent to which you want to work with us, and we want you to work with us, but that would not be—that would be sometime within the next 2 months because our time table is Medicare issues to be on the floor of the Senate by July—or by mid-June. So in that time frame we would welcome very much.

I'm going to start with Dr. Kitchell. I'm not sure I'll have questions of everyone. And one of the things said by some analysts that

contributes to low Medicare spending in Iowa is the low utilization, low intensity, compared to utilization and intensity of other States. These analysts say that Medicare money follows beneficiaries and their service utilization. These same analysts say that the conservative physician practice in Iowa are the major reasons why Medicare reimbursement for beneficiaries in Iowa is low and simply ask you as a professional who deals with this practice of medicine in Iowa to respond.

Dr. KITCHELL. Yes. I think the first thing that I'd like to say is it's very clear that the training, experience, and effort of the physician is very important. And higher quality care is actually lower cost because the physician does the right procedures, and the patients have better outcome. Preventative care is actually much better than the lower paid, lower reimbursed States, than in higher reimbursed States. So to answer this, I don't know how we get physicians all over the country to practice high-quality, cost-effective care. That is certainly a major problem. But here in Iowa we are penalized for our low utilization, high-quality care.

The CHAIRMAN. Mr. Forsyth, I'd like to clarify Medicare's contribution to the cost-shift problems that you discussed. You mentioned that care received by those without insurance contribute to cost-shifting. Do you know how much uncompensated care contributes to cost-shifting? And then, of course, I don't know whether this program is not about Medicaid, but would—that, obviously, is a big player in Iowa. Is that an adequate payer? And I ask that from the standpoint that at least on Medicaid the Federal Government have an open checking account that States can draw on for Medicaid. We pay 16 percent of a dollar spent. So it's kind of determined by the state and practice of medicine how much is spent; but most importantly Medicare, possibly Medicaid.

Mr. FORSYTH. I don't know the answer of how much relates to uncompensated care. But when you have 8 plus percent of your population and they're all receiving care, that clearly has to have an impact on physicians and hospitals. On the issue of Medicaid, there are significant issues in the State of Iowa currently as it relates to Medicaid reimbursement, inadequacies of the Medicaid reimbursement. And off the top of my head, Senator, I don't have all these numbers, but I could easily get those for you.

The CHAIRMAN. Okay. And if you do and you can get them to us in a period of time before our transcript is finished, I'd appreciate it. Are they readily available? I don't think we should put you through a lot of extra work.

Mr. FORSYTH. They're readily available through the Hospital Association and Medical Society in the state.

The CHAIRMAN. Let me ask you also as a follow-up, you made a number of suggestions for ways to make Medicare reimbursement to Iowa providers more equitable. Are you able to say how much additional Medicare money those changes, even if it were a rough guesstimate, would bring to Iowa providers? Or let me say it another way. Would additional reimbursement for services match what your analysis found the dollar value for cost-shift?

Mr. FORSYTH. The answer would be no. If you were just to do the 5 percent add-on for the most highly efficient, high-value States that that does not make up the entire difference of the cost shift.

It would be in 5 percent value dollars assuming you're in and you're out. Iowa was in that. And we already said the cost-shift is 10 to 15 percent, so it would be a fraction of that amount.

The CHAIRMAN. Mr. Earley, you made a very good statement, there's some—about the reimbursement differences between Des Moines and neighboring communities seem very difficult to understand. How could a major hospital and a sophisticated facility like we have in Des Moines be paid at a rate less than the smallest rural hospital in Minnesota? Some of the material with your attachments was very graphic. For instance, it's hard to understand how the wage index in Des Moines is at .8827 could be less than the rural Minnesota 0.1951, or rural Wisconsin 0.9162, or Sioux Falls 0.9257.

Is there any way that the financial officers, for instance, at Mercy have been able to explain to you why there's such a counterintuitive difference between these communities? And if you can't explain, maybe we can get it through the record. Or could anybody else on the panel explain the difference.

Mr. EARLEY. I'm sorry. I don't have an answer to that.

The CHAIRMAN. Maybe we could get an answer in writing, then. Can you do that?

Ms. DEPARLE. Mr. Chairman?

The CHAIRMAN. Yes. Go ahead.

Ms. DEPARLE. This may be one of those places we have some discussions after this, but I was curious when Mr. Earley was testifying because the information that I have indicates that at least—I think this goes back to what I was saying before about the swing among counties within a state. It's one thing to look at the state level, and that's what we're talking about today. But if you look at Iowa, for example, you can go from counties that are 30 percent below the national average to counties that are 25 percent above the national average in Medicare.

If you look at physician payment rates, these are averages, again, state averages, but in Iowa the Medicare physician payment rate for an initial office visit for this year is supposed to be \$92.80, for Nebraska it's \$89.32, for Minnesota it's \$95.69. So Iowa's slightly higher than Nebraska, slightly lower than Minnesota. If I look at San Francisco, it's \$123. That's a lot higher. But then the rest of California—and that probably includes some rural areas—is closer to \$104. So there seems to be—I think this shakes out a little bit more the way you suggested earlier, as an urban rural issue, and it isn't—at least some of the numbers I have are a little different than the ones I think some of my colleagues on the other panel have. So we could probably talk about that.

Dr. KITCHELL. Actually, if I could make a comment, I think, because Ms. DeParle is correct. The physician's fees here in Iowa are not the lowest in the country. We rank 80th out of 89 regions. But as I was saying, the differential in those payment rates is between 20 to 30 percent in Chicago, California, San Francisco, and New York. And the work ethic part of the physician fee that should not vary is actually a differential 14 percent. New York City versus rural Missouri, for example, is 14 percent higher for the same effort, the same work.

The CHAIRMAN. I'm going to ask a question from the audience. Do we think Medicare should reimburse all U.S. doctors and hospitals at the same rate per service provided regardless of cost of living in their geographic areas, regardless of price of office rent, regardless of price of wages in the geographical area, regardless of the cost of malpractice insurance in the areas? That's one question. And then what would be a valid gypsy; that's a geographical variation.

And I would suggest for the second question I would answer—other people can answer as well—but we did have a factor involved in that in the Grassley-Bockus Bill last fall that I think would have brought us up to the full .100, as I recall.

And then maybe just before other people comment on the first question, I think mostly from Dr. Kitchell, and maybe also from Mr. Holcomb, I think what the pleading is for professional services that it be reimbursed the same, large city versus small city, as opposed to other things that are affiliated with the practice of medicine and the delivery of health care. Would that be a fair summary?

And then anybody that wants to respond to this question from the audience, please do that now.

Dr. KITCHELL. Would you like me to respond first?

The CHAIRMAN. Yes. You don't have to agree with me. I'm just trying to summarize.

Dr. KITCHELL. Physicians certainly agree that the cost of professional liability is much higher in Miami, Florida, than it is in Iowa. Physicians certainly agree that there are differences in practice of cost. We do have cheaper rent. But our equipment, our technology, our magnetic resonance scan here is the same cost as it is in New York City. Our equipment is the same cost.

What is the cost, though, of being on call more often? I go to Marshalltown, Iowa Falls, Webster City. I go to those places five times a month. No one reimburses me for my travel time to those places. So we need to make sure that the costs that are being measured are not just those of New York City. We actually strive to see patients.

But getting back to your question, Senator Grassley, the issue here for most physicians is if there are going to be geographic differences, let's make them realistic. Let's make them actual costs. And the substantial growth rate is a national adjustment, whereas the work effort, which should be not a national adjustment, is adjusted. The sustainable growth rate penalizes us, rather than penalize the States where the physicians take six times as many visits from the patient. The study from Darmouth group also indicated that if the last 6 months of life of the patients in Miami, Florida, they actually were seen six times as often by specialists as in the Minneapolis area.

So physicians make those decisions about how many office visits, how many procedures are done. They do control cost. They do control some of the reimbursement. So if there are geographical variations, let's make it more fair.

The CHAIRMAN. I think that was Dr. Wineburg between Minneapolis and Miami. There was \$50,000 difference between the last

few years of the life of a senior. I'd like to have on the same question as a commentary from one or the other.

Dr. WILENSKY. The issue about whether you should ignore the cost-of-living differences is a simple one, at least from a market-based economy, is no, because these are real legitimate cost of differences, and you can't ignore them. That doesn't respond to the issue about whether the right ones are being used. I actually think the problem with physician payment is much bigger than any of you are talking about. The issue with regard to the sustainable growth rate is, why does it make sense to limit physician spending in growth of the national economy? The answer is, it doesn't. So one of the serious questions is whether or not to keep the sustainable growth rate measures at all.

And the second is that many conservative practices in the state. It will hurt all conservative-practicing physicians because everybody's fees get whacked across the board. But in the States that are aggressive in terms of volume of services they can make up in volume what they lose in the price per unit.

I personally think actually the problem is even greater still, and that is that the entire resource base relative value scale may need to be re-thought, somehow re-thought that coming out with 9,000 right prices, basically the number of codes in the CPT system, was going to drastically improve the system we had been using before it, which did penalize primary care physicians and did penalize rural physicians, but I'm not at all sure why we thought we made the system better by the relative value scale.

So if the finance committee was sufficiently aggressive in its undertaking, it should not only rethink the sustainable growth rate, I think it needs to rethink these whole relative value judgments that are being used that are brought into question by physicians all of the time. I'm not sure as to why there's a geographic adjustment on the work effort, but I have as many problems about the work effort in its entirety as I do about having a geographic adjustment. You do, obviously, have to acknowledge that both practice expenses and malpractice differ dramatically around the country, and to ignore them would be fool-hearted, at best. But I think there are major problems with how we reimburse physicians. And any conservative-practicing physicians has been particularly hard-hit when the sustainable growth rate has been reducing fees as it would have this year if the Congress hadn't intervened and as it did last year and it will next year.

The CHAIRMAN. Nancy-Ann, this question was to you. What would increase payments due to Iowa premiums and copays?

Ms. DEPARLE. Well, when Medicare—first of all, I agree with everything Dr. Gail Wilensky said. I think she's right. We have a bigger problem with physician payment adjustment, geographic adjustment. And I think the issue is what are the appropriate things to take into account. And, unfortunately, this may involve going back to the drawing board, which would be a very difficult process.

Higher spending in Medicare, for example, if there is more spending in part B of Medicare for physician office visits and other things, then that drives people's premiums up in Medicare in Iowa and across the country. There, though, as well, at least on the Medicare premium that every beneficiary pays, to some extent, I

think Iowa is helping other parts of the country in the conservative practice pattern. To some extent, Iowa, perhaps Iowa beneficiaries, are hurt a little bit by more aggressive practice patterns, more aggressive spending in other parts of the country.

And you and I talked about this, Senator, back during the Balanced Budget Act days when the home health issue was very big. And as you'll recall, there were parts of the country where there were more home health agencies, I think one of your colleagues said, than there were McDonald's in his state. That was not the case here in Iowa, but it was driving up home health spending to a point where all beneficiaries were probably paying more than they should. So this was one of those issues that's very difficult to solve.

The CHAIRMAN. I remember in those days the average Iowan got a home health visit of times a year, compared to Texas in the neighborhood of 140, Louisiana in the neighborhood of 140, as an example.

The next question is to me. Can we increase payments to providers and give all Iowans who seek Medicare prescription drug programs in an affordable, meaningful benefit? The macro answer is, working within \$400 billion, yes, based upon what we were trying to do a year ago within \$370 billion, of which a larger share of it would, of course, be for the prescription drug program. But remember, we're talking about more than just providing prescription drugs for seniors. We're talking about that if we were to write the first Medicare program that the United States ever had, if we were writing that right now, we would include prescription drugs in that.

So it's about bringing Medicare into the 21st century. In 1965 the practice of medicine was to put everybody in the hospital, and drugs were about 1 percent of the cost of medicine. Today, I believe, they're 11 or 12 percent the cost of medicine. And the practice of medicine is to keep people out of hospitals as much as you can, and prescription drugs have a great part to do with it. So we're talking about more than just an additional benefit for seniors.

And within the program that we put together in October in what's called the Grassley-Bockus Bipartisan Bill at that time, which, obviously, didn't become law or we wouldn't be talking about it now, but within in framework, I would say, yes, it is doable. But I would also say to you this way, that I think that at least as far as the Senate is concerned, beyond \$400 billion, if something happened so that prescription drugs/improvement Medicare ate up that money, I would find it necessary to take the issue of Medicare equity to the floor and be subject to a point of order and hopefully get the 60 votes necessary to go beyond the \$400 billion.

One other factor is that there's people trying to squeeze into the \$400 billion, the \$54 billion we did for doctor adjustment last January; otherwise, it would have taken a 4.4 percent decrease. As it turns out, the formula had a flaw in it. We fixed that flaw, and there was a 1<sup>6</sup>/<sub>10</sub> percent increase. That's the national standard that Dr. Kitchell was talking about.



Some people in the House are trying to take the view that that \$54 billion comes out of \$400 billion. I'm talking the view that if the formula had not had a flaw in it, the doctors would have been paid that \$54 billion, and I don't intend to get charged for \$54 billion for something that was somebody else's fault.

Is it true—I think Iowans will have to answer this, and I'm not sure I have an answer to it. Is it true that property tax that is used by rural hospitals has reduced Medicare reimbursement? Can anybody—

UNKNOWN SPEAKER. No. I don't believe that's the case. I think, though, what happen is when the budget shortfalls because of Medicare reimbursement, they might increase the tax to maintain the viability of the county hospital.

The CHAIRMAN. Now, that's what I heard when I've had my county meetings at county hospitals.

Then let's go—this one would be for this panel. What's wrong—from a public policy perspective—with having the labor portion of the wage index reflect that percentage of salaries and benefits in a given county, state, et cetera? Is that clear?

Dr. WILENSKY. The idea of having a DRG payment, a payment to hospitals, is to have a national payment rate and then make local adjustments to reflect the cost of actually providing the service in that local area.

You definitely want to measure the cost of providing the service locally, the input cost. But the idea was to get away from this cost-based system. And what this would be doing is moving back toward a cost-based system.

So you don't want to have the share bearing, you should say, well, if you do that, why don't you just pay what the cost is. And the answer is you don't do that because it gets very inflationary to have cost-base reimbursement. So you want to pick at the national, at the average level, what share is labor and what share is other expenses but use the actual labor cost. To try to do this balance of saying, you're trying to get to an average reimbursement, but you're trying to do so reflecting actual cost. Again, all of this reflects the difficulty of having the price-administered system go into place where you're trying to come up with the government determine the price rather than the market determine the price. Again, from a market-based economist, it reminds me why it's hard.

The CHAIRMAN. Here's a question for both of you. Because of the MedPAC relationship, why does MedPAC use 2000 data when it is purportedly 2003? In 2000 my hospital lost 430,000 from cost care for Medicare patients. In 2001 that loss grew to 1.6 million, and for 2002 we expect that it will grow to over 2 million. By the time you use 2001 data, we may have to stop caring for Medicare patients. The problem is payment is well below cost.

Ms. DEPARLE. That's a very good question. And if you go on the Internet and look at [www.medpac.government](http://www.medpac.government), and look at the transcript of our last meeting back in March, you will see that the commissioners spent quite a bit of time complaining about that themselves. The problem—and that's why this is helpful for us to hear your stories about how things are going in your hospitals. The problem is that the data that the Centers for Medicare and Medicaid that any of us have is lagged partly because of the way that

hospitals are paid by Medicare and the cost-reporting process. And as we can all see here, it's very important to get the numbers as close to accurate as possible.

But that process takes a lot more time than any of us would like, and there have been efforts made to speed it up. But it just takes a long time. So that's one that we love a solution to. And any more current data that you can provide through the senators is obviously very helpful.

The CHAIRMAN. Dr. Wilensky, this would be kind of a challenge to your opening remarks. Do you know the number of Iowans who seek health care in our States and those who go south in the winter? If so, what are those numbers? And if not, how can those figures play into your estimate about reimbursement in Iowa?

Dr. WILENSKY. I shared some of the data from MedPAC that Nancy DeParle had cited earlier. And the numbers, as I recall by memory, is that 16 percent sought care outside of the state, and there was an 8 percent inflow. So there was a net of in migration of services of approximately 8 percent. I will provide that in writing. But that is my recollection of the numbers that MedPAC had put together, unlike a place, for example, like Washington, DC, where I live, which had a net inflow into the community rather than a net outflow.

Again, what the Centers for Medicare and Medicaid services can do is to actually look at—or maybe MedPAC staff has done this, actually—look at Iowans who seek care outside because it causes the Medicare data, the files actually paid to the hospitals, will allow that to be seen. What we don't know is why they were doing it, whether they were doing it because they were wintering someplace warmer—as a Midwesterner, I can make that comment originally from Michigan—or whether it's because they chose to go to places like the Mayo Clinic, certainly near the northern part of Iowa, for major procedures. That would be a little harder to figure out, although, if you spend enough time trying to isolate, you could, but I would provide that in writing. But I recall by memory, I think it was a net differential of 8 percent, which is why the cash receipts become misleading. Expenditures by Iowans on Medicare who are on Medicare eligibility, that is the relevant figure to use.

The CHAIRMAN. Here's a question for me. I was disappointed that you, meaning Senator Grassley, didn't support Senator Harkin's efforts at Medicaid reimbursement. I hope that there are other efforts underway to address the shortfall as well as Medicare problems. Was my information incorrect?

No. The vote was accurately reported in the newspaper, and it came—well, maybe I ought to explain. When we have a budget up, it's the only process in the Senate that is that limited to a certain number of hours of debate. Everyone else, as you know, some of you might consider it a shortcoming of the Senate. There's no limit on debate, but that's where my interests are protected. But there's a feeling that the budget policy is so important that those minority interests should not be protected, that majority ought to rule.

So we had the budget up. And when we got done with the 50 hours of debate, there was an effort by democratic leadership, and a lot of democratic members joined in that, and Senior Harkin's amendment was one of those. About 80 amendment were filed at

the end of 50 hours with the sole purpose of extending the debate three to 4 days longer, in other words, a filibuster by amendment outside the process.

Now, we don't have debates on the amendments. The amendments are put up, and you vote them up or down. So this was a series of amendments where the democrats were trying to make the point that we shouldn't have tax cuts, that that money ought to go someplace else. So every one of those amendments took "X" number of dollars from the figure to put it into something else. And this was Senator Harkin's effort. There's nothing wrong with the effort because it's within the rules of the Senate, but it was one that, as I indicated earlier, if we don't adopt a budget and have \$400 billion set aside in the budget for all of the Medicare things we are talking about, then anything you do in that area is subject to a filibuster, and you have to have 60 votes to override it. And you'd never get 60 votes to get a prescription drug bill passed with Medicare equity as part of it.

So we wanted to move along the budget process. So we decided that since it was our responsibility as a majority party to produce a budget and we weren't going to get any support by the democrats in reducing the budget that we had to vote down all of the 80 amendments that were offered over the next 3 days. So that's what we did.

Now, in the meantime, I'd already gotten down in the budget question in a bipartisan language in the \$400 billion that that money—some of that money could be used for the Medicare equity situation. So my goal then was the same as it was last Thursday night when I made a decision to override the House of Representatives and not go with more than a \$350 billion tax cut, instead of \$750 billion tax cut to move a budget along because, without a budget, we're not going to get anything done including Medicare issues because of the inability to get 60 votes, which is proven by the 2 weeks of debate that we had last year and didn't get a Medicare prescription drug bill.

Let's see here—

Dr. WILENSKY. May I just qualify a statement I made earlier, the 16 percent figure that I cited was 16 percent of the hospital spending was spent by Iowans out of state. 8 percent came in that was by not Iowans, which means there was a net outmigration with regard to hospital spending, which MedPAC had looked on from this data that was spent by Iowans outside of the state. So the numbers I gave were with respect to hospital spending.

The CHAIRMAN. One other comment on what I just said because I want to differentiate a vote to a budget as opposed to the substance of Medicare inequity. This budget does not decide policy, so there could be "X" amount of dollars put in the budget for something, but it doesn't have to be spent on that. The Committee of Jurisdiction has the responsibility to decide how it's spent. So it wasn't really a vote directly related to—even though each person offered the amendment says that's what it should be used for, it doesn't have to be used for that.

Now, let's ask what would be probably the last question here. Does Medicare+Choice provide a mechanism to promote quality

and cost efficiency? It's not directed to anybody. Anybody want to answer that?

Mr. HOLCOMB. Unfortunately, I don't know we're going to know in Iowa because nobody found it attractive enough to offer. I think it's a moot question from the standpoint of the State of Iowa.

Ms. WILENSKY. And I think the answer is, not really, because the payments under Medicare+Choice follow what goes on in fee for service, except for the floor. And as we've discussed, those are very dramatic on a per-beneficiary basis because of the different use pattern that goes on across the country. If you want to look at trying to use these per person payments to promote efficiency, you have to get away from the current spending under Medicare and per beneficiary, per senior.

Dr. KITCHELL. I had a question to clarify some concerns Ms. Wilensky said earlier. I certainly understand the flaws in the formula of the substantial growth rate, but I want to make sure I understood. You are also agreeing that there were problems with the relative value system and the geographic index, and you are recommending that those be changed too; is that correct?

Dr. WILENSKY. I am no longer in a position to make the recommendation. I had the interesting position of being the administrator on board when the relative value scale was actually implemented. I indicated at the time I had great concerns about the wisdom of implementing the 9,000 prices under this new scale at MedPAC and since have indicated that this was designed to fix a particular problem. But I wasn't sure how many more problems it created. So I think the first order of business is to worry about the sustainable growth rate that's put a lot of burden on physicians in general, in particularly conservative practicing States. But while we're at it, I think we ought to rethink the whole issue.

Ms. DEPARLE. I believe MedPAC is on record saying the same thing, saying it doesn't make sense and we need to relook at the whole thing.

The CHAIRMAN. At this point I want to adjourn the meeting. But before I do, I'd like to make some closing comments. Most obvious is for the two people who have been involved, each one of them for at least four years in the administration of these programs and some of them well in their respective work now keeping some relationship to these problems we're talking about. I think that professionally you're all very, very busy people, and I thank you for taking time out of your schedule to come here to Iowa to help us and see our way through this. And I'll, obviously, be working with you as you want to help us develop some policy for our objection during the month of June. And, obviously, I suppose there's hundreds. We can get to some and address the issues as you did—as each of you have, but each of you represent in each of your respective ways, and in some cases thousands of people.

And so we appreciate very much for you to take time out of your busy schedule. I think that I've learned a lot about the way our payment system in Medicare works. I guess I feel it's an elaboration of understanding that I've had over a long time, or I wouldn't be involved in these issues. We've learned also how they don't work, and I think there are real improvements we can make this year and do it also in a bipartisan way.

I'm most struck by the consensus that seems to have emerged among the panel of quantity issue, quality index, whatever you might want to call it, under our traditional system. Medicare pays providers for how much they do, not how well they do it. Favoring quantity over quality is costly, as we've seen some studies that were just recently published, made very clear and referred to here today, and also in the end, then, are unfair to States like Iowa and to our residents by directly rewarding quality and conservative medical practices like we find here in Iowa. We can provide much more flexibility and fairness to this system while at the same time improve the lives of our seniors.

I thank you all very much for coming, and the meeting is adjourned.

[Whereupon, at 12:36 p.m., the hearing was concluded.]



## APPENDIX

---

### PREPARED STATEMENT OF NANCY-ANN DEPARLE

Chairman Grassley, Senator Baucus, distinguished Committee members. I am Nancy Ann DeParle, Senior Advisor, JP Morgan Partners and Adjunct Professor of Health Care Systems, The Wharton School of the University of Pennsylvania. I served as Administrator of the Health Care Financing Administration (now the Centers for Medicare & Medicaid services) from 1997–2000, and I am currently a member of the Medicare Payment Advisory Commission (MedPAC). I am pleased to be here today to discuss geographic variation in Medicare expenditures. MedPAC is very interested in understanding the factors underlying geographic variation in Medicare expenditures and is studying that issue, but I want to emphasize that the views I express today are my own.

#### *Medicare payment how does it work?*

To understand geographic variation in Medicare expenditures it is necessary to first understand how Medicare payment systems work. Most services covered by Medicare are now paid for under a prospective payment system (PPS). A PPS pays a set amount for a health care service, such as an office visit. That amount is set prospectively, that is before the office visit occurs and before payment is made. The base payment amount is the same wherever the service is delivered. Adjustments to the payment are made for local conditions including the level of prices in the local area—for example, the prices for labor and rent. Payments may also be adjusted depending on the circumstances of the provider. For example, some hospitals may get different payments according to their teaching status or the proportion of low-income patients they treat.

Medicare has moved toward prospective payment systems because of the incentives that costbased payment systems create. In a cost-based system there is no incentive to increase efficiency or hold down cost increases, rather the opposite incentives pertain. Prospective payment systems encourage efficiency in the provision of a service because the payment is set in advance. Although, PPSs might encourage efficiency in the way a service is provided, they may not create incentives to limit the volume of services provided.

#### *What does geographic variation in Medicare look like?*

To understand what geographic variation looks like in the Medicare program it is essential to start with a reasonable measure.

**A misleading measure.** Unfortunately, one measure of Medicare expenditures that has been frequently cited is actually very misleading. It shows Iowa to be 50th among States in Medicare payments per beneficiary. The measure has two serious shortcomings:

- The measure does not account for beneficiaries going across state borders to receive care. Thus it can be particularly misleading in States that experience significant migration either in or out. For example, providers in Washington, DC treat significant numbers of beneficiaries from nearby States. As a result, this measure of Medicare payments to Washington, DC providers per resident beneficiary exceeds \$10,000, nearly double the national average, reflecting the high concentration of providers in a city with relatively few beneficiaries. Conversely, in some States, such as Iowa, there is significant net out migration for health care. Simply totaling the Medicare payments to providers in those States and dividing by the number of Medicare beneficiaries, will always underestimate health care actually received by beneficiaries residing in them.
- The measure accounts for the payments providers **receive** in a year rather than the payments that result from services **provided** in a year. This can be a problem when new payment systems are introduced, because there are usu-

ally delays in claims and payments resulting in an uneven flow of payments over the year. Also, Medicare managed care plans sometimes receive more than 12 cash payments in a year, and other times receive fewer than 12. This may cause payments received by providers in a state to vary considerably from year to year.

For these reasons, CMS has concluded that “the average payment per beneficiary is not meaningful and will no longer be provided.” CMS no longer publishes this measure but rather reports simply total annual state-wide payments to providers.

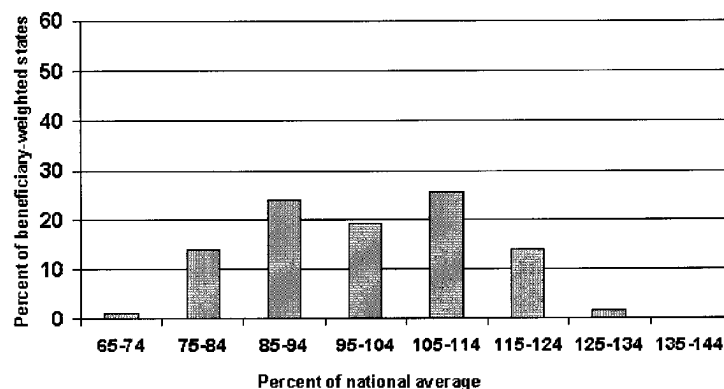
**A better measure.** In its efforts to try to understand geographic variation in Medicare payments, MedPAC starts with the amount Medicare spends for beneficiaries in the traditional fee-for-service (FFS) program. It does not consider the amount spent on beneficiaries who instead are in some form of Medicare managed care or in the Medicare+Choice private FFS program. These Medicare private plan alternatives to the traditional FFS program are interesting and important subjects in their own right, but their payment methods reflect many objectives and tend to obscure the underlying causes of variation in per beneficiary expenditures.

This measure has two major advantages over the misleading measure discussed above. First, it captures all expenditures on behalf of beneficiaries who reside in the county regardless of where the beneficiary goes for health care. That is, if beneficiaries tend to go to a nearby state for health care, those expenditures are still accounted for and attributed to the beneficiaries and their counties of residence. Second, it accurately captures expenditures for services provided during a year.

**The distribution of Medicare expenditures.** This better measure results in the distribution shown in Figure 1. The figure shows the distribution of beneficiary weighted States according to their relation to the national average expenditure per beneficiary of \$5,360. To effectively evaluate variation, the unit of observation should be the beneficiary because providing benefits to beneficiaries is the reason the Medicare program exists. Consequently, MedPAC’s analysis illustrates variation among States by weighting each state by its Medicare population. The result is beneficiaries, not States, being weighted equally. Without weighting, beneficiaries in less populous States would count more than those in more populous States.

Figure 1 shows that weighting each state’s per beneficiary fee-for-service expenditures by its number of beneficiaries produces a nearly bell-shaped curve that is fairly symmetric around the national average per beneficiary expenditure. However, it reveals a large variation in per beneficiary expenditures among States and only 19 percent of the distribution is within 5 percent of the national average.

Figure 1. Beneficiary-weighted state-level per beneficiary Medicare expenditures as percent of national average (\$5,360), 2000



Source: MedPAC analysis of CMS data

Using this measure Iowa is at 78 percent of the national average expenditures per beneficiary, or alternatively, the eighth lowest state in expenditures per beneficiary.

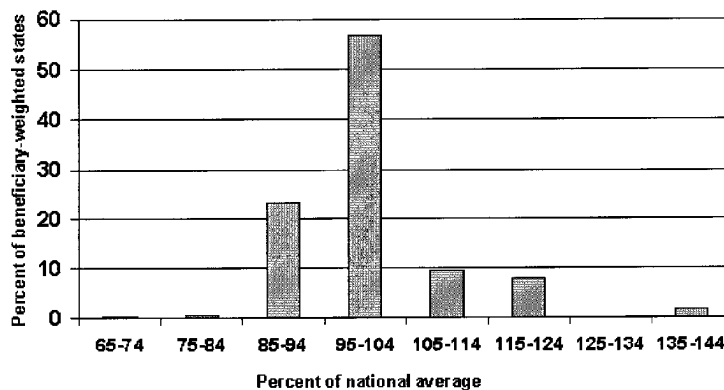
Much of the variation is due to two factors: adjustments for input prices and differences in beneficiaries’ health status. Adjustments for input prices are intended



to make payments more closely reflect differences in the costs of providing care and generally track with other measures of cost of living. Differences in beneficiaries' health status are important because sicker beneficiaries usually use more health services than healthier beneficiaries. I believe this variation is appropriate, because it makes sense that payments should reflect differences arising from those two factors. Some of the variation is due to special payments to hospitals (e.g., Graduate Medical Education payments to teaching hospitals) and some to other causes. After adjusting for input prices, health status, special hospital payments and differing participation rates in Part A and B by state, we arrive at the distribution shown in Figure 2.

The variation in Figure 2 is much less than in the previous figure. What this means is that the variation among States in use of Medicare covered services (which figure 2 can be thought of as representing) is much less than the apparent variation in Medicare expenditures shown in figure 1. About 57 percent of the population is within 5 percent of the national average in the adjusted measure while only about 19 percent is within 5 percent looking at expenditures per beneficiary. These adjustments bring per beneficiary adjusted service use in Iowa to about 90% of the national average. Removing the effects of varying input prices, health status, and special payments to hospitals reveals that the rate of service use by state varies much less than would appear from looking at unadjusted Medicare expenditures.

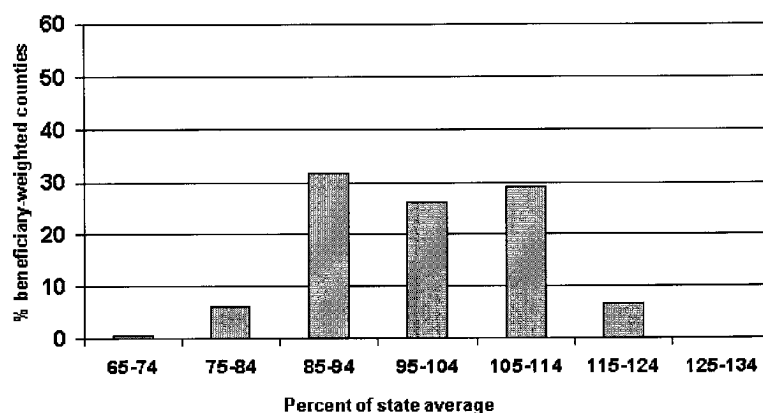
Figure 2. Beneficiary-weighted state-level per beneficiary Medicare expenditures, adjusted for input prices, health status, part A&B participation, and special hospital payments as a percentage of national average (\$5,360), 2000



Source: MedPAC analysis of CMS data

**Variation at other levels.** Contriving a system that eliminated variation among States would not eliminate variation in Medicare expenditures (in addition to being very difficult to accomplish). Variation is a fact of life and exists at all levels. For example there is wide variation in county level expenditures even after adjusting, as we discussed above, for known causes of variation. Figure 3 shows adjusted service use for Iowa counties relative to the state average. At the extremes, per beneficiary adjusted service use ranges from about 30 percent below the state average to about 25 percent above the state average. A similar result is found among counties in New York, which although quite different from Iowa, is similar in that it has large differences in adjusted service use among its counties. The standard deviation (a measure of how spread out the counties' per beneficiary service use is), is similar in the two States, \$434 in Iowa and \$516 in New York.

Figure 3. Variation in county per beneficiary service use (Iowa, 2000)



Source: MedPAC analysis of CMS data

The causes of the remaining variation in adjusted service use are probably found at the local level where health care is delivered. Differences in provider practice patterns and beneficiary propensity to seek services are local phenomena. That is one reason why seeking to eliminate variation at the state level will not necessarily provide beneficiaries the right amount of services, be more equitable to providers, or even be feasible to accomplish.

*What are beneficiaries in Iowa getting?*

Although all these measures of variation are interesting, the question that should concern beneficiaries is: Are they getting appropriate health care from the Medicare program? Iowa beneficiaries, as we have shown, are getting a reasonable quantity of services—about 90 percent of the national average. In addition, according to a measure of Medicare quality published in the January 15, 2003 Journal of the American Medical Association, Iowa beneficiaries get high quality health care relative to other States, ranking eighth in the nation. (An interesting finding from MedPAC's analysis of variation shows that this quality measure varies inversely with service use. In other words, higher use is often associated with low quality and lower use with high quality—a finding that should give pause to those who wish to increase service use in low-use States.)

Even more compelling, Medicare beneficiaries in Iowa have one of the lowest levels of beneficiary cost sharing in the nation. This not only lowers out-of-pocket costs but carries over to Medigap and other supplemental premiums. About 97% of Iowa Medicare beneficiaries have some form of supplemental insurance, one of the highest rates in the nation. Those who have Medigap pay less for the coverage than the national average. (For example, for plan F they pay about \$1,300 versus the national average of almost \$1,500.)

*Provider perspective*

Of course, even if from the beneficiaries' perspective Medicare payment seems adequate, I understand that if providers are not compensated sufficiently to care for Medicare beneficiaries they could eventually withdraw from the program or the area creating an access problem. To investigate that thesis let us look at physicians and hospitals.

**Physician payments.** Medicare physician payment rates are found in the Medicare physician fee schedule. The fee schedule sets the number of relative value units for the categories of physician work, practice expenses, and professional liability insurance for each physician service or procedure (e.g. an initial office visit, an appendectomy) adjusts for local rates in each category and then multiplies by a national

conversion rate. In the physician work category, the adjustment for local variation is limited—75 percent of the payment is not adjusted at all, the other 25 percent is adjusted to prevailing professional wage rates. This means that 75 percent of physician work is paid at the same national rate throughout the country, benefitting low cost areas. The example in Table 1, shows how the resulting Medicare physician payments in Iowa compare to those in neighboring States.

Table 1 shows the physician payment rate for an initial office visit in selected locations. The payment rate in Iowa is very similar to those in surrounding States, slightly higher than Nebraska and South Dakota, slightly lower than in Minnesota and most of Missouri. Rates in Iowa are lower than in some high cost areas of the country for example, San Francisco as shown in the table. This should not be surprising, because, for example, office rents in rural Iowa are probably much less than in San Francisco one of the highest cost areas in the country. However in rural California, rates are not all that dissimilar from Iowa. The payment rate for an initial office visit there is only about 11 dollars higher.

**Table 1. Medicare physician payment rate for an initial office visit.**

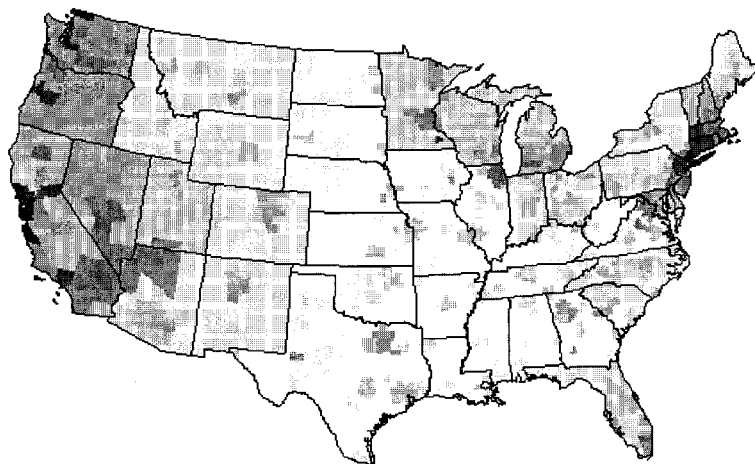
locality	payment
Iowa	\$92.82
Nebraska	\$89.32
South Dakota	\$88.30
Minnesota	\$95.69
rest of Missouri	\$93.69
San Francisco, CA	\$123.35
rest of CA	\$104.31

Source: Federal register Vol. 67, No 251/ Tuesday, December 31, 2002/ p 80171

It is interesting to note that according to the November 22, 2002 issue of Medical Economics, physicians in the Midwest in group practices have higher incomes (measuring revenue minus expenses) than doctors in the East or West. Only doctors in the South have higher incomes.

**Hospital payments.** Medicare hospital payments are also adjusted for local wage levels. The hospital prospective payment systems use the hospital wage index to adjust for local wage and price levels. For the most part, the hospital wage index accords well with other measures of input prices such as the cost of living index. Looking at the hospital wage index in Iowa and neighboring States does not reveal major disparities. Figure 4 shows a map of the hospital wage index across States and although the wage index in Iowa is less than in some States such as Connecticut, it is higher than that in others such as Alabama, and much like the wage index in the other States in its neighborhood, such as Nebraska and Missouri.

Figure 4. Hospital wage index values



Index ranges from lowest 0.73 (lightest) to highest 1.53 (darkest).  
Source: 2002 Wage index from federal register

Nevertheless, because many of the hospitals in Iowa are small and rural there may be some aspects of the payment system that could disadvantage them. In recognition of some of those factors, MedPAC has made several recommendations that taken together would help such hospitals. The recommendations include:

- raising the inpatient base rate for hospitals in rural and other urban areas to the level of the rate for those in large urban areas,
- enacting a low-volume adjustment to the rates used in the inpatient PPS,
- reevaluating the labor share used in the wage index system, and
- raising the cap on the disproportionate share add on.

These recommendations are discussed in MedPAC's March 2003 report to the Congress. That report is also the source for some of the analysis included in this testimony, the other major source is work supporting the forthcoming June 2003 report to the Congress.

#### *Conclusion*

After adjusting for differences in their health status, Medicare beneficiaries in Iowa appear to be using about the same amount of services as the national average, getting higher quality, and paying lower levels of cost sharing to get it. Providers appear to have payment rates in the Medicare system similar to that of providers in nearby States. However, variation in Medicare expenditures, equity in the Medicare program, and how to preserve access where there is no economic base for providers are complicated issues. I hope to contribute to the debate on those issues through my position at MedPAC and in other forums, and to work with those in Iowa and the Congress seeking to ensure that Medicare pays fairly for services Medicare beneficiaries receive. That fairness is essential for the Medicare program to continue to enjoy wide support while protecting taxpayers and Medicare beneficiaries from unnecessary burdens.

## PREPARED STATEMENT OF J. MICHAEL EARLEY

My name is Mike Earley and it is my privilege to serve as president and chief executive officer of Bankers Trust Company, based in Des Moines. Bankers Trust is the largest independent bank in Iowa, with approximately \$1.5 billion in assets. Bankers Trust has eight offices serving the greater Des Moines area.

I am very honored to have the opportunity to provide input to the U.S. Senate Committee on Finance regarding this extremely important topic of Medicare payments in Iowa and the challenges around the unfairness of the current Medicare system. I would like to begin by thanking you for bringing this field hearing to our community, and for your continued efforts in Washington, DC on behalf of our health care providers and all of the businesses and people of Iowa that they serve.

In addition to my role at Bankers Trust, I also am presenting to you as a volunteer member of the Board of Mercy Medical Center-Des Moines. Mercy is a 917-bed tertiary referral center based in Des Moines. It has three acute care inpatient campuses in the metro area. In addition, Mercy operates a nursing home, assisted living facility, inpatient hospice, home care, outpatient rehabilitation facilities, ambulatory surgery centers, and 26 physician clinics in the greater Des Moines area. Mercy also provides management services to more than a dozen rural hospitals and nursing facilities in Central and Southern Iowa. Lastly, I am presenting to you as a citizen of Iowa who is concerned about the future of health care services and the economic development climate in our state.

As a member of the Board at Mercy Medical Center-Des Moines, I have become increasingly aware of the unfairness of our current Medicare system, and of the challenges the inadequate reimbursement poses for our hospitals and doctors, and their patients and communities. In trying to quantify the extent of the problem, I became aware of the data from the federal Center for Medicare and Medicaid Services (CMS), showing that Iowa averages \$3,414 per Medicare beneficiary per year; the United States averages \$5,994 per beneficiary per year; and the highest state, Louisiana, averages \$8,099 per beneficiary per year. (See the chart labeled "Medicare Program Payments Per Enrollee by State" with this document). By this measure, Iowa is the lowest reimbursed state in the nation.

As a person with a financial background, I believe there is an even better measure of the financial impact of the Medicare payment system and its fairness or lack thereof. That is the profits or losses—the margins—hospitals realize as a result of caring for Medicare patients. As a backdrop to this, it must be noted that Iowa ranks very highly in quality, as reported most recently in the January 15, 2003 issue of the Journal of the American Medical Association. In that national study, Iowa ranked sixth in quality.

Iowa also is recognized for its low costs, always ranking in lowest 10% of States, as reported by CMS and in studies such as the Dartmouth Atlas of Health Care by Dartmouth University. It is especially troubling to note that despite this track record of low cost and high quality, Iowa hospitals lose money taking care of Medicare patients. In fact, Iowa hospitals' average Medicare margins were a *negative* 6.5% in 1999, the most recent year for which data is available. These were the worst losses in the nation, demonstrating once again that Iowa is the lowest reimbursed state in the nation. (See the exhibit entitled "Medicare Margins Comparison" with this document.) It is simply indisputable that Iowa is being cheated by the current Medicare payment system.

In preparing this testimony, I asked Mercy Medical Center-Des Moines for assistance in identifying specifically what are the consequences of this unfair system. The Finance Department at Mercy completed an analysis showing the impact on payments to Mercy-Des Moines, if it received payment rates that currently are used for other Midwest cities or regions. This analysis shows that if Mercy-Des Moines was to receive the payment rates of almost any other place, it would receive significantly more money every year for doing exactly the same work. For example, if Mercy-Des Moines was:

- Paid at either Lincoln or Omaha, Nebraska's rates, Mercy would receive \$7.3 million in additional payments from Medicare annually.
- Paid at St. Cloud, Minnesota's rates, Mercy would receive \$6 million in additional payments from Medicare annually.
- Paid at the rate of the SMALLEST RURAL hospital in Minnesota, Mercy would receive \$2.23 million in additional payments from Medicare annually.

(A copy of this financial analysis, entitled "Medicare Reimbursement Comparisons for Des Moines" is included with this document.) Of course it must be noted that all of these comparisons involve Iowa's rural neighbors—States that also are underpaid by Medicare as compared to other States around the U.S.

The consequences of these unfair and inadequate payments are dramatically negative. Because Iowa hospitals do not have the same resources as hospitals in other States, they have more difficulty recruiting and retaining well-trained health professionals. Currently the starting wages for newly-graduated nurses entering the work force are \$2 to \$3 higher in Minneapolis, Minn. and Kansas City, Missouri, than they are in Des Moines. As the CEO of Bankers Trust, I know I must pay salaries and benefits comparable to banks all over the Midwest. I know the cost of living is not much different in Des Moines than in larger cities such as Minneapolis and Kansas City. If I don't pay competitively, I don't succeed in recruiting the best people. It is no different in health care, and government policy should recognize this simple fact.

Of course the consequences of unfair reimbursement are felt in virtually every part of Iowa's health care organizations. Due to Medicare losses, Iowa hospitals have more difficulty replacing and keeping up-to-date medical equipment and facilities. They also find it more difficult to invest in information technology and other innovations to reduce costs and improve quality. They have fewer resources for continuing education and for community outreach services. Their financial performance suffers, which puts them at risk and increases their cost of capital when they need to borrow money or issue bonds.

Medicare's unfairly low payments to Iowa's doctors are an equally troublesome issue. As background, there is a 43% difference in average payments, from highest to lowest paid regions of the country, according to the Iowa Medical Society. Iowa again ranks near the bottom. Health care organizations, patients and communities all across our state feel the results of these systemic, ongoing underpayments. For example, Iowa ranks 47th in the nation in physicians per capita—even lower in some specialties such as obstetrics and pediatrics. The lower number of physicians per capita results in longer hours and more strained lifestyles for the physicians who do practice here, which exacerbates their frustration with unfairly low reimbursements. As a result, Des Moines has lost at least 14 specialists in the past 12 months who have relocated to other States, due to their rising costs and declining reimbursements in Iowa. This has an immediate and dramatically negative impact on patients. In one rural Iowa example, a general surgeon resigned March 1, 2003, from four community hospitals that he served, citing the same issues of rising costs and inadequate payment. One of those towns has had no surgical coverage for the past several weeks. Mercy is stepping in to assist that community hospital, beginning today. It is simply unacceptable that the federal government allows the challenges of recruiting and retaining doctors to be felt disproportionately in Iowa.

Speaking as a business person in Iowa, it is becoming better understood by more and more members of the business community, that the rates we are paying for commercial health insurance are being pushed higher due to the underpayments by Medicare. This is a very simple issue: when Iowa hospitals lose money on nearly half of their patients—the Medicare half—then they must charge everyone else more in order to remain financially viable. To put it in terms very close to home, the health care premiums paid by Bankers Trust for its employees rose 13% in just one year. Even more striking, a benefits manager from a plant in Marshalltown, that is part of a large national company, said that in the past 10 years Iowa has gone from his company's least expensive state for health care premiums to its most expensive. Again, this is due to commercial health care insurers being forced to charge higher rates, as Iowa health care providers are forced to shift more of the costs of Medicare to other payers. Yes, health care premiums are rising everywhere, but as the Marshalltown company's experience attests, they are rising faster here.

Of equal concern is the fact that the inverse is true in other States. Officials in Washington, DC have told us that hospitals in some States make a 20 percent or more POSITIVE margin on Medicare patients, despite having higher costs than Iowa providers. This has allowed those hospitals, in States such as New York, to offer deep discounts to their commercial insurance companies. The effect of these divergent trends is obvious—the federal government is subsidizing economic development in those States with high Medicare reimbursement by creating a more positive business environment. This is why Michael Blouin, the Economic Development Director for the State of Iowa, said just this week: "Addressing Medicare and Medicaid fairness is critically important to supporting the quality of life Iowans always have enjoyed." I am not a health care expert, but I do know this: the federal government should NOT be providing incentives for people and businesses to leave Iowa and locate in other States.

I want to note here that Bankers Trust's health care insurer is Wellmark Blue Cross/Blue Shield. That company has worked very closely with us in an attempt to address these rising cost pressures. As an example, Wellmark has developed a pilot project at our bank to help reduce health care premiums through changes in em-

ployees' utilization of services. Also, Wellmark has created the "Wellmark Report" in which it reports variations in health care utilization and medical practice. These variations are analyzed and reported regularly, in multiple areas of health care services, to assist employers and health care providers in better managing utilization and thereby lowering costs. We appreciate having Wellmark as a partner in these efforts.

From the perspective of an Iowa citizen, the issue with Medicare fairness is very simple. Everyone in America pays into the Medicare system at exactly the same payroll tax rate of 1.45%. However, when the time comes for the government to pay out those benefits, they are not distributed equally or fairly.

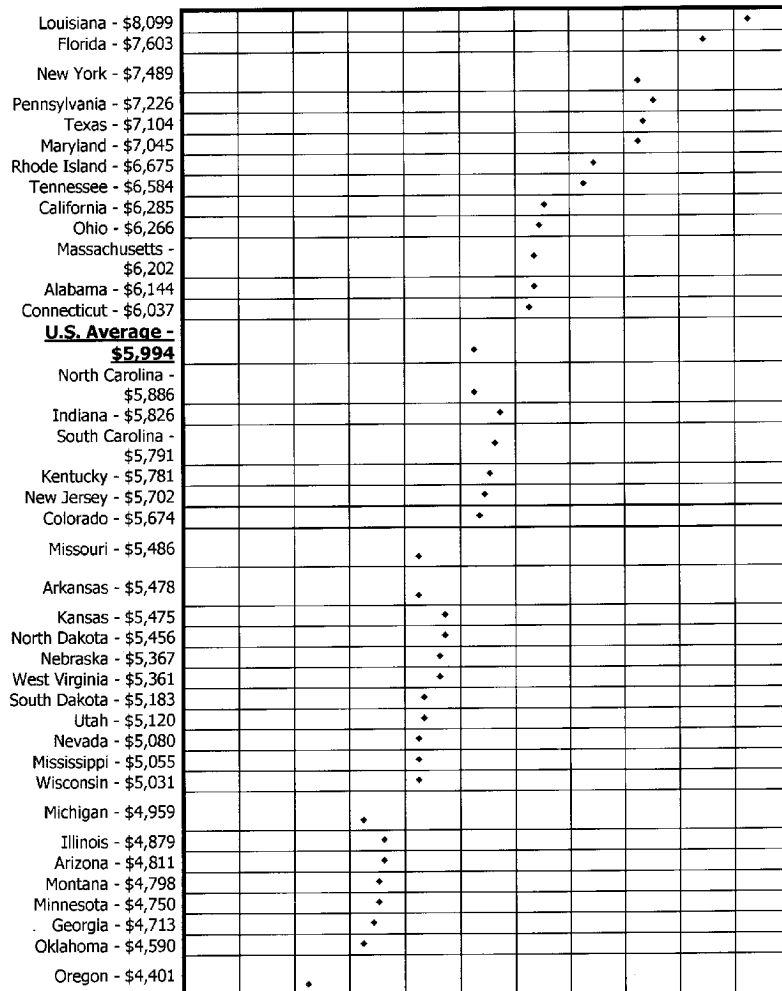
Another simple way to view this is to simply do the math. There are 475,000 Medicare recipients in Iowa, and Iowa receives about \$2,580 less than the national average every year for every recipient. This *totals 1.2 Billion in additional payments that would flow to Iowa annually*, if its payment rate simply were raised to the national average. If you increase Iowa's reimbursement only to the point where providers break even taking care of Medicare patients, you add about \$80 million per year to the payments to the state. These types of corrections obviously would have a tremendously positive impact on the quality, accessibility and cost of health care in Iowa.

Equally important, a fair and equitable Medicare payment system would result in a tremendous economic boost to the state. These additional dollars would turn over in the economy as investments, taxes, purchases of goods and services, and in many other ways. Also, as mentioned, the economic development climate in Iowa would improve, as the disproportionate pressure on private health insurance rates diminished.

In conclusion, I want to be clear that I am very proud to live and work in Iowa. We have a wonderful health care system, with documented high quality of care, and wonderful health care organizations and providers. We also have a state economy that has weathered these and many other challenges. However, my fear is that all of this is at risk and perhaps already eroding, as doctors leave our state, hospitals and clinics close in small town, and services are discontinued even in our larger cities.

As noted, I am not a health care expert, so I cannot discern what the appropriate level of payment is, or provide specific recommendations for changes in the complex Medicare payment formulas or systems. Others providing you with input can do that far better than I. However, I CAN state my belief that whatever you do, Iowa must have fairness and equity from Medicare. We cannot tolerate federal policies that make Iowa a second-class state. Senator Grassley, I respectfully urge you and your colleagues in Congress to aggressively seek changes in the Medicare payment system that ensure Iowa has the opportunity to operate on a level playing field with other States. As we move into ever more challenging times in health care, fairness and equity from Medicare is essential to sustaining the health care system and business environment that Iowans deserve. Thank you again for the opportunity to testify. It was an honor to participate in this process.

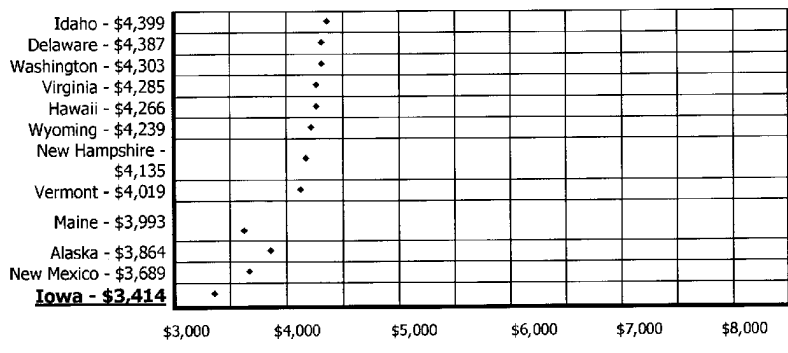
**Medicare Program Payments Per Enrollee by State**





MEDICARE REIMBURSEMENT COMPARISON FOR DES WORKERS

	Florida	Del. Masses	National Average	Pa. Minneste	Pa. Wisconsin	Rhode Island/ Conn. Alaska	Calif. Hawaii	Chicago, Ill.	Ill. Mich.	Grand Prairie, North Dakota	Ohio, Nebraska	Ill. Minneste	Alaska Pa. South Dakota
<b>I OPERATING DRG RATE</b>													
National: (See Federal Register)													
A LABORATORY OF BASE DRG	\$2,974.75	\$2,974.75	\$2,974.75	\$2,974.75	\$2,974.75	\$2,974.75	\$2,974.75	\$2,974.75	\$2,974.75	\$2,974.75	\$2,974.75	\$2,974.75	\$2,974.75
B WAGE INDEX per Federal Register	0.8872	0.8872	0.8872	0.8872	0.8872	0.8872	0.8872	0.8872	0.8872	0.8872	0.8872	0.8872	
C WAGE INDEX ADJUSTED LABORATORY	\$2,637.39	\$2,637.39	\$2,637.39	\$2,637.39	\$2,637.39	\$2,637.39	\$2,637.39	\$2,637.39	\$2,637.39	\$2,637.39	\$2,637.39	\$2,637.39	
D HOSPITAL PORTION OF BASE DRG	\$1,209.15	\$1,209.15	\$1,209.15	\$1,209.15	\$1,209.15	\$1,209.15	\$1,209.15	\$1,209.15	\$1,209.15	\$1,209.15	\$1,209.15	\$1,209.15	
E BASE DRG RATE	\$3,834.96	\$3,834.96	\$3,834.96	\$3,834.96	\$3,834.96	\$3,834.96	\$3,834.96	\$3,834.96	\$3,834.96	\$3,834.96	\$3,834.96	\$3,834.96	
<b>CAPITAL RATE</b>													
F FEDERAL RATE	\$407.01	\$407.01	\$407.01	\$407.01	\$407.01	\$407.01	\$407.01	\$407.01	\$407.01	\$407.01	\$407.01	\$407.01	
G CAP ADJUSTED CAPITAL RATE	\$375.88	\$375.88	\$375.88	\$375.88	\$375.88	\$375.88	\$375.88	\$375.88	\$375.88	\$375.88	\$375.88	\$375.88	
H TOTAL RATE (OPERATING + CAPITAL)	\$4,210.84	\$4,210.84	\$4,210.84	\$4,210.84	\$4,210.84	\$4,210.84	\$4,210.84	\$4,210.84	\$4,210.84	\$4,210.84	\$4,210.84	\$4,210.84	
<b>II GEOGRAPHIC IMPACT</b>													
J Des Moines Actual Medicare Volume	13,200	13,200	13,200	13,200	13,200	13,200	13,200	13,200	13,200	13,200	13,200	13,200	
K Heavy Medicare Case Mix Index	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	
L Net Case Mix Adjustment	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	
M Net Case Mix Adjustment	\$1,119,723	\$1,119,723	\$1,119,723	\$1,119,723	\$1,119,723	\$1,119,723	\$1,119,723	\$1,119,723	\$1,119,723	\$1,119,723	\$1,119,723	\$1,119,723	
N Net Case Mix Adjustment	\$2,335,266	\$2,335,266	\$2,335,266	\$2,335,266	\$2,335,266	\$2,335,266	\$2,335,266	\$2,335,266	\$2,335,266	\$2,335,266	\$2,335,266	\$2,335,266	



Source: Centers for Medicare and Medicaid Services, FY 2001

PREPARED STATEMENT OF JOHN D. FORSYTH

Chairman Grassley, Ranking Member Baucus, and members of the Committee:  
 Good morning. Thank you for holding this hearing and for all of your efforts to address the concerns of Iowans about inadequate Medicare reimbursement rates. I appreciate your invitation to participate in a continuing discussion about this most important matter.

I am John Forsyth, Chairman and Chief Executive Officer of Wellmark Blue Cross Blue Shield. Wellmark is a mutual insurance company, domiciled in Iowa, and licensed to do business in Iowa as a member of the Blue Cross and Blue Shield Association. Our company offers a full range of health insurance and related products to more than 1.5 million Iowans, including Medicare Supplemental coverage for approximately 172,000 senior Iowans. Through our subsidiary, Wellmark of South Dakota, Inc., we also provide coverage and services to 250,000 South Dakotans, of whom approximately 25,000 are senior citizens.

The mission of our company is to continuously help to improve the health of our customers and their communities by providing access to a broad array of high value health benefit products and services. We work hard to keep health insurance affordable for Iowans.

Iowans take pride in their state's health care system, which has delivered good value in terms of quality and efficiency. Recent studies reinforce these notions.

- Iowa consistently is ranked among the healthiest States in the nation as evidenced by two recent studies, third healthiest in the Morgan Quinto Press Health Care State Rankings (2002) and seventh healthiest in the November 2002 report of the United Health Foundation.
- Iowa's percentage of insured citizens is the highest in the country, at 91.3 percent, with only 8.7 percent of persons under age 65 uninsured, according to the

*Institute of Medicine's* March 2003 report: "A Shared Destiny—Community Effects of Uninsurance".

- Health insurance rates are competitive in Iowa. According to *Families, USA*, the average premium for a standard plan for a 25-year-old in Iowa is \$2,088, 15 percent lower than the national average of \$2,459. The standard plan for a 55-year-old in Iowa is \$4,152, 16 percent lower than the national average of \$4,934.

However, Iowa's health care system is under threat on a number of fronts, of which increasing costs and inadequate Medicare reimbursement are the most significant. We have become increasingly concerned about the drivers of costs that threaten affordability. While Wellmark has been successful in keeping our administrative costs (on a per member basis) relatively flat over the past five years, monthly medical costs for our leading product have increased from \$128 in 1998 to \$142 in 1999 to \$148 in 2000 to \$168 in 2001 and to \$186 in 2002—a 45 % increase over this period. Among the major factors driving health care costs for the private sector today are the following:

- Technological advances (new treatments, medical devices, etc.) that enhance the quality of life and outcomes;
- Increased demand of services due, in part, to Iowa's relatively high elderly population, who generally utilize more care as they grow older;
- Spending for prescription drugs, which now consumes nearly 15 percent of the health premium dollar;
- Cost-shifting from government program payment shortfalls and uncompensated care; i.e., services for the uninsured.

A major government program that impacts health cost trends is Medicare. About 19 million Americans enrolled in Medicare in 1966 shortly after its inception. Today, over 40 million Americans are enrolled in the program. Medicare pays out approximately \$235 billion in benefits annually, including over \$1.6 billion in Iowa. Medicare's reimbursement system plays a critical role, as discussed more fully below, in the ability of the Iowa hospital and medical community to control costs while sustaining access to quality health care for seniors.

#### MEDICARE IN IOWA'S HEALTH CARE LANDSCAPE

The Medicare Payment Advisory Commission (MedPAC) has stated that Medicare's most important objective is to ensure that beneficiaries have access to high-quality care. Iowans share this objective, and believe that such care should be delivered as efficiently as possible. In fact, Iowa ranks sixth nationally among the States in the 2000–01 Medicare Quality Improvement Organization's study that utilized 22 indicators to measure the quality of care delivered to Medicare beneficiaries.

Medicare provides health coverage to over 475,000 eligible Iowans, or about 17 percent of our population. While Wellmark provides coverage for a greater number of Iowans, Medicare is the largest single payer for health services in terms of total dollars expended for health care.

Demographic trends clearly show that Medicare will become an even more important source of payment for essential health care services to Iowans in the future. Iowa has one of the highest elderly populations in the country, ranking second in the nation in the percentage of persons age 85 and older; third in the nation in the percentage of persons aged 75 and older; fourth in the nation in the percentage of persons aged 65 years old and older; and, fourth in the nation in the percentage of persons aged 60 years and older. Our state lags other States in population growth, due largely to this aging population combined with low birth rates and an out-migration of young adults. The "baby boomer" population (people born between 1946 and 1964) will soon move into retirement years and will add substantially to the number of Iowans dependent on Medicare.

All Americans pay the same payroll tax (1.45 percent) for Medicare benefits. As we know, however, Medicare does not pay the same amount for the same services across the country. The well-publicized, comparative rankings show wide variations among the States for Medicare reimbursement. Based on 1999 reports, Iowa providers received \$3,053 per beneficiary, well below the national average of \$5,490. Medicare spending per beneficiary for Iowans is \$4,248 compared to a national average of \$5,379. Certainly there are policy reasons supporting the present reimbursement system. Nonetheless, payment inequities that have developed in the system over time now threaten the efficient delivery of quality health care in Iowa, and must be addressed. This is why Wellmark joined with the Iowa Hospital Association and other business interests in the state to form the Iowa Cares About Medicare coalition last year. This experience, in turn, reinforced our belief that the reimbursement problems extend well beyond the borders of Iowa. Accordingly, we have come

together with leaders of seven other midwestern States' Blue Cross Blue Shield Plans and Hospital Associations to develop a better understanding of the issues concerning Medicare's reimbursement system.

The Medicare reimbursement inequity is one of several factors that discourages development of alternative health plans for Medicare beneficiaries, such as Medicare+Choice, in a rural state like Iowa. Medicare+Choice was designed to encourage private competition and managed care in the delivery of services under Medicare. Wellmark has not participated in Medicare+Choice, though we have spent significant resources on several occasions to carefully consider participation and ultimately, we would like to be in the position to provide this option to Iowa seniors. Iowa, like other rural areas, faces several challenges in implementing a Medicare+Choice plan. These include the absence of organized provider networks or group practices able to share in financial risk, small populations spread over large geographic areas resulting in too small an enrollment base to recover fixed costs, and lower than average utilization, which means less opportunity to achieve incremental efficiency gains than in areas of high utilization.

Providers in rural areas have little incentive to join a Medicare+Choice network that pays them at or near the Medicare Fee-For-Service payment. Many rural areas in the state are served by a single provider, who is already providing services to the entire Medicare population in that area. When one considers the added burden to providers of dealing with a new Medicare+Choice health plan, the emphasis on medical management, and possible acceptance of financial risk, it is understandable why many would decide not to participate. Thus, Iowa seniors have effectively been denied the opportunity to participate in alternate plans that have provided a more generous benefit package than traditional Medicare and which are available in other parts of the country.

#### ECONOMIC IMPACT: THE NEGATIVE EFFECTS OF COST-SHIFTING

Hospitals and physicians in Iowa, as in many States, experience negative margins between their costs of caring for Medicare patients and the reimbursement received from Medicare for that care. The losses providers incur on their Medicare patients must be recovered from other sources; thus, cost-shifting results. "Cost-shifting," or the movement of payment for unreimbursed costs to those with insurance or other private payment, is now estimated to cost Iowa businesses and other privately insured persons more than \$80 million annually. These costs are thought to be a significant factor in Iowa's private health insurance premiums.

According to MedPAC's analysis of data from American Hospital Association's Annual Survey of Hospitals, Iowa hospitals' Medicare payment margin in 1999 was a negative 6.5 percent compared to a national average of a positive 0.4 percent while their comparable private payer margins were 12.3 percent and 5.2 percent, respectively. In late 2002, Wellmark participated in a national survey of private health plans concerning their physician fees and payment methodologies in comparison to Medicare's practices. The survey confirmed that private health plans' fees are generally 15–20 percent higher than Medicare's physician fees for comparable services, with higher differentials for health plans operating in the Midwest and in rural and small urban markets such as Iowa.

This demonstrates clearly that substantially higher margins are being sought from private payers such as Wellmark Blue Cross and Blue Shield by providers in order to meet their financial needs. Wellmark estimates at least 10–15 percent of the dollars Wellmark pays to Iowa hospitals and physicians is to compensate for government programs' shortfall, most notably Medicare. Thus, inadequate Medicare payments not only result in financial challenges for providers but also have the insidious effect of "surreptitiously" increasing private insurance premiums. In effect, the cost shift means that private insurance purchasers (both businesses and individuals) are taxed twice to subsidize the program, directly by payroll taxes as well as indirectly by the cost shifts.

The long-term impact of cost-shifting on Iowa's economic climate could prove devastating, especially as Iowa seeks to reinvigorate its economy, provide incentives for existing companies, develop new industries and attract businesses to the state. Medicare reimbursement inequities are likely to erode the high quality health care system that Iowa enjoys today, especially given the changing demographics.

#### LONG-TERM SOLUTION

The hospital associations and Blue Cross and Blue Shield Plans of seven Midwestern States have come together to exchange ideas and consider options for addressing the reimbursement inequities in the Medicare program. These States include Iowa, Minnesota, Montana, Nebraska, North Dakota, South Dakota, and Wis-

consin. Wellmark is pleased to be a part of these discussions. The group is still in the process of finalizing a proposal but it will include the following concepts.

*Payment Incentive for Value—A Conceptual Framework*

The Medicare program should reward quality and efficiency by developing an incentive payment program that will encourage hospitals and physicians, on a state-by-state basis, to provide high quality care in the most cost effective manner. In other words, the Medicare program should seek out and reward value, just like other purchasers in the American economy.

States could be ranked on both quality and cost measures. Hospitals and physicians in States that have the highest cumulative combined scores (i.e., top quartile) would receive a 5 percent “add-on” as a reward for outstanding performance.

Quality rankings would be based upon data used in the report published annually in the *Journal of the American Medical Association (JAMA)* that uses Medicare’s current quality of care measures. The report evaluates each state in terms of how frequently their hospitals and physicians provide certain evidence-based, clinical procedures that have been shown by scientific evidence to be effective in enhancing outcomes of care.

Cost rankings would be based on Centers for Medicare and Medicaid Services’ annual report ranking States based on average Medicare spending per recipient for each state.

States in which providers fail to meet quality or cost targets would not receive the incentive payments. This “carrot” approach should provide constructive motivation for hospitals and physicians to meet targets in order to capture additional incentive payments. Our initial review of this approach would place Iowa fourth in the nation in terms of Medicare value, i.e., combining cost and quality to determine value for purposes of payment equity.

*Reduce Payment Inequities*

In addition to a payment incentive for value, actions on the following items would significantly help to address current inequities in the Medicare reimbursement system.

- **Adequate Inflation Increases.** MedPAC has recommended a full inflationary update for hospital outpatient services and for inpatient services delivered in rural and small urban hospitals. Full Medicare inflationary updates are essential in addressing escalating health care clinician salaries, pharmaceutical costs, new technology, and soaring professional liability rates. In addition, Congress should act promptly to improve payments to States having overall negative Medicare hospital margins.
- **Medicare Base Payment Rate.** Medicare hospital inpatient payment rates (DRGs) are based on standardized national amounts adjusted to reflect differences in local area wages. However, urban hospitals in large metropolitan areas (over one million population) currently receive higher base payment than facilities in small urban and rural areas. This base rate differential, which amounts to millions of dollars in underpayments annually for Iowa hospitals, is unnecessary given the fact that the Medicare wage index already differentiates the most significant geographic cost variation.
- **Medicare Wage Index Adjustment.** Medicare’s faulty wage index is applied to 71 percent of hospital payments. However, in Iowa, a substantially smaller percentage of hospital expenses go to wages and benefits. This system penalizes all hospitals with a wage index below 1.00. The labor-related share of Medicare payment should be reduced.
- **Funding Adjustments.** A final item for your consideration would be to utilize specific dollar increases rather than percentage increases, when making funding adjustments. Actual dollar adjustments would more expeditiously address the range of disparity that has developed over time in Medicare reimbursement. Percentage increases tend to continue to accentuate disparities that have already accumulated in the base amounts being adjusted—a specific dollar mechanism for adjustments does not have this effect.

We share your deep concern about the current Medicare reimbursement system. We believe the current system fails to recognize and reward Iowa for quality and efficiency in the delivery of health care services. We understand how the system forces doctors and hospitals to shift costs to the private sector, thereby creating higher costs for employers and a disincentive for economic growth. With your continued leadership, however, we are confident that a workable and realistic solution can be implemented to address the inequities in the current Medicare payment system.

## REFERENCES

- Medicare Fee-For-Service Statistics FY 2001, Centers for Medicare & Medicaid Services.
- Report to the Congress: Medicare in Rural America (June 12, 2001); Statement of Glenn M. Hackbarth, J.D., Chairman, Medicare Payment Advisory Commission Before the Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives.
- “Change in Quality of Care Delivered to Medicare Beneficiaries, 1998–1999 to 2000/2001”, *Journal of the American Medical Association*, January 15, 2003—Volume 289, No. 3. Authors: Stephen F. Jencks, M.D., M.P.H.; Edwin D. Huff, PhD; Timothy Cuerdon, Ph.D.
- “Observations on State-level Variation in Medicare Spending”, Medicare Payment Advisory Commission (May 13, 2002).
- Statistical Fact Sheets—Facts About Iowa’s Aging Population, Iowa Department of Elder Affairs.
- Factsheets, Iowa Department of Economic Development.
- 2000 Information, United States Census Bureau.
- Iowa Cares About Medicare, Iowa Hospital Association.
- 2002 Annual Report, Iowa Hospital Association.
- Employer Health Benefits Study, 1988–2002, Kaiser Family Foundation/HRET.

## PREPARED STATEMENT OF DAVID M. HOLCOMB

Good morning Mr. Chairman. Thank you for inviting me to testify in this hearing. I appreciate you recognizing the vital role Medicare holds not only in Iowa’s health care system, but in the entire Iowa economy.

Senator Grassley, I am here as the representative of 116 Iowa hospitals, nearly 70,000 hospital employees, and 60,000 volunteers who each day dedicate themselves to serving their communities and their patients.

I want to speak plainly about Medicare and Iowa. Medicare and its payment policies cheat Iowans. I say that because the Medicare program continues to penalize high quality, efficient health care providers, like Iowa’s, even while solid research proves it overspends in other areas of the country. Medicare does this by simply paying Iowa providers lower rates for superior service. The system as it now stands flies in the face of common sense and is an affront to any reasonable concept of fairness.

However, there is much more to what is wrong about Medicare in Iowa than that. It is also wrong because low Medicare payments drive up the cost of private insurance. It is wrong because hospitals must ultimately curtail services and limit access. It is wrong because doctors must begin to limit Medicare patients. It is wrong because, in the midst of an unprecedented shortage of health care workers, Iowa is at a huge recruiting disadvantage, particularly against adjacent States. It is wrong because Iowa has a health care system that is known for its quality and cost-effectiveness, yet Iowans find themselves subsidizing States where quality is low and waste is high.

It is wrong because Medicare has become an unnecessary and unfair burden to the Iowa economy. As Iowa struggles to redefine itself economically, our hospitals offer a deep and constant wellspring of opportunity and service that attracts young, well-educated professionals and their families. A financially stable health care system is critical to supporting existing businesses and attracting growth to Iowa, but Medicare’s tremendous shortfalls undermine Iowa’s efforts to be economically competitive. Good health care provided by well supported hospitals is a large and irreplaceable block within the foundation that defines quality of life in Iowa.

The current unfair Medicare system is cracking and weakening that block, creating instability, and seriously threatening Iowa’s future.

Today, 475,000 Iowans depend on Medicare. Thousands of them live in and around Council Bluffs. They are important to us; more than 40 percent of our gross revenue comes from Medicare. But today my hospital is losing about 20 cents on the dollar each time we treat a Medicare patient. For skilled nursing, we are losing 74 cents on the dollar. This is fairly typical. The result: many Iowa hospitals are closing their skilled nursing units and home health services.

My hospital is simply one example of how Medicare damages Iowa. All told, Iowa has the worst Medicare margin in the country and is losing at least \$80 million a year to the program. Hospitals have to cover that loss. They can only increase private-sector fees or, in the case of public facilities, increase taxes. Whatever the method, those Medicare losses are absorbed by businesses and individuals, through

their insurance premiums, through their tax bills, through their prices for goods and services. It means Iowans are taxed twice for Medicare and forced to subsidize this program, allowing Medicare to pay higher and provide better benefits in other States. It is to those States that thousands of Iowa seniors have fled, taking with them hundreds of millions of dollars each year from the Iowa economy.

Can this situation be fixed? Yes, it can. There are real and significant changes that can be made to Medicare payment now that would begin to make it fair for Iowa.

First, authorize full inflationary updates of Medicare payments. Escalating clinician salaries, pharmaceutical costs, new technology, and soaring professional liability rates simply cannot be ignored. Medicare must pay its fair share.

Second, equalize the Medicare base payment amount; make the 1.6 percent fix permanent. This provision within the Medicare formula has no basis in sound payment policy, and it needs to be eliminated.

Third, fix the wage index. This is a major fault in the Medicare payment system. The wage index is applied to 71 percent of hospital payment, but in reality only about 50 percent of Iowa hospital expenses go to wages and benefits. Every hospital in Iowa is cheated by this simple lack of reality within the formula. The labor-related share of Medicare payment must be reduced to reflect reality.

Finally, let's create a Medicare system that really does reward high-quality, cost-effective health care. The current nearly inverse relationship between payment and quality is well documented. Studies have shown that States receiving the greatest Medicare payments tend to also have low quality and much wasted spending in their health care systems. Meanwhile, States like Iowa that have proven themselves to be high in both quality and cost efficiency are receiving the lowest payments.

This is clearly wrong and a flat contradiction of stated congressional intent. The Medicare program should reward quality and efficiency by developing an incentive payment program based on those measures. In other words, it should seek and reward value, just like other consumers in the American economy. Under this system, States where providers fail to meet quality or per-beneficiary cost targets would be motivated to improve and Iowa would be rewarded proportionately.

Here is how such a system might work: States would be ranked on both per-beneficiary cost and overall quality measures, and hospitals and physicians in States that have the best combined scores would receive a five percent "add-on" as a reward for outstanding performance. Quality data is already published in the *Journal of the American Medical Association*, which uses CMS's current quality of care measures. The JAMA report is founded on evidence-based, clinical procedures that have been reliably shown to be effective in enhancing outcomes of care. Cost rankings would be based on CMS's annual report ranking States based on average Medicare spending per recipient.

Members of Congress and representatives of the Department of Health and Human Services and the Centers for Medicare & Medicaid Services have repeatedly come to Iowa and told us how wonderful our health care system is, and how unfortunate it is that Medicare is formulated in such a way that Iowa is cheated rather than rewarded. That needs to change, Senator Grassley. It's time that Iowans, who have invested so much in their community hospitals, who depend so completely on the services and the jobs our hospitals and physicians provide, start seeing real equity to go with the kind words.

These are but a few of the avenues you and your colleagues in Congress might pursue in order to start bringing Medicare equity to Iowa. These inequities can be corrected. Iowa hospitals have illustrated a pathway to cost-effective quality. We need you to lead Congress toward a fair and equitable Medicare system.

Your Iowa constituents greatly appreciate your leadership and commitment on this issue. We are proud of your chairmanship of the Senate Finance Committee and your relationship with President Bush. Please let us know how we can help.

---

PREPARED STATEMENT OF MICHAEL KITCHELL

THE IMPACT OF THE MEDICARE INEQUITY ON IOWA HEALTH CARE

#### *Introduction*

Senator Grassley, thank you for allowing me the opportunity to bring the perspective of Iowa physicians on a critically important area of public policy to the nearly 500,000 Medicare beneficiaries in Iowa. With my comments today, I am representing over 4,000 members of the Iowa Medical Society, as well as the patients who we provide care for 24 hours every day, seven days each week, all year.

Iowa citizens are victims of inequities in the Medicare fee schedule. Despite historically receiving the lowest reimbursement per enrollee per year, Iowa health care providers have been able to keep our quality of care very high (currently sixth in the latest CMS ratings). Our increasing practice expense and professional liability costs make it necessary for us to have increased funding to avoid cuts that could jeopardize care to our patients. It is imperative that federal legislators move quickly to eliminate these disparities.

#### *Overview*

A recent national survey found that 42% of physicians said they would consider dropping out of Medicare participation if further cuts were made in physician fees. The reasons for physician discontent are many. Increasing paperwork, regulations and compliance issues which add time and cost, such as HIPAA, have not been reimbursed. The costs of technology and equipment have risen without adequate reimbursement. The nationwide shortage of nurses, techs, and other health care workers has added to the difficulty in practicing today. Professional liability insurance has skyrocketed all across the country, with more threat of litigation that makes a complex task even more challenging. The threat of bioterror and other disaster preparedness have added many costs to the system as well.

The nationwide cut of Medicare physician fees by 5.4% in 2002 added to physicians' concerns. According to the AMA, Medicare physician payments have been cut four times since 1991, and the payments have only increased 1.7% per year since then. As of 2001, Medicare physician payments had dropped 13% behind inflation. The 2003 Medicare fee schedule was going to be cut again by 4.4%. By Congressional action recently, the fees were instead increased by 1.6%, but physician fees are not keeping up with inflation in our costs.

The reason for the nationwide cuts in 2002 and 2003 is the conversion factor adjustment, a nationwide adjustment that is computed yearly and is based on the sustainable growth rate (SGR). The SGR was designed to limit the growth of physician payments, to avoid over-utilization or "excess productivity." There has been controversy about errors in the calculation of the SGR, and it has been called a "flawed formula." There have been a number of methodological problems such as using the gross domestic product (GDP) growth, changes in fee-for-service enrollment, and use of increasing chemotherapy drug charges as "physician fee" charges. Because of the perception of increased utilization, the SGR computation has triggered the decreases in the conversion factor and these nationwide cuts in Medicare fees. This flawed formula, unless it is changed, will cut fees even more in the future, until it is forecast that Medicare fees will be lower than they were in 1991!

It is a sad irony that, because of utilization patterns in more highly-reimbursed States, beneficiaries in the lower-reimbursed States will have their access to care impeded.

Practice pressures, increased costs, and these across-the-board payment cuts affect all physicians. But those of us in Iowa and other rural areas feel as though we have a double Medicare penalty—from the SGR and secondly from geographical adjustments because of where we live.

#### *The Iowa Experience*

Physicians in Iowa and other rural areas have for many years suffered from low Medicare reimbursement, and we have become increasingly frustrated because of cuts in physician Medicare fees which make it even more difficult to deliver good care to our patients. It has affected McFarland Clinic, a multi-specialty group of physicians, where I work as a neurologist. Our clinic serves about 300,000 current patients, with 880,000 patient visits last year. Thirty-two percent of our patients are enrolled in Medicare. Over the last two years we have downsized, from 192 physicians to 154. We also had offices in 34 different sites in central Iowa, but we are now covering just 23 offices. Recruitment in Iowa is very difficult because of the low Medicare reimbursement. We are currently recruiting 16 different physician positions, including some specialty searches we have not filled in the last 4–5 years. Though we could have a lengthy discussion about the reasons for the downsizing, suffice it to say that the Medicare disparity played a significant role.

Obviously, with such difficulty recruiting and retaining physicians, the ability to serve our patients' needs becomes quite difficult. Timely access is a major problem. Patients either have to endure long waits or they have to leave their communities to find the primary or specialty physician they need.

Our physicians also feel the burden of an increased workload because of the pressure to see more and more Medicare patients. Iowa currently ranks 49th in the nation in practicing physicians per 100,000 population (Oklahoma is 50th). With our very high percentage of Medicare population in Iowa, this must mean we have the

most Medicare patients per physician in the country. In fact, statistically, each practicing Iowa physician is caring for the needs of 622 patients. In contrast, each practicing Massachusetts physician cares for the needs of 280 patients. Believe me, the added burden matters when a community needs a gastroenterologist, an orthopedist, a neurologist, or a family physician.

Iowa has the lowest Medicare reimbursement per enrollee per year at \$3,414, with the total state Medicare payment of about \$1.6 billion. Though it is true that much of that imbalance is a function of consumption, it appears that Iowans simply do not go to the doctor as much as patients in some other States. But, on a per service basis, Iowa physicians are reimbursed considerably less than if that service had been provided in many other areas of the country. Patients in Iowa suffer from unfair geographic adjustments called geographic practice cost indices (GPCIs).

In 1989, a national Medicare fee schedule for physicians was derived by the Physician Payment Review Commission to slow growth of spending and remove some wide discrepancies in payments to primary care physicians and specialists and to providers who practiced in different geographical areas (ref 1). The payments for physicians since 1989 have been based on resources needed to provide services, known as a resource-based, relative value scale (RBRVS). The fee schedule was derived by using what is called relative value units (RVUs) and for each procedure, whether it is surgery, an office visit, consult, etc., there is a value in RVUs that is adjusted by the nationwide conversion factor and geographical factors (GPCIs). There are now 89 payment localities nationwide, each with different GPCIs affecting the physician fee, and Iowa physicians rank near the lowest fees in the country (80th out of 89).

The relative value units (RVUs) have three components. The first is work effort—the time, mental effort, physical effort, and training required to provide the service. The second is the practice expense, including rent, utilities, equipment, supplies, and staff salaries. The third is cost of professional liability insurance. On the average, these RVU components account for 55%, 42%, and 3%, respectively, of the average physician fee. These three components are each adjusted by the GPCIs to come up with the fee for a particular service code.

I will use an example to illustrate the inequity. The most commonly used procedure code is 99213, a recheck office visit fee; reimbursement varies from \$64.09 in San Francisco, \$63.10 in New York City, and rural Missouri at \$45.13 (Iowa's is \$46.53). The overall difference is 30%, though other codes have even greater differences. The reason for the variation is each of the three RVU components is adjusted by a geographic factor, a GPCI. This adjustment of the components varies by locality. For example, the work component adjustment is increased by a factor of 1.094 for New York and decreased by .959 in Iowa—a difference of about 14%. So what is the difference in a physician's work effort in New York vs. Iowa? In Iowa, we physicians have the same training, time, and effort applied for our patient care. Do we adjust our military salaries for the region where they live, or the salaries for our members of Congress?

Apparently the justification for the difference in the payment for the work RVU component is to reflect a portion of cost-of-living differences. The work GPCI is based on the 1990 census results of variation in earnings between college-educated workers. The reasoning behind this adjustment in the work effort for cost-of-living is not clear to me. The impact, however, is very clear: we cannot recruit physicians because they are going to more highly-reimbursed locations. Data supports that conclusion, and that impacts the care that Medicare patients in Iowa receive.

Another unique problem in Iowa is call coverage for both primary and specialty care. We currently have two otolaryngologists and are recruiting a third. The candidate has a choice of joining our clinic where the call would be every third night and every third weekend. If the candidate chose an area with a greater population of physicians, the call might be every eighth or tenth night. We are currently recruiting a second pulmonologist, and will we find someone who wants to take every other night and weekend call? This is a significant barrier for recruiting to Iowa, as the increased work and personal cost is greater because of the greater call burden to serve our patients.

The GPCI adjustments for practice expense and professional liability are also suspect, as the data used for practice expense does not always represent the true costs. For example, in rural areas many physicians have to travel many miles on outreach to serve their patients. McFarland Clinic providers (44 physicians, nurse practitioners, and physician assistants) made 3,581 trips to other communities to do outreach in 2002, and the total miles driven were 265,912. The cost for rent of these outreach facilities was \$73,000 and the mileage at \$.345 per mile was \$91,000 last year. The real cost, however, is the time it takes to travel: about 60 minutes for



each 50 miles, or 5,318 hours, or about 120 hours per provider that is not reimbursed.

A true practice expense adjuster would accommodate that very real cost. So while I must agree that office space in Brooklyn, New York is more expensive than office space in Brooklyn, Iowa, there are factors that make it more expensive to provide care in a state that is populated with small towns and rural areas. The formula ignores those factors.

Our costs for equipment, supplies, and staff are not necessarily lower in rural areas as these are affected by national markets. The GPCI determination for practice expense also includes a survey of apartment rental costs. Apartment rental costs are not the same as medical building rental costs, which have more detailed specifications and, therefore, higher relative costs in rural areas.

Of the three GPICs, the one that can be calculated with the most validity is the professional liability GPCI. But even this GPCI is flawed in its implementation. The liability GPCI calculation being used today is based on data from 1996 through 1998. As you well know, the liability situation in our society is exceedingly fluid. Our McFarland Clinic liability insurance went up over 60% last year and over 30% this year, and ours is not an uncommon experience.

Though GPICs might be a good idea in theory, and they might be an interesting intellectual exercise, they are severely flawed in their implementation, and the disparities they instill are harmful to millions of Medicare beneficiaries throughout the nation.

#### *Utilization*

Decisions on utilization are primarily made by physicians. Choices of which or how many tests, surgery vs. conservative care, admission vs. outpatient treatment, expensive vs. cheaper drugs, intensive care unit admission, specialty consultation, and length of stay all affect the total costs for health care. It has been estimated that 80% of health care costs are controlled by physician decisions. Many physicians feel pressured by patients who demand more tests, drugs, or procedures, and there is threat of litigation to do more.

Fisher et al (ref 2), after extensive research of regional variations in Medicare spending, concluded that there is no evidence that Medicare enrollees in high-spending regions had higher quality of care. The methods used in this study eliminated the question of "regional differences in illness levels (enrollees in Louisiana are sicker than those in Colorado) and price (Medicare pays more for the same service in New York than in Iowa)." This research used the "End-of-life Expenditure Index," which showed that the Medicare spending is "due to physician practice rather than regional differences in illness or price." In this study they found there were 60% higher costs in some regions of the country without any differences in quality compared to areas where lower costs were noted. One could conclude that this 60% is wasted on ineffective care.

Another study (ref 3) concluded also that Medicare "expenditures are strongly related to the volume of services provided," not the per unit reimbursements. If every state had the same fee schedule, practice efficiency, and utilization per enrollee as Iowa, at 57% of the average state reimbursement, the \$235 billion total costs of the nationwide Medicare program could theoretically be cut by about \$100 billion.

In Iowa we were rated (ref 4) as sixth best in health care quality by the latest CMS (Centers for Medicare and Medicaid Services) study. The state with the highest per enrollee reimbursement (at \$8,099) is Louisiana, which ranked last in quality. Obviously, the residents of Iowa receive tremendous value for their tax dollars, but our infrastructure is on the brink of disaster if we continue to lose health professionals.

Mr. Chairman, I will bring my comments to a close by mentioning the formation of the Geographic Equity in Medicare (GEM) Coalition. The Iowa Medical Society played a leadership role in forming the GEM Coalition last June. Today, the coalition consists of 23 state medical societies and the American Academy of Family Physicians. Nearly nine million Medicare beneficiaries are being cared for in GEM Coalition States. I will close by reading from the GEM Coalition position statement:

*Americans everywhere pay equal premiums to support Medicare, yet there is substantial geographic disparity in patient services and physician reimbursement levels in the Medicare Part B program. The degree of this disparity is unjustified and inherently unfair—and is having an increasingly negative impact on patient care and access in many parts of the United States.*

*GEM is formed to remedy this alarming inequity. The member organizations believe that federal policymakers must assign a high priority to eliminating Geographic Practice Cost Indices and other components of the Medicare Part B program that result in this inappropriate and inequitable reimbursement to the tens of thousands of*

*physicians across this country providing medical care to millions of Medicare beneficiaries. The critical nature of this problem compels immediate attention and action.*  
Thank you.

*Bibliographic References*

- Barry William A., MD; and Gary E. Rosenthal, MD, "Medicare Expenditures and Quality of Care. Brief Report: Are Higher Medicare Expenditures Associated with Better Quality of Care?", Univ. of Iowa 2002 (Unpublished study) (ref 3)  
Fisher, Elliott S., MD, MPH; David E. Wennberg, MD, MPH; Therese A. Stukel, PhD; Daniel J. Gottlieb, MS; F.L. Lucas, PhD; and Etoile L. Pinder, MS, "The Implications Of Regional Variations In Medicare Spending. Part 1: The Content, Quality, and Accessibility of Care", *Ann Intern Med* 2003; 138:273-287 (ref 2)  
Iglehart, John K., "Medicare's Declining Payments To Physicians", *N Engl J Med* 2002; 346:1924-30. (ref 1)  
Jencks, Stephen F., MD, MPH; Edwin D. Huff, PhD; and Timothy Cuerdon, PhD, "Change In The Quality of Care Delivered to Medicare Beneficiaries, 1998-1999 to 2000-2001 ", *JAMA* 2003; 289: 305-310 (ref 4)

PREPARED STATEMENT OF GAIL R. WILENSKY

Mr. Chairman: Thank you for inviting me to appear before you. My name is Gail Wilensky. I am a senior fellow at Project HOPE, an international health education foundation and I am also Co-chair of the President's Task Force to Improve Health Care Delivery for our Nation's Veterans. I have served as the Administrator of the Health Care Financing Administration (now the Centers for Medicare and Medicaid Services) during the first Bush Administration and also chaired the Medicare Payment Advisory Commission from 1997 to 2001. My testimony today reflects my views as an economist and a health policy analyst as well as my experiences at HCFA and MedPAC. I am not here in any official capacity and should not be regarded as representing the position of either Project HOPE or the Presidential Task Force.

My testimony today discusses geographic variations in Medicare payments per senior and variations in Medicare payments to physicians and institutional providers, the reason these variations occur and some reforms to Medicare payments that should be considered. I also discuss the implications of Medicare payment variations for seniors and for the business community and include some final observations on what other reforms might be of interest to States like Iowa.

*Geographic Variations in Spending by Medicare*

There are two types of geographic variations in Medicare payments that are frequently discussed: variations in Medicare payments per senior and variations in Medicare payments to physician and institutional providers. Although these two types of variation are related to each other, i.e., one is a subset of the other; they are fundamentally separate phenomena and are therefore best considered separately.

*Medicare Spending Per Beneficiary*

The first measure, variations in Medicare spending per beneficiary, has received a lot of attention in Iowa although the precise measure that has received most of the attention is not the right measure to use. The measure that has received most of the attention in Iowa is cash receipts to providers in Iowa divided by the number of Iowa beneficiaries. This measure purports to show what Medicare is spending on behalf of Iowans but it does not do so for two reasons. The most important reason is that it doesn't account for services provided to beneficiaries outside the state. Since there is a significant net use of services outside the state, probably a combination of the relative proximity of major health centers such as the Mayo Clinic and the use of health care services by Iowans in the South during the winter, the use of provider cash receipts per beneficiary understates the Medicare services received by Iowa residents. Second, cash receipts are generally regarded as a less appropriate measure for analysis than accrued claims because cash receipts can reflect timing issues in the actual payment for services and may cause some years to look artificially high or low if payments get bunched.

If Medicare spending in the traditional fee for service program per Iowa beneficiary is considered rather than provider cash receipts per Iowa beneficiary, Iowa is 35th in terms of Medicare spending rather than 50th. In other words, Iowa is in the lower half of Medicare spending per beneficiary by state but certainly not the lowest.

There are two main reasons that explain why States differ in their per capita Medicare expenditures. The first is differences in the cost of providing services as reflected in the prices that Medicare pays for services. Service costs reflect differences in local input prices and differences in the mix of providers used to provide the service. MedPAC has estimated that a little less than half (46%) of Iowa's deviation from the average spending per beneficiary is attributable to differences in the cost of providing services and a little more than half (54%) is attributable to differences in the quantity of services used. About a third of this service-use difference can be attributed to Iowa's beneficiaries being healthier than average and the rest reflects a more conservative practice style by physicians and other providers and perhaps by Iowans seeking less care.

*Medicare Payments for Physicians and Institutional Providers*

As indicated above, slightly less than half of the difference in Iowa's Medicare spending per beneficiary relative to the national average is attributable to Medicare's calculation of the costs of providing services in Iowa and the mix of providers used, particularly the use of hospitals that receive extra payments for teaching or that treat large numbers of Medicaid patients.

There has been a lot of debate about whether Medicare properly measures differences in the costs of local inputs and whether Medicare properly distinguishes between the inputs that are purchased in national markets (which shouldn't have local adjustments) from those that are purchased in local markets.

Let me make a few observations. The adoption of the resource-based relative value scale in 1992 as the reimbursement mechanism for physicians was designed to produce an increase in payments to physicians in rural areas relative to physicians in urban areas and to increase payments to physicians in primary care specialties relative to those in procedure-based specialties. Both of these changes would have helped Iowa in general. MedPAC tracked the relative increases from 1991–1997, the transition period for the implementation of the new fee schedule, and reported substantially greater increases in rural counties relative to metropolitan areas during that period. The most significant current debate with regard to physician payments is the use of a spending limit that is tied to the economic growth of the economy—a strategy that has been hitting all physicians rather than rural physicians disproportionately, although the apparent use of a conservative practice style by the physicians of Iowa does exacerbate the problem for Iowa.

With respect to hospital payments, there have been a variety of special provisions that have been put in place to help rural hospitals over the years but there are several more reforms that MedPAC has proposed, some of which have been proposed now for at least several years. These include the use of a low volume adjustment to the inpatient rate, the re-evaluation of the labor component, the elimination of differential base rates between large urban hospitals and other hospitals and an increase in the cap for disproportionate payments to rural hospitals. I support all of these changes and I hope that the Congress will pass legislation supporting these reforms.

*What Does Medicare's Per Beneficiary Spending Rate Mean for Iowa's Seniors?*

There is no indication that Iowa's lower Medicare spending per beneficiary is disadvantaging its beneficiary population, and there are some reasons to believe the lower spending rates provide certain advantages. Some of the advantages are obvious. Lower spending rates mean lower cost sharing for Iowa's beneficiaries. Not surprisingly, lower Medicare spending rates are also associated with lower Medigap rates. Iowans also pay less into the HI trust fund because their wages tend to be lower.

There is also no indication that lower spending rates are associated with lower rates of quality of care. In a recent set of articles reported in the *Annals of Internal Medicine*, Elliot Fisher and his colleagues at Dartmouth provided the results of detailed studies on three medical conditions. They found that areas with greater expenditures received more discretionary services but not greater improvements in health outcomes. This finding was upheld for measures that encompassed quality of life (such as patient satisfaction and functional status) as well measures of quantity of life (such as mortality rates). In a more direct measure of quality of care to Medicare beneficiaries on a state-by-state basis, Iowans also fared well. In a study reported earlier this year in *JAMA*, Steve Jencks et al. looked at how States performed according to 22 quality improvement indicators for a variety of disease States. Iowa had an average state rank of 8th in 1998–99 and 6th in 2000–2001.

*What Does Medicare's per beneficiary Spending Rate Mean for Business?*

Since more than half of the reason that Iowa's Medicare spending rate per beneficiary is lower than average is attributable to the lower quantity of services used,

Iowa's business community stands to gain. The more conservative practice style that physicians use in treating their Medicare patients should also be occurring for their employer-sponsored patients. Earlier studies that examined the effects of DRG's in Medicare indicated that the length of stay changes that resulted from DRG's were found in the private sector as well as in Medicare and that physicians who changed their admitting behavior did so for all patients and not just their Medicare patients. Also, to the extent that some of the lowered use reflects a healthier population in Iowa, this is undoubtedly true for the employed population as well.

Whether or not the level of Medicare payments impacts pricing in the private sector is the subject of some dispute. In some very competitive areas, Medicare is among the higher payers, especially for physicians. In other areas or sectors, where Medicare is a lower payer, it is unclear whether the lower payments result in any cost shifting. In part, it depends on the relative power of the provider and payer communities and in part on the competitiveness of each sector.

#### *Conclusions*

Medicare spending per beneficiary is lower in Iowa than the national average but the Iowa's ranking is 35th, not 50th as is sometimes claimed when an inappropriate measure of spending is used. Iowa's lower than average spending occurs because both the cost of providing services is lower in Iowa than the national average and because the quantity of services provided is lower.

The lower spending per beneficiary has advantages for seniors in terms of lower cost-sharing for Medicare services and lower Medigap premiums. Iowans also pay less into the HI trust fund because of lower wages. The lower spending also does not appear to negatively affect quality. Based on 22 quality improvement indicators, Iowa scores high on quality and independent studies on geographic variations in spending do not show improved health outcomes in areas with higher expenditures.

There is also no indication that the lower Medicare spending per beneficiary negatively affects the business community. More than half of the lower spending is attributable to a lower use of services, because of better health status, a conservative practice style and maybe less care demanded by Iowans. All of these will be true for the under-65 population as well. The evidence regarding cost shifting as a phenomenon is at best mixed and would require a compliant payer community and a very noncompetitive environment.

Some of the providers, especially small, low-occupancy hospitals continue to complain about underpayments. MedPAC has recommended several payment reforms that would help rural hospitals, including a low volume adjustment and an increase in the cap on disproportionate share payments to rural hospitals. I support the four recommendations in MedPAC's most recent report.

However, there are some problems that Medicare cannot fix. A small hospital with low occupancy isn't likely to be made solvent no matter what Medicare pays. Iowa has an extensive network of critical access hospitals and to the extent that this has resulted in some hospitals that are too small to be solvent, even with the extra payment, reconsideration may need to be given to the viability of some of them. Also, some of the problems that rural States have in recruiting physicians may be beyond Medicare's ability to fix.

Iowa has a record of high quality health care according to the measures currently available. Medicare does not currently reward physicians or institutional providers who provide higher quality with higher payments. In fact most of the efforts of the last two decades have focused on formulating the "right" or "just" price, without an allowance for quality differentials. This is not uncommon in an administered pricing system where government sets reimbursement rather than reimbursement being set by the market, but it is a deficiency that is starting to be noticed by CMS and MedPAC. Because Iowa historically has had an unusually good and extensive data collection system, perhaps it would be possible for Iowa to serve as a demonstration site for strategies that would reward physicians and hospitals that provide high quality.

## COMMUNICATIONS

---

### STATEMENT OF THE AMERICAN BENEFITS COUNCIL

[SUBMITTED BY THE GROOM LAW GROUP FOR THE AMERICAN BENEFITS COUNCIL]

Nonqualified deferred compensation plans provide a valuable source of retirement income for many thousands of U.S. employees. These plans benefit not only senior corporate officers, but also many mid-level managers, salespersons, and other professional staff.

Nonqualified plans have been thoroughly scrutinized by Congress and the media in recent months. Although some abuses may have developed in this area that need to be addressed, recent legislative proposals would needlessly curtail many beneficial and non-abusive nonqualified deferred compensation plans.

We provide below some general background on the differences between qualified and nonqualified plans, and the key rules that apply to nonqualified plans. We explain how nonqualified plans play a meaningful role in the retirement and compensation programs of U.S. companies, and how these plans help fill the gaps in retirement income caused by various Internal Revenue Code (the "Code") limitations. We explain that unlike "tax shelters" nonqualified plans have substantial economic and legal consequences for employers and employees. Finally, we address some of the non-abusive plan features that Congress and the media have recently scrutinized.

#### *"Qualified" and "Nonqualified" Plans*

It is difficult to know exactly what types of arrangements are intended to be covered when the term "nonqualified deferred compensation plan" is used. Generally, any employer-sponsored retirement plan or arrangement that does not meet the requirements for a "qualified retirement plan" under §401(a) of the Code can be described as a "nonqualified deferred compensation plan" or a "nonqualified plan." For purposes of this discussion, only nonqualified plans sponsored by for-profit employers will be considered.

#### *Employers Prefer to Provide Qualified Plan Benefits*

Favorable federal income tax rules apply to an employer maintaining a "qualified" retirement plan. The employer may deduct amounts as they are contributed to the plan's trust and the earnings on the trust assets are not taxed. By contrast, an employer may not deduct amounts set aside to meet its obligations under a nonqualified plan until plan benefits are paid to, and taxable to, employees. Further, the employer must pay tax on the earnings generated by any such amounts set aside. Given these tax advantages, an employer would strongly prefer to provide retirement benefits to its employees through its qualified plan(s), rather than a nonqualified plan.

#### *Employees Prefer to Receive Qualified Plan Benefits*

Employees would also strongly prefer to have their retirement benefits provided for in a qualified plan, because (1) an employer is not required to set aside any assets to fund a nonqualified plan, and (2) any amounts it does set aside must remain subject to the claims of its creditors. Thus, if an employer goes bankrupt, employees are very likely to lose a significant portion, or all, of their nonqualified plan benefits. By contrast, employers are required to fund benefits earned under a qualified plan by contributing assets to a trust. If the employer becomes insolvent, its creditors may not reach these assets, as they must be held by the trustee for the "exclusive benefit of plan participants." In addition, benefits under qualified plans (but not nonqualified plans) generally are exempt from the employee's own creditors in bankruptcy.

The federal income tax treatment of an employee is also more favorable under a qualified plan. Generally, benefits earned under both qualified and nonqualified plans are taxed only upon distribution to an employee. However, the taxation of certain distributions from a qualified plan will be deferred if the employee “rolls over” the distribution into an IRA or another qualified plan. Distributions from a nonqualified plan may not be rolled over, and thus, are subject to immediate taxation. In addition, except for 401(k) contributions, there are no social security taxes on contributions or benefits under qualified plans.

Thus, there are a host of reasons why both employers and employees prefer to have retirement benefits provided under a qualified plan rather than a nonqualified plan. However, as explained below, the Code contains numerous limits on contributions and benefits under qualified plans. These limits are intended to cap the so-called “tax subsidy” provided by the government and to promote substantial coverage of rank and file employees. However, the limits are so restrictive and complex that they act as a disincentive to the maintenance of qualified plans by employers and result in large gaps in retirement savings and preparedness for many thousands of employees. Therefore, retirement benefits which are in excess of these limits must be provided under a nonqualified plan.

*See the attached Appendix A for a brief comparison of qualified and nonqualified plans.*

#### *Brief History of Nonqualified Plans*

Nonqualified deferred compensation plans and arrangements have existed for more than 50 years. In their earliest and simplest form, these plans generally involved an advance agreement between an employer and an employee that an amount to be earned in a given year would be paid to the employee in a subsequent year, generally upon retirement or termination of employment. If the agreement was structured properly in accordance with all Code requirements, the employee would not pay tax on the deferred amount until it was paid to him. The employee hoped to be in a lower income tax bracket when payment was received, and thus, pay less taxes on the deferred amount. While nonqualified plans now take many forms, this same basic structure and tax treatment still applies. The governing tax principles have been based essentially on general constructive receipt principles discussed later in this paper.

#### *ERISA Accommodates Nonqualified Plans*

When the Employee Retirement Income Security Act (“ERISA”) was enacted in 1974, nonqualified plans were common enough and so well accepted that Congress created exceptions to most of ERISA’s substantive requirements for them (although ERISA’s enforcement provisions do apply). As discussed below, the primary exception applies to a so-called “top hat plan.” A top hat plan is one that is “unfunded and is maintained by an employer primarily for the purpose of providing deferred compensation for a select group of management or highly compensated employees.” Another exception applies to “excess benefit plans,” *i.e.*, nonqualified plans that provide benefits in excess of the Code section 415 limits for qualified plans.

#### *Limits Placed on Qualified Plan Benefits*

Beginning with the enactment of ERISA, Congress has periodically added limitations to the Code to restrict the benefits that may be provided under qualified plans.<sup>1</sup> For example:

- In 1974, the Code was amended to limit the annual amount that could be contributed to an employee’s account under a defined contribution plan, and the annual amount of benefits that could be paid to an employee from a defined benefit plan. Code § 415.
- In 1986, the Code was amended to cut the annual amount of employee pre-tax contributions to a 401(k) plan from \$30,000 (the then current Code § 415 limit) to \$7,000. Code § 402(g).
- In 1986, the “ADP” nondiscrimination testing requirements were tightened, and “ACP” nondiscrimination testing requirements were added to the Code to further limit the amounts that highly compensated employees could contribute, and the employer matching contributions they could receive, under a 401(k) plan. Code §§ 401(k) and 401(m).
- In 1986, and again in 1993, the Code was amended to limit the amount of compensation which could be considered in calculating the amount of a participant’s

<sup>1</sup>Many of these changes were made to raise revenue—in some cases, to help offset the cost of unrelated revenue-losing provisions.

benefit. The reduction in the compensation limit to \$150,000 in 1993 resulted in a major increase in the employees affected. Code § 401(a)(17).

These Code limits have repeatedly reduced the amount of benefits that highly paid employees would otherwise receive under the normal provisions of a qualified plan.<sup>2</sup> In addition, due to budget constraints, Congress has periodically frozen or rolled back inflation increases in the qualified plan limits. In recent years, these limits have impacted larger and larger numbers of employees. Employers increasingly have had to offer middle and senior level managers, salespersons, and non-management professional staff benefits under nonqualified plans to make up for the reduced benefits that may be paid from qualified plans.

#### *Types of Nonqualified Plans*

While traditional deferred compensation plans are still widely used, nonqualified plans now take various forms. Two of the more common types of nonqualified plans, “mirror” 401(k) plans and “SERPs,” provide benefits that would otherwise be provided under qualified plans if the limits under the Code did not exist. These plans are described in more detail below.

##### *Supplemental or “Mirror” 401(k) Plans*

These defined contribution plans allow an employee to defer amounts he would have been able to defer under his employer’s qualified 401(k) plan but for the limits under the Code. Deferred amounts are credited to a bookkeeping account the employer maintains for the employee. The employer may also credit the employee’s account with the amount of matching contributions he would have received under the 401(k) plan had his contributions not been limited by the Code. The account balance is credited with interest or earnings until paid to the employee. In many cases, an employee will be able to choose the investment vehicle(s) used to measure earnings credited to his bookkeeping account, and the vehicles will often be very similar or identical to those available under the employer’s 401(k) plan. These elections do not, however, control the actual investment of any amounts set aside by the employer to meet its nonqualified plan obligations. In fact, the employer is not required to set aside any assets to meet its nonqualified plan obligations, and any assets that are set aside remain subject to the claims of the employer’s creditors.

##### *Supplemental Pension Plans or “SERPs”*

These defined benefit plans typically provide an employee with benefits he would have received under his employer’s qualified defined benefit pension plan but for limits under the Code.

These and other types of nonqualified plans are structured to meet certain requirements under the Code and ERISA. We outline those requirements below and discuss briefly how certain common nonqualified plan features have been designed to fit within these rules.

#### *Code Rules*

The Code requirements a nonqualified plan needs to meet are less complex than those imposed on qualified retirement plans. The two primary sets of rules under the Code that apply to nonqualified plans are the constructive receipt and economic benefit rules.

##### *Constructive Receipt Rules and Employee Elections*

Under the constructive receipt rules, a taxpayer may be subject to taxation on an amount prior to actually receiving it. These rules apply when an amount has been set aside and a taxpayer may draw upon it without substantial limitations or restrictions. Accordingly, a nonqualified plan must place substantial restrictions on an employee’s ability to receive his plan benefits. Thus, an employee may not simply demand an immediate payment of his nonqualified plan benefits.

A few examples of how substantial restrictions are placed on an employee’s ability to receive nonqualified plan distributions follow:

- If a plan permits an employee to elect the time and method for the post-employment distribution of his plan benefits, the election must be made well in advance of the employee’s termination of employment.
- Any “subsequent election” to change an originally scheduled date to commence the payment of benefits or the method of payment must be made sufficiently in advance of the originally scheduled distribution date.

<sup>2</sup>Increased in some of these limits under the Economic Growth and Tax Relief Reconciliation Act of 2001 (“EGTRRA”) have provided some incremental relief for employers and employees, but these changes have not been made permanent.

- A “hardship” distribution will typically only be allowed if the employee suffers an “unforeseeable emergency” for reasons beyond his control and which result in severe financial hardship (as currently permitted under published IRS authority).
- If a plan does permit an employee to elect an immediate distribution of his plan benefits, typically an employee making such an election will forfeit a substantial portion (often 10%) of his benefit under the plan, and may not earn additional benefits for some period of time (a so-called “haircut” distribution).

Qualified plans are not subject to the constructive receipt rules. So employees may elect the time and method for distribution of their qualified plan benefits after they have terminated employment and have a better sense of their retirement income needs. Less stringent rules also apply to the ability to change payment elections and to elect in-service distributions in certain types of defined contribution plans. This flexibility is yet another reason why employees would prefer to have their benefits payable from a qualified plan.

#### *Economic Benefit Rules and Rabbi Trusts*

An employee may also be taxable on the value of his nonqualified plan benefits under “economic benefit” principles. These rules would apply if an employer sets aside funds outside the reach of its creditors to meet its obligations to the employee under such a plan. In order to avoid this result, an employer will normally keep any assets earmarked for payment of plan benefits either in its own accounts or in a so-called “rabbi trust.” In either case, the assets will remain available to meet the claims of the employer’s creditors in the event of its insolvency.

A “rabbi trust” is typically established with a financial institution serving as trustee. Because the assets of such a trust remain subject to the claims of an employer’s creditors, a rabbi trust does not protect an employee from the risk of his employer becoming insolvent and unable to meet its obligations under the plan. However, if an independent financial institution holds these assets in trust and the trust agreement has appropriate provisions, the trust may provide the employee with some protection from a change in the control of his employer, or from the employer otherwise having a change of heart and attempting to avoid making payments due under the plan.

Some employers irrevocably set aside assets in a “secular trust” to meet their nonqualified plan obligations. Because the assets of a secular trust are not subject to the claims of an employer’s creditors, the “economic benefit” rules apply, and an employee will be taxable on the value of his vested interest in the trust assets. For this reason, secular trusts are rarely used in practice.

#### *ERISA Rules—“Top Hat Plans”*

Employer-sponsored plans that provide employees with deferred compensation benefits generally are subject to ERISA’s requirements. However, so-called “top hat” retirement plans are exempt from almost all of the substantive rules of ERISA. In order to qualify as a top hat plan, a plan must be (1) unfunded, and (2) “maintained by an employer primarily for the purpose of providing deferred compensation for a select group of management or highly compensated employees.” The top hat exception generally recognizes that federal law should not dictate a plan’s terms or funding with respect to employees at these levels of the company. Nonqualified plans are typically designed to fit within this exemption.

Basically, a plan will be considered “unfunded” for this purpose if the employer has not set aside assets outside the reach of its creditors to meet its obligations under the plan (similar to the economic benefit rules discussed above). Because the assets of a rabbi trust are subject to the claims of an employer’s creditors, plans with rabbi trusts are considered “unfunded.”

Whether a plan meets the “select group” requirement is a more difficult question. In most of the cases on the subject, courts have focused on specific objective measures, such as the percentage of the workforce covered by the plan and the average salary of the covered employees compared to the average for the workforce, to determine whether a plan covers a select group. The Department of Labor indicated in 1990 that, in its view, participation in such plans should be limited to individuals with the ability to “influence” the terms of the plan.

#### *Key Aspects of Nonqualified Plans*

Several key aspects of nonqualified plans deserve closer inspection than that given them in recent months. Specifically, we explain below why:

- nonqualified plans are an important source of retirement income for a large number of employees;
- these plans have economic substance and are properly disclosed;



- certain devices used by a small percentage of nonqualified plans are potentially abusive; and
- recent legislative proposals would go much farther than is necessary to address potentially abusive practices and would needlessly curtail many common and nonabusive practices.

*Plans Meet Retirement Income Shortfalls*

Due to the many Code limitations described above, the retirement benefits many executives, salespersons, and management employees receive from qualified plans will represent a considerably smaller percentage of their final pay than that received by rank-and-file employees. The same is true of the social security benefits these employees will receive in retirement. Nonqualified plans help fill these gaps in retirement income, so that these employees can receive a percentage of final pay in retirement more comparable to that received by a rank-and-file employee.

It is important to keep in mind also that many employers that used to offer both a qualified defined benefit pension plan and a 401(k) plan now offer only a 401(k) plan. Thus, many employees are covered under only one qualified plan, which may or may not provide significant retirement income.

*Plans Benefit Numerous Employees*

The number of employees covered by nonqualified plans has grown significantly in recent years. Any employee earning over \$90,000 is now considered a “highly compensated employee” for qualified plan purposes, and thus the employee’s benefits may be reduced based on some of the Code limits described above. Thus, many middle managers and salespersons in this income range rely on nonqualified plans to supplement their qualified plan benefits. Often, these employees are the ones most severely affected by Code limitations (*e.g.*, the ADP test). Notably, a recent survey on nonqualified plan coverage found that persons with incomes below \$100,000 were eligible to participate in approximately 50% of the nonqualified plans.

*Plans Have Economic Substance*

Unlike many tax shelters and other arrangements some companies have entered into in recent years, nonqualified plans have substantial economic and legal consequences for employers and employees beyond their tax treatment. An employee who participates in such a plan foregoes current cash compensation, in return for his employer’s unfunded, unsecured promise to pay deferred amounts in the future. The employee bears the risk that the employer will become insolvent and unable to pay these benefits. The employee also bears the risk of his own insolvency.

An employer sponsoring a nonqualified plan retains the use of the cash that it would have paid to the employees absent the nonqualified plan. However, the employer generally is still subject to tax on the income generated by this amount, even if the amount is placed in a rabbi trust. Moreover, the employer can not deduct these amounts until they are actually paid to the employee.

In many cases, an employer may use cash it would have paid to the employees to make capital investments in the business or hire new workers. Particularly in the case of small employers, nonqualified plans may be integral to the ability of the employer to grow and create new jobs.

*Plans and Liabilities Are Publicly Disclosed*

Unlike some corporate liabilities which have drawn attention in recent corporate scandals, an employer’s liabilities under a nonqualified plan are included on its financial statements. Similarly, any assets set aside to fund these liabilities, including amounts placed in a rabbi trust, are included as assets of the employer on its financial statements.

Public companies also file electronic copies of their nonqualified plans with the SEC as exhibits to their periodic Form 10-K and Form 10-Q filings. Thus, the nonqualified plans of public companies are available for inspection through the SEC’s web site. Additional information about the amount of benefits under certain nonqualified plans maintained by a public company will be provided in the company’s annual proxy statement (also available for inspection on the SEC’s web site).

*Potential Abuses and Legislation*

Recent legislative proposals and media attention has focused on potentially abusive nonqualified plan practices. Specifically, concerns have been raised about devices intended to prevent an employer’s creditors from accessing assets set aside by the employer to meet its nonqualified plan obligations. These devices include the use of off-shore rabbi trusts and early payment triggering devices. A triggering device could provide, for example, that when an employer’s finances deteriorate to a certain

predetermined level, the assets set aside would be paid out to plan participants or be moved to a secular trust. The vast majority of nonqualified plans do not utilize these types of devices.

Recent legislative proposals in the nonqualified plan area would go significantly beyond these potentially abusive devices. These proposals would subject an employee to federal income taxes on deferred amounts (or invite the IRS to issue regulations doing the same) merely because amounts were set aside in a rabbi trust or the nonqualified plan contained certain distribution elections.

As explained above, placing assets in a rabbi trust does *not* remove the assets from the reach of an employer's creditors. At most, a rabbi trust provides employees with limited protection against nonpayment in the event of a change in control of their employer or a change of heart by current management. And, again as explained above, most nonqualified plans place substantial restrictions on an employee's ability to elect a distribution of his plan benefits.

It is worth noting that the IRS routinely issues private letter rulings to employers on their nonqualified plans and related rabbi trusts. These rulings are issued pursuant to two IRS revenue procedures on the subject (one of which includes a "model" rabbi trust) and provide assurance that the plans and related trusts achieve the desired tax treatment. Routine IRS approval of these plans stands in marked contrast to the IRS's recent attacks on certain abusive executive compensation arrangements as tax shelters.

*Joint Committee on Taxation's Enron Report*

Recently, the Joint Committee on Taxation ("JCT") issued a report which described certain aspects of Enron Corporation's nonqualified plans and made recommendations for extensive changes in the tax laws for such plans.<sup>3</sup> The report recommended restrictions on rabbi trusts and prohibitions on the use of "haircuts" and other provisions for the acceleration of payment. The report also recommended prohibiting subsequent payment elections and participant-directed investments in nonqualified plans.

As noted above, assets held in a rabbi trust must remain subject to the claims of an employer's creditors, and rabbi trusts do not protect employees from the risk of his employer becoming insolvent and unable to meet its obligations under the plan.

"Subsequent elections" are often permitted under nonqualified plans to provide employees with limited flexibility in their retirement planning. Longstanding case law makes clear that such an election does not result in constructive receipt of deferred amounts, provided the election is made sufficiently in advance of the originally scheduled distribution date.

Employees in some nonqualified plans, particularly mirror 401(k) plans, may be permitted to designate the investments used to measure earnings credited to their bookkeeping accounts. In recent private rulings, the IRS has determined that the ability to make such elections does not result in constructive receipt. These elections do *not* control the actual investment of any amounts an employer sets aside to meet its nonqualified plan obligations, and they have no impact on the ability of an employer's creditors to access any such amounts. Thus, it is difficult to understand why the ability to select the earnings crediting vehicle should result in constructive receipt or economic benefit issues.

*Conclusions*

Nonqualified plans are an important part of the retirement income and compensation programs of many employers. They help employees—including many below the executive ranks—to achieve their retirement income goals. These plans are not concealed, abusive perquisites reserved for a handful of top executives. Any legislation in the nonqualified plan area should target only potentially abusive practices, such as the use of inappropriate off-shore rabbi trusts or insolvency triggering devices. Legislation should not limit the ability of employers and employees to establish non-abusive deferred compensation arrangements consistent with longstanding tax principles.

<sup>3</sup>Joint Committee on Taxation, *Report of Investigation of Enron Corporation and Related Entities Regarding Federal Tax and Compensation Issues, and Policy Recommendations* (JCS-3-03), February 2003.

**Appendix A**  
**Comparison of Qualified and Nonqualified Plans**

Tax (or Other) Effect	Qualified Plans	Nonqualified Plans
<b>Employer Deduction</b>	Deduction at time of contribution to trust.	Deduction deferred until employee is taxed.
<b>Tax on Investments</b>	Tax on earnings of assets deferred until amounts are distributed to employee.	Employer currently taxed on earnings of any assets (unless earnings are tax-exempt).
<b>Tax on Employee's Benefits</b>	Tax deferred until amounts distributed to employee. Tax-free rollovers to IRAs and qualified plans allowed.	If properly structured, employee is not taxed until actual receipt. Rollovers are not allowed.
<b>Limits on Contributions/Benefits</b>	Section 415 limits (DC and DB); \$200,000 compensation limit; 401(k) deferral limit (\$12,000 for 2003); nondiscrimination rules (e.g., ADP and ACP).	Only as imposed by employer.
<b>Payment Flexibility</b>	Constructive receipt rules do not apply; thus, great flexibility.	Constructive receipt rules apply; thus, employee's access to funds subject to substantial restrictions.
<b>Claims of Employer's Bankruptcy Creditors to Assets Set Aside</b>	Amounts must be placed in trust; employer's creditors have no claim to assets.	Employer's creditors have claims to assets, even if held in a "rabbi trust."
<b>Claims of Employee's Bankruptcy Creditors</b>	Protected from claims	Not protected from claims
<b>Social Security Taxes</b>	No (except for 401(k) contributions)	Subject to limited extent

STATEMENT OF ELLIOTT FISHER, MD AND JONATHAN SKINNER, PH.D.

COMPARING THE HEALTH CARE OF STATES: MORE SPENDING DOESN'T HELP

A strong consensus seems to be emerging that spending more on Medicare is a good idea. After all, senior citizens have been promised a prescription drug benefit. Hospitals, physicians and home health agencies claim that they can't provide adequate care at the current payment levels. And there are persistent concerns about the problems of poor quality and medical errors. With the surplus brimming with cash, why not spend more and provide better quality for our senior citizens?

A recent report suggest one good reason: the Medicare Trust fund looks like its going to run out of cash even sooner than previously forecast. Equally important is the need to better manage the more than \$200 billion we're already spending. Two issues deserve attention: the widespread belief that spending more will lead to improved quality and the dramatic regional differences in Medicare spending.

A widely publicized article in the Journal of the American Medical Association recently reported serious shortcomings in the quality of care across all States. By

state, New Hampshire and Vermont did the best while Arkansas and Mississippi did the worst. On the face of it, this study might sound like a clarion call for Medicare reform—spend more to improve the quality of care. But the study did not look at state-level differences in spending.

We have. The Figure shows state level per capita Medicare spending in 1995, correcting for differences in age, sex, race and illness levels across States. (The elderly in States like Louisiana and West Virginia are indeed sicker—and we allow for this in calculating percapita Medicare spending.) The spending data come from the Dartmouth Atlas of Health Care working group ([www.dartmouthatlas.org](http://www.dartmouthatlas.org)) and show remarkable differences in percapita Medicare spending across States, ranging from \$2657 in Oregon to \$5284 in Louisiana. The vertical axis shows the quality ranking of each state, with the best quality at the top of the scale and the worst quality at the bottom. The pattern of the dots, each of which represents a state, implies that more spending is associated with worse quality care, not better.

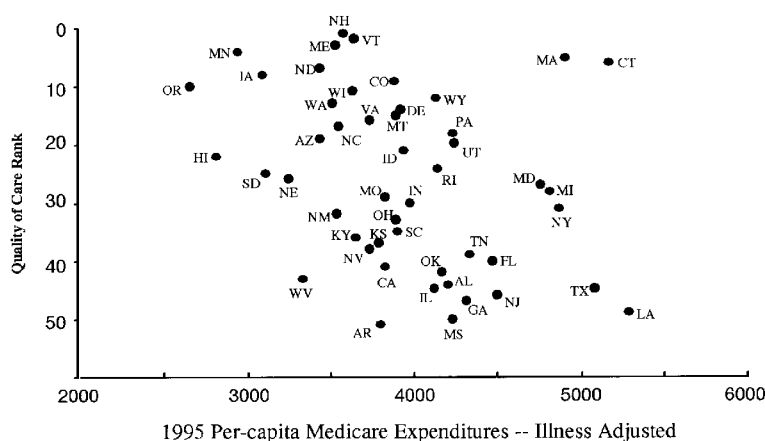
What's going on? We do not mean to suggest that spending more will result in worse care. Connecticut and Massachusetts are both high cost States, but ranked in the top ten in terms of quality. It is simply that high quality care is not necessarily expensive care.

The figure also highlights the second issue—dramatic variations in spending that are not due to differences in illness or need across States. Our own research shows that spending more does not offer substantial benefits: the elderly in high cost regions are not living any longer. Rather, high cost regions tend to have more hospital beds and more specialists per capita, tend to rely on inpatient and specialist care more than outpatient and primary care, and tend to do many more complex tests and procedures. High cost regions tend to treat the chronically ill and those near death much more intensively, with possible adverse effects on their quality of life. It should be no surprise that in such an environment, physicians may be too distracted to pay attention to the simple and effective interventions that represent higher quality.

The fiscal costs of continuing to ignore these differences in state spending are real. Despite rosy projections for the next decade, baby boomers are still on course to clean out the hospital Medicare trust fund by 2021. Additional drug benefits for the elderly will either hasten the bankruptcy of the Medicare trust funds or impose additional financial burdens on the elderly once the surplus is gone.

The implications for Medicare reform policy are clear—quality of care should and can be improved, and it need not put more pressure on the long-term financial viability of the Medicare program. Moreover, the Medicare program can safely save money by scaling back per capita expenditures in the high cost States to levels commensurate with those in the low cost, high quality States. Such a policy would generate enough revenue savings to fund a generous drug benefit program for every elderly person in the Medicare program without raising a dollar in premiums.

The next Congress should try to spend smart, not spend more.



## STATEMENT OF THE COVENANT HEALTH SYSTEM

[SUBMITTED BY JON WACHS, INTERIM PRESIDENT/CEO]

Covenant Health System is an integrated network of not-for-profit hospitals and physician clinics that share in the common goal of providing quality health care for all those in need throughout northeast Iowa. Covenant Health System hospitals include Covenant Medical Center, Waterloo; Sartori Memorial Hospital, Cedar Falls and Mercy Hospital of Franciscan Sisters, Oelwein. These three hospitals had a total of over 15,500 inpatient admissions for fiscal year ending June 30, 2002. In addition, these hospitals provided over 315,000 outpatient visits during the same time period. Covenant Clinics are located in 16 locations in the service area and annually provide over 240,000 office visits to patients.

Hospital losses caused by inadequate Medicare payments are now approaching \$100 million annually, meaning Iowans are subsidizing the Medicare system over and above the Medicare payroll tax that is taken out of each pay check. This subsidization of the program is a drain on the Iowa economy and a financial burden for hospitals, which are already dealing with shortages of employees and rising costs for equipment and insurance.

Our ability to provide high quality, comprehensive health care services is threatened by inadequate government payment for the services we provide. The federal Medicare program accounts for 31.2 percent of all hospital revenue at Covenant Medical Center, Mercy and Sartori, but this revenue does not cover the cost of providing care for Medicare beneficiaries. These losses are compounded by Iowa's Medicaid program. Medicaid accounts for 4.7 percent of revenue for our hospitals. However, Medicaid now reimburses us at FY2000 levels, which ignores the growing cost of caring for patients and actually makes the Medicare inequity in Iowa worse. Last fiscal year the shortfall created when the payment Covenant received was below the cost of caring for Medicare and Medicaid beneficiaries total \$2.7 million.

It is time to recognize that the current payment formulas are flawed and that regional equity enhancements need to be considered in long-term Medicare discussions. Medicare is the single largest payer for health care services in Iowa, yet it continues to cheat Iowa providers and citizens in its payment formula.

Medicare's faulty wage index is applied to 71 percent of hospital payments, despite the fact that only about 50 percent of Iowa hospital expenses go to wages and benefits. This penalizes all hospitals with a wage index below 1.00. Covenant Medical Center and Sartori Memorial Hospital currently have a wage index of .8902. Due to a change in our MSA both Covenant and Sartori will default to the rural Iowa wage index of .84 which will mean a projected \$1.4 million loss in revenue. In addition we will still compete with southern Minnesota and Illinois to attract and retain qualified health care staff.

Despite having one of the oldest populations of any state in the nation and the country's worst Medicare reimbursement, Iowa hospitals continue to provide the 8th highest quality of any state in the nation (CMS data published in the *Journal of the American Medical Association*).

Failure of Iowa's Congressional Delegation to deliver Medicare equity relief initiatives seriously compromises the financial viability of Covenant Health System and Iowa hospitals. In addition, it threatens access to quality health care services for Iowa seniors. Action is needed in both the short and long-term to protect current payment levels and improve Medicare reimbursement to Iowa compared to the rest of the nation.

---

STATEMENT OF DEERE & COMPANY/JOHN DEERE HEALTH

Deere & Company is pleased to submit this statement for the record to the Senate Finance Committee concerning the Medicare program in rural communities. John Deere is one of Iowa's leading employers with over 16,000 employees in Iowa and the Illinois Quad Cities area. In this region, Deere provides health care benefits to over 76,000 employees, retirees, and dependents. This number includes 23,000 retirees. This statement will focus on the health care benefits provided to Deere Medicare eligible retirees as well as non-Deere Medicare beneficiaries covered by John Deere Health Care (JDH), a wholly owned subsidiary of Deere & Company that operates in the States of Iowa, Illinois, Tennessee and Virginia. This statement contains positions relating to the potential of Deere & Company and John Deere Health Care entering into a Medicare Plus Choice contract with CMS in Iowa and Illinois. This statement does not address other issues relating to Medicare or any Medicare reforms currently being considered.

*John Deere Health Care*

JDH offers managed care products in the commercial market place and has a total membership of 530,000 including 113,000 Medicaid members, 32,000 Medicare members, and over 3,000 employers in addition to John Deere. JDH is accredited by the National Committee for Quality Assurance and has held the rating of "Excellent" since 2000. JDH has been recognized as an industry leader in customer satisfaction through independent surveys, and has achieved the highest possible rating for customer satisfaction within the NCQA HEDIS scoring system.

It is important to recognize that JDH carries the perspective of a rural managed care company. JDH does not operate in a large urban setting, and does not ever anticipate doing so. Because health care dynamics differ greatly between rural and urban settings, JDH's comments and suggestions should be considered from its perspective as a rural managed care business, and are not intended to be applicable to manage care plans operating in large, urban centers.

*JDH and Medicare*

JDH holds two contracts with the Center for Medicare and Medicaid Services (CMS) for the administration of Medicare benefits.

- Cost Contract for Medicare eligible members in Iowa and Illinois,
- Medicare Plus Choice (M+C) contract in Tennessee and Virginia. JDH is currently working on a 21 county M+C expansion in Tennessee and Virginia.

JDH has not yet been able to justify the financial viability of converting its Medicare Cost Contract to a M+C contract in Iowa. Medicare reimbursement rates in Iowa under M+C are currently inadequate to cover the associated costs and financial risks. While JDH's cost structures are comparable between Iowa and Tennessee, JDH has found that Iowa M+C payments would be approximately \$350 per year per beneficiary less than those in Tennessee. This gap was reduced but not eliminated by the additional floor payments realized in Iowa. Other issues that present difficulties in moving to an M+C contract include:

1. The financial viability of the program in the long run. Annual revenue increases for M+C contractors are not keeping pace with annual medical cost increases. If CMS has a stated objective of increasing payments to M+C contractors by 2% per year it is impossible to see the survival of the program beyond a relative short period of time. Deere cannot venture into a program unless it has confidence that the program is viable in the long run.

2. As an employer, Deere's ability to shift its retiree population into limited access M+C provider panels is hampered by the broad geographic distribution of retirees and collective bargaining agreements. Although a significant issue for Deere, this is not a difficult issue for most Medicare beneficiaries in our communities since they are not covered by employer-sponsored plans.

3. JDH's success with M+C in Tennessee is based, in part, on adequate funding from CMS and reasonable contracts with providers. Those contracts are at or slightly higher than Medicare fee-for-service reimbursement and contain limited financial risk. As we have discussed the possibility of bringing a M+C program to Iowa, JDH's Iowa based providers have expressed a reluctance to enter into any Medicare arrangements that contain financial risk.

*Potential Reforms*

JDH believes that certain basic reforms to the Medicare Plus Choice program could be undertaken to make a M+C contract more feasible as an option for Deere retirees and the communities in which it operates. These reforms should include the following:

1. CMS payments under the M+C contract must be adequate to cover the cost of the program, cover the financial risk of the program, and provide a reasonable return on the investment in the program. In JDH's experience M+C CMS payments for Iowa should be comparable to those currently realized in East Tennessee.

2. Deere must have confidence that the program will remain financially viable for the long term. The company cannot be put in the position of changing programs for its retirees or other Medicare-eligible persons in its communities, based on an insufficiently financed M+C program. This will require a commitment and expectation that CMS payments to M+C contractors will reasonably keep pace with medical costs, and will not be artificially limited to 2% annual increases.

3. CMS should also be encouraged to consider more innovative, flexible approaches that support existing programs in rural communities while encouraging new ones. For example, JDH could be allowed to continue to offer benefits to Deere's Iowa retirees under its Cost contract for an extended period of time, while JDH offers a M+C program to the non-Deere community. This approach is currently not allowed by CMS, as only one type of contract per contractor is allowed within a given service area. It should be noted that this approach would require the extension of the Medicare Cost Contract program sunset date through legislation.

4. Prior to the development of a M+C program in Iowa, Deere would need clarity on the issue of prescription drug coverage for Medicare beneficiaries. Deere believes that such a program should provide a basic prescription drug benefit for all beneficiaries, should not penalize employer-sponsored plans currently covering prescriptions drugs, and should not neutralize initiatives aimed at containing prescription drug costs, such as generic substitution.

Deere & Company and John Deere Health Care look forward to working with this Committee in the months ahead to make constructive improvements to the Medicare program that will benefit rural communities.

April 9, 2003

Senator Charles Grassley  
 Chairman Senate Finance Committee  
 Public Hearing Monday, April 14, 2003  
 A FAIR DEAL FOR IOWA: FIXING MEDICARE REIMBURSEMENT

Dear Senator Grassley:

First let me take the time to say thank you for your willingness to hear our thoughts on the Medicare issue in Iowa. Ellsworth Municipal Hospital is located in Iowa Falls, Iowa and is a 42-bed rural hospital. We provide general medical/surgical, obstetrical, emergency, and psychiatric services and are a vital part of both Iowa Falls and Hardin County. We are a municipal not for profit hospital and are governed by an elected five member board. All of the hospital's in Iowa are being negatively impacted by the low Medicare reimbursement. Approximately 60% of the people seen at Ellsworth are on Medicare. Based on preliminary data from the year 2001, which was the last cost reporting period available, we lost an average of 10.1% on every Medicare patient who presented to the building. This was broken down into a loss of 8.5% for inpatients and 20.7% for outpatients. We had a positive margin of 4.3% on psych patients. Ellsworth Municipal Hospital receives no tax funds as a city hospital and we work very hard to be efficient and effective as stewards of the public good. We have lost money for the last five months and for the first time in seven years are in the red for the year. Poor reimbursement makes it difficult for us to recruit and retain staff who can take care of their neighbors and friends in our community. Because of reimbursement we are also being forced to look at programs that are good for the community and decide whether we can continue to operate them at the loss they generate. The impact of losing these programs would be detrimental to the quality of life in this vibrant community. Hospitals are part of the vital economic engines of their communities both of the jobs they generate and being vital in attracting new business opportunities to small or rural areas. I am not asking for any major largesse but instead am hoping for good old Iowa fairness in dealing with the glaring inequities within the Medicare program.

Again, my thanks to you and the other members of the Senate Finance Committee for being willing to listen to our concerns. You and your members are always welcome to visit our hospital and our community should you need any additional information.

John O'Brien, Administrator  
 Ellsworth Municipal Hospital  
 110 Rocksylvania Ave.  
 Iowa Falls, Iowa 50126

JOB/th

---

STATEMENT OF THE GRINNELL REGIONAL MEDICAL CENTER

[SUBMITTED BY TODD C. LINDEN, PRESIDENT AND CEO]

*"What's up with that?"* My nine year-old son, Grant, says this phrase when he encounters something strange, crazy, or unfair. I use it when I think about Medicare. Iowa's average Medicare reimbursement of \$3,414 per beneficiary ranks the lowest in the country, \$2,580 less than the national average and \$4,685 less than Louisiana—the best paid in the country.

Although Iowans pay the same Medicare tax as other United States residents, reimbursement for the care on their behalf is far less than that provided other residents in other States. It would be like Iowans paying 74 cents for a postage stamp while folks in more urban States getting by for only 37 cents for the same service.

The Medicare system is not equitable . . . and everyone knows it. Thomas Scully, the administrator of the Centers for Medicare and Medicaid Services, the agency responsible for the program said it when he visited Iowa last summer. When the Minnesota Medicare Justice Coalition sued the federal government in 2001, U.S. District Judge Donald Alsop said the system was unfair. Both the incumbents and challengers in the 2002 Congressional races used their campaign ads to discuss



Medicare unfairness. Governor Vilsack has initiated a legal challenge to Medicare. And heaven knows that Iowa doctors and hospitals know the system is unfair. So do others. Iowa snowbirds know it when they head South and see their counterparts receive healthcare incentives to join Medicare HMOs. Even President Bush noted the inequity in a speech on Nov. 4, 2002 when he said, "The Medicare issue is an important issue . . . . The formulas need to be fair for the Iowa citizens."

So, if we all know it, why can't something be done to change it? It may have something to do with the fact that there are more than 100 U.S. House members from California, Texas, New York, and Florida. The system is biased in favor of more urbanized States. They control the House and the votes to make change. With only five house members from Iowa it is unlikely we can sell a national, Robin-Hood solution that would give less money to big States and more to Iowa and other upper mid-western States that are cheated by the current system. In addition, the Baby Boomers are marching into a "Senior Boom," the implications which will be catastrophic and they want a prescription drug benefit. Finally, the complexity of the Medicare payment formulas, rules, and regulations do not lead to any easy solutions.

A systemic overhaul of the Medicare program is really the only answer and the prescription drug benefit debate could be a likely vehicle to address the inequity that exists. If we wait until patients no longer have access to care, it may be too late. In the short term, politicians can raise taxes and/or cut benefits to pay for increasing costs (not an electionwinning strategy) or they can cut payments to hospitals and doctors ( a past strategy but nearing the breaking point). When politicians choose to cut payments to the healthcare field, the cuts hurt States like Iowa the hardest.

Grinnell Regional Medical Center spent \$1.6 million more caring for Medicare patients in 2001 than the government paid. That was up from \$430,000 in shortfalls in 2000. When the Medicare cost report is finalized for 2002, the expected shortfall from costs will likely top \$2 million. *This trend is unsustainable and could close hospital doors and medical practices.* For every dollar spent on Medicare patients, GRMC loses 14 cents. Grinnell Regional Medical Center also losses about \$500,000 from costs caring for the poor through the Medicaid Program. With cost on the rise due to higher utilizations, the workforce shortages, and increases for pharmaceuticals, inadequate reimbursements from Medicare and Medicaid is the most serious threat to our state today. Iowa Hospitals suffer the worst Medicare margins in the Nation, further evidence of the flawed formulas that unfairly reimburse hospitals in this state.

We have to stand together and support our congressional delegation. Truth and fairness usually win out if everyone is determined, focused, and unwilling to accept injustice, especially when it comes to the primary mission of meeting the needs of seniors who deserve the best care possible. Senator Grassley, in your role as chair of the Senate Finance Committee we need your help to mend Medicare inequity. We stand ready to support you. We appreciate your hearing today and we will continue to ask: "What's up with that?"

---

STATEMENT OF GRINNELL REGIONAL MEDICAL CENTER

[SUBMITTED BY TODD A. NELSON, VICE PRESIDENT AND CFO]

Senator Grassley, I appreciate you recognizing the vital role Medicare holds not only in Iowa's health care system, but also in the entire Iowa economy. I am proud to represent my hospital, Grinnell Regional Medical Center, where I have worked since 1991, and what a decade it has been as far as change in the Medicare program.

As you are no doubt aware, Medicare and its payment policies cheat Iowans. I say that because the Medicare program continues to penalize high quality, efficient health care providers, like Iowa's, even while solid research proves Medicare overspends in other areas of the country. Medicare does this by simply paying Iowa providers a lower rate for superior service. The system as it now stands flies in the face of common sense and is an affront to any reasonable concept of fairness.

However, there is much more to what is wrong about Medicare in Iowa than that. It is also wrong because low Medicare payments drive up the cost of private insurance. It is wrong because hospitals must ultimately curtail services and limit access. It is wrong because doctors are beginning to refuse Medicare patients. It is wrong because, in the midst of an unprecedented shortage of health care workers, Iowa is at a huge recruiting disadvantage, particularly against adjacent States. It is wrong because Iowa has a health care system that is known for its quality and cost-effec-

tiveness, yet Iowans find themselves subsidizing States where quality is low and waste is high.

It is wrong because Medicare has become an unnecessary and unfair burden to the Iowa economy. As Iowa struggles to redefine itself economically, hospitals offer a deep and constant wellspring of opportunity that attracts young, well-educated professionals and their families to jobs in communities throughout the state. A financially stable health care system is critical to supporting existing businesses and attracting more growth to Iowa, but Medicare's tremendous shortfalls undermine Iowa's efforts to be economically competitive. Good health care provided by well-supported hospitals is a large and irreplaceable block within the foundation that defines quality of life in Iowa.

The current unfair Medicare system is cracking and weakening that block, creating instability, and seriously threatening Iowa's future. Today, 475,000 Iowans depend on Medicare. Thousands of them live in and around Grinnell Regional Medical Center. Financially, they are important to us; more than 46 percent of our gross revenue comes from Medicare. In 2002 my hospital is losing about 15 cents on the dollar each time we treat a Medicare patient, up from a loss of 13 cents in 2001 and 4 cents in 2000. Based on that growth rate we predict we will lose 22 cents on every dollar by 2005.

In dollars and cents our payment shortfalls from costs on Medicare were (\$428,113) in 2000, (\$1,630,023) in 2001 and ballooned to (\$1,926,272) in 2002. If we continue to grow at that rate, we predict a shortfall in Medicare payment from costs of (\$3,949,845)! The cost shifting of this additional shortfall to our local employers would be unsustainable for many of them and I fear they would discontinue offering insurance to many of their workers. Please see the attached spreadsheet, which outlines payment information for Grinnell Regional since 2000 and predicts 2005 numbers.

My hospital is simply one of 116 examples of how Medicare damages Iowa. All told, Iowa has the worst Medicare margin in the country and is losing at least \$80 million a year to the program. Hospitals have to cover that loss. They can only increase privatesector fees or, in the case of public facilities, increase taxes. Whatever the method, those Medicare losses are cost-shifted back to businesses and individuals, through their insurance premiums, through their tax bills, through their prices for goods and services. It means Iowans are taxed twice for Medicare and forced to subsidize this program, allowing Medicare to pay higher and provide better benefits in other States. It is to those States that thousands of Iowa seniors have moved, taking with them hundreds of millions of dollars from the Iowa economy.

Can this situation be fixed? Yes, it can. There are real and significant changes that can be made to Medicare payment now that would begin to make it fair for Iowa.

First, to help hospitals pay their costs, authorize full inflationary updates of Medicare payments. Escalating clinician salaries, pharmaceutical costs, new technology, and soaring professional liability rates simply cannot be ignored. Medicare must pay its fair share.

Second, equalize the Medicare standard payment amount; make the 1.6 percent fix permanent. This provision within the Medicare formula has no basis in sound payment policy, and it needs to be eliminated.

Third, fix the Medicare wage index. This is a major fault in the Medicare payment system. Medicare's wage index is applied to 71 percent of hospital payment, but in reality only about 50 percent of Iowa hospital expenses go to wages and benefits. Grinnell Regional and every other hospital in Iowa are cheated by this simple lack of reality within the formula. The labor-related share of Medicare payment must be reduced to reflect reality.

Finally, let's create a Medicare system that really does reward high-quality, cost-effective health care. The current nearly inverse relationship between payment and quality is well documented. Studies have shown that States receiving the greatest Medicare payments tend to also have low quality and much wasted spending in their health care systems. Meanwhile, States like Iowa that have proven themselves to be high in both quality and cost efficiency are receiving the lowest payments.

This is simply and clearly wrong and a flat contradiction of stated congressional intent. The Medicare program should reward quality and efficiency by developing an incentive payment program based on those measures. In other words, Medicare should seek and reward value, just like other consumers in the American economy. Under this system, States where providers fail to meet quality or cost targets would be motivated to improve and Iowa would be rewarded proportionately.

Here is how such a system might work: States would be ranked on both per-capita cost and overall quality measures, and hospitals and physicians in States that have the highest cumulative combined scores would receive a five percent "add-on" as a

reward for outstanding performance. Quality data is already available from the *Journal of the American Medical Association*, which uses Medicare's current quality of care measures. The JAMA report is founded on evidence-based, clinical procedures that have been shown by scientific evidence to be effective in enhancing outcomes of care. Cost rankings would be based on CMS's annual report ranking States based on average Medicare spending per recipient.

Members of Congress and representatives of the Department of Health and Human Services and the Centers for Medicare & Medicaid Services have repeatedly come to Iowa and told us how wonderful our health care system is, and how unfortunate it is that Medicare is formulated in such a way that Iowa is cheated rather than rewarded. That needs to change. It's time that Iowans, who have invested so much in their community hospitals, who depend so completely on the services and the jobs our hospitals and physicians provide, start seeing real equity to go with the kind words.

These are but a few of the avenues you and your colleagues in Congress might pursue in order to start bringing Medicare equity to Iowa. There are other issues dealing with Critical Access Hospitals, home health, emergency care, and Indirect Medical Education that also need attention and that I know you are aware of. These issues can be fixed. Iowa hospitals have illustrated a pathway to quality with equity. We need you to lead Congress toward a fair and equitable Medicare system.

Your Iowa constituents greatly appreciate your leadership and commitment on this issue. We are proud of your chairmanship of the Senate Finance Committee and your relationship with President Bush. Please let us know how we can help.

**GRINNELL REGIONAL MEDICAL CENTER**  
Comparison of Medicare Payments, Costs and Charges  
Years Ended December 31, 2000, 2001, 2002, & projected 2005

	2000	2001	2002	2005 proj.
TOTAL Medicare COSTS	10,284,737	12,534,878	13,212,436	17,904,199
TOTAL Medicare Payments	9,856,624	11,004,855	11,289,164	13,954,354
<b>TOTAL Shortfall from Costs</b>	<b>(428,113)</b>	<b>(1,630,023)</b>	<b>(1,923,272)</b>	<b>(3,949,845)</b>
Loss from <u>costs</u> on every Medicare Dollar	\$ (0.04)	\$ (0.13)	\$ (0.15)	\$ (0.22)
TOTAL Medicare Charges	17,195,756	20,466,663	22,461,586	33,277,828
Medicare LOS	3.81	3.63	3.85	3.94
Medicare Admissions	1,395	1,499	1,535	1,777
GRMC, when looking at its costs to provide care is 2.1% <u>below</u> the statewide average of costs for Iowa hospitals, which are already recognized as low cost for the Medicare program.				
Overall Operating Margin	\$ 860,439	\$ 642,508	\$ 679,259	\$ 495,180
Overall Operating Margin %	3.10%	1.98%	1.93%	1.02%

Iowa Hospitals rank 6th highest in quality (based on CMS data) and also provide excellent value to its employers (based on AHA data), ranking OP and IP charges in Iowa 2nd lowest and 5th lowest as compared to all other states.

STATEMENT OF THE HAMILTON COUNTY PUBLIC HOSPITAL

[SUBMITTED BY ROGER W. LENZ, ADMINISTRATOR]

Senator Grassley, as the Administrator/CEO of Hamilton County Public Hospital, Webster City, Iowa, I represent a hospital staff of 230 employees and a county of 16,000 residents that depend on our hospital for quality health services.

Hamilton County Public Hospital was established in 1930 by the voters of Hamilton County, Iowa. It is organized under Chapter 347 of the Code of Iowa. Our hospital is classified as a rural PPS (prospective payment system) hospital by CMS and is licensed for 49 beds. In addition, we are accredited by the Joint Commission for Accreditation of Healthcare Organizations.

Utilizing information from the Iowa Hospital Association Databank for fiscal year 2002, our hospital's Medicare inpatient revenue was 61.2% of our total inpatient charges as compared to 62.5% for the 38 Iowa hospitals that are also classified as rural by CMS. Hamilton County Public Hospital's Medicare outpatient revenue was

45.7% of the total outpatient charges as compared to the 40.4% for the 38 rural hospitals in Iowa. As a result of inadequate Medicare payment, our hospital only collects 56.9% of billed charges compared to 53.6% for Iowa hospitals classified as rural. Overall, Iowa rural PPS hospitals have a negative margin of -8.77%. As a result of the high Medicare patient population, Hamilton County Public Hospital had a negative patient service margin of -6.14% for fiscal 2002 compared to -1.44% for Iowa rural PPS hospitals. For fiscal 2002, our hospital had a loss from operations of -\$348,781 and a loss in fiscal 2001 of -\$241,441. Unfortunately this trend of losses from operations is not ceasing. **In the current fiscal year, after eight months of operation, we have a loss from operations of -\$584,237!**

*If our hospital were not provided tax support by the residents of Hamilton County would be in desperate financial straits.* On the other hand, it is also unfair to the taxpayers to have to pay for Medicare inequities twice; first, with the Medicare payroll tax of 1.45% of which Iowa does not receive its fair share, and second, through property taxes to assist the hospital in attaining financial solvency due to Medicare's inequitable payment policies.

Since the Medicare PPS system was put into place in the 1980's, the inflationary updates never have been adequate. Our hospital has to deal with increasing clinician salaries, supply costs, technology costs and ever increasing professional liability increases.

The Medicare wage index is applied to 71% of the hospital's payment. Hamilton County Hospital's payroll and benefits are 56.5% of total operating expense. The 38 rural Iowa PPS hospitals payroll and benefits are 53.3%. This methodology penalizes hospitals with a Medicare wage index below 1.00 (Hamilton County Public Hospital's wage index is .8315). The labor related share of Medicare payment must be reduced for Iowa hospitals.

As a 49-bed hospital with an average daily census of 16 patients, Hamilton County Public Hospital is too large to qualify as a Critical Access Hospital. On the other hand, the hospital is too small to absorb the financial shortfalls of the Medicare payment system. The CriticalAccess Hospital program needs be refined to increase the 15 acute care inpatient bed limit to include 25 total acute and swing beds.

We are now preparing our fiscal year 2003-2004 operating and capital budgets. As a result of the inadequate Medicare payment, we must make some very hard choices. We are faced with the possible elimination of services because we simply can no longer afford to provide them. Some of the services that may need to be eliminated are: the E-911 ambulance service, cardiac rehabilitation, diabetes education, wound clinic, and community education programs. As we prepare our capital budget we are faced with deciding what equipment our patients must do without. Hamilton County Public Hospital has long prided itself on providing quality healthcare at reasonable cost, but it is getting more difficult to provide the kind of healthcare Iowans deserve when budget cuts become necessary for the hospital's survival.

Compounding our budgeting issues is employee recruitment and retention. We are finding that our hospital is competing with the Critical Access Hospitals, Rural Referral and Urban Hospitals for employees. Recruitment and employee retention has become a major issue that is becoming more and more difficult due to the inadequate Medicare payment.

Iowans are fortunate to have you as the Chairman of the Senate Finance Committee. Only another Iowan can truly appreciate the frustration Iowa hospitals are facing due to Medicare inequities. Again, Senator Grassley, we ask your assistance in ensuring that Iowa hospitals receive adequate inflationary updates, that the Medicare wage index is adjusted to reflect Iowa hospitals actual wage expenses, and most importantly, that the Critical Access Hospital program be expanded to include up to 25 inpatient beds.

Be assured, Iowans appreciate your history of commitment to Iowa's seniors and know that you will do your best to help Iowa's hospitals and citizens receive Medicare equity. Thank you for your time and commitment in getting a "fair deal" for Iowa by fixing Medicare reimbursement.

---

STATEMENT OF THE HANCOCK COUNTY MEMORIAL HOSPITAL

[SUBMITTED BY TONI EBELING, ADMINISTRATOR/CEO]

Hospitals today face increasing pressure from many sources affecting our ability to provide services to our patients and communities 24 hours a day, every day of the year. Many of these challenges are well known to hospital professionals and leg-

islaters alike. However, *every hospital in Iowa* has the additional burden of being financially stressed by low Medicare payments.

Financially, Medicare patients are important to Iowa hospitals. At Hancock County Memorial Hospital, 62% of our gross revenue comes from Medicare. More than 17% of the total population of Hancock County is over the age of 65.

National payment policies, specifically prospective payment systems, fail to recognize the special and unique circumstances of rural hospitals. Hancock County Memorial Hospital is licensed by Medicare as a Critical Access Hospital (CAH). This alternative payment structure based on a reasonable cost-based reimbursement system is necessary to ensure our survival as an essential provider of care in Hancock County and to ensure that Medicare beneficiaries located in Hancock County continue to receive access to quality health care services.

There are real and significant changes that can be made to Medicare payment now that would begin to make it fair for Iowa and ensure our survival.

- First, in order to help hospitals pay their costs, authorize full inflationary updates of Medicare payments. Escalating clinician salaries, pharmaceutical costs, new technology, and soaring professional liability rates simply cannot be ignored. Medicare must pay its fair share.
- Second, eliminate the requirement that Critical Access Hospital's (CAH's) must be 35 miles away from the closest hospital in order to receive cost based reimbursement for ambulance services.
- Third, provide cost-based reimbursement for home health services furnished by a CAH.

Extending such reimbursement to post-acute care settings, including home health and ambulance services would eliminate the most troublesome aspects of the BBA, which is a patient's inability to access a full continuum care of services.

Medicare and its payment policies have a direct unfair impact on all our patients. Low Medicare payments drive up the cost of private insurance. Low Medicare payments undermine our hospital's efforts to recruit health care workers against nearby States. The Iowa nursing shortage is not due to Iowa's school's not graduating enough nurses, as Iowa does graduate enough nurses for its needs. However, a high percentage of graduating nurses leave Iowa for nearby States that can afford to pay higher wages. Low Medicare payments will eventually cause Iowa hospitals to cut services and limit accessibility.

Iowa hospitals have been documented as providing high quality service in an extremely efficient manner. While rated high in quality, Iowa hospitals continue to receive the lowest reimbursement nationally. Regardless of how you look at the issues, the Medicare program penalizes Iowa's high-quality, efficient delivery of health care services.

The Medicare payment system presents tough challenges, but they can be overcome. Iowa's most powerful force is its people. Our staff, our patients and our community heavily support Hancock County Memorial Hospital. They depend on the services, the employment and the economic benefits we provide. They deserve a Medicare system that rewards the high-quality, efficient care that we provide.

These are but a few of the avenues you and your colleagues in Congress might pursue in order to start bringing Medicare equity to Iowa. We need you to lead Congress toward a fair and equitable Medicare system. Your Iowa constituents greatly appreciate your leadership and commitment on this issue.

April 24, 2003

The Honorable Charles Grassley  
135 Hart Senate Office Building  
Washington, D.C. 20510

Re: April 14, 2003 Public Hearing on Medicare

Dear Senator Grassley:

Thank you for your leadership in sponsoring the April 14<sup>th</sup> Des Moines public hearing on Medicare. While a representative of Health Policy Corporation of Iowa (HPCI) was unable to attend this meeting, I want to give you some background on HPCI (enclosed) and share the following for the record and for your consideration:

1. HPCI actively supports efforts to gain Medicare payment equity for Iowa and elsewhere. This is not only a fairness issue, but also will help reduce cost shifting to the private sector and should enable more health industry investment in patient safety and process improvement.
2. The current Medicare payment method is not only inequitable but needs to be revised to improve health industry performance and accountability for cost and quality. A demonstration project should be conducted in which health systems or centers around the U.S. could commit to address unwarranted variations in practice and thereby provide national benchmarks of efficient and high quality care. Some regions within Iowa would be important participants of such a demonstration program.

This recommendation is made based upon HPCI's extensive experience in geographic variation analysis and on numerous recent research articles and publications. The following has been demonstrated:

- There is marked variation in spending and resource use across states and spending more at the state level is not associated with improved quality. In fact, it seems there is an association with worse quality. See attached editorial from the *Providence Journal* entitled "Comparing the Health Care of States: More Spending Doesn't Help."
- There is also great variation within states. For example, Rochester and Syracuse, New York are in the lowest fifth of the country in per capita spending, while East Long Island and Westchester County, New York

are in the highest spending fifth. Likewise, Fresno, California is in a low spending region, while Orange County, California is in the highest spending region. See the map on page 276, figure 2 of the article enclosed article entitled "The Implications of Regional Variation in Medicare Spending. Part One: The Content, Quality, and Accessibility of Care" (*Annals of Internal Medicine*, 2003 American College of Physicians – American Society of Internal Medicine; also available from the website: [www.annals.org](http://www.annals.org)).

- Spending more does not lead to higher quality or better health outcomes. See the enclosed abstract of "The Implications of Regional Variations in Medicare Spending. Part 2, Health Outcomes and Satisfaction with Care," *Annals of Internal Medicine*, Feb. 18, 2003, Vol. 138, No. 4 (Full article available from the website: [www.annals.org](http://www.annals.org)).

Improving the quality and efficiency of care will require addressing these variations in practice.

The goal is to develop a Medicare payment and accountability approach that is equitable and also recognizes and rewards health industry performance improvement and accountability for cost and quality. This is consistent with two of HPCI's priorities for 2003-2004: (1) to apply Iowa LEAN manufacturers' industrial quality systems to help fix health care (LEAN enterprise); and, (2) to improve accountability, transparency of health information and recognize and reward results of health care providers.

HPCI stands ready to work with you on these issues and in other ways. Thank you again for your efforts to bring Medicare equity to Iowa. Best wishes.

Sincerely,

Paul M. Pietzsch  
President

Cc: Ted Totman  
Colin Roskey

**HEALTH POLICY CORPORATION OF IOWA**  
*Working for Quality, Affordable Health Care*

**HPCI**

Health Policy Corporation of Iowa (HPCI) is a group of employers and other purchasers developing joint health purchasing initiatives, conducting research and education, and leveraging solutions to improve the quality and affordability of health care in Iowa. Established in 1982 as a private, tax-exempt corporation incorporated under Internal Revenue Code section 501(c)(3), HPCI has received national recognition and awards for health care leadership.

**GOALS**

HPCI is leading a joint initiative in Iowa to address fundamental issues in the health care system through the use of sound purchasing and quality improvement principles.

**Goal 1:** Employers (purchasers) receive the greatest value for dollars invested in health care in local markets, and providers receive economic and other incentives to improve performance.

**Goal 2:** Contribute to improvements in the health of the community.

**Priorities and Initiatives for 2003-2004**

**PRIORITY: Apply Iowa manufacturers industrial quality systems to help fix health care (LEAN Enterprise)**

- Advance LEAN Enterprise and the culture of continuous improvement in Iowa's health sector (driving out cost).

**PRIORITY: Improve accountability, transparency of health care information and recognizing/rewarding results**

- Develop and conduct the Leapfrog Iowa initiative with support from the Business Roundtable-founded Leapfrog Group for Patient Safety Rewarding Higher Standards.
- Participate in the Consumer and Purchaser Disclosure Project
- Develop interest in and use of "eValue8" health evaluation tool in Iowa (the V-8 Group Request for Information – RFI).
- Pursue the Risk-Adjusted Episodes of Care project.

**PRIORITY: Move toward consumer-centered health care**

**PRIORITY: Promote prevention, chronic disease care improvement, and Healthy Iowans 2010**

**Organization**

- Board of Directors and Steering Committee of Iowa leaders
- Work Plan Task Forces

**More Information**

Contact the Health Policy Corporation of Iowa: (515) 282-7727, or e-mail: [health@hpci.org](mailto:health@hpci.org)



**Health Policy Corporation of Iowa  
Summary of Goals and Priorities for 2003-2004**

**Goals:**

- Employers (purchasers) receive the greatest value for dollars invested in health care in local markets, and providers receive economic and other incentives to improve performance.
- Contribute to improvement in the health of the community.

**Four Priorities**

1. **Apply Iowa manufacturers industrial quality systems to help fix health care (LEAN enterprise)**
  - Strategy
    - Move from health care provider and health plan administrator "fee discounting" cost containment strategy to driving the cost (nonvalue activities or waste) out of the system using LEAN principles, value stream mapping, Kaizan methods, Six Sigma and supply chain integration.
    - Develop new business partnership (customer/supplier) with joint expectations and specifications for both health providers and health plans.
    - Apply purchasing standards (national and local) to accelerate health industry improvement.
  - Leadership and resources:  
Led by Iowa companies including HON Industries, Maytag, Rockwell-Collins, Iowa Manufacturers Extension Partnership, the Iowa Association of Business and Industry, and others.
2. **Improve accountability, transparency of health care information, and recognize/reward results.** These efforts will help:
  - 1) Control health care costs;
  - 2) Improve quality;
  - 3) Engage employees/consumers/patients to make more informed health care choices.
  - Strategy
    - Leverage national solutions and resources such as the Business Roundtable-founded Leapfrog Group, the National Consumer and Purchaser Disclosure Project, the eValue8 Evaluation Tool and V-8 Group Request for Information (RFI), and Risk-Adjusted Episodes of Care project.

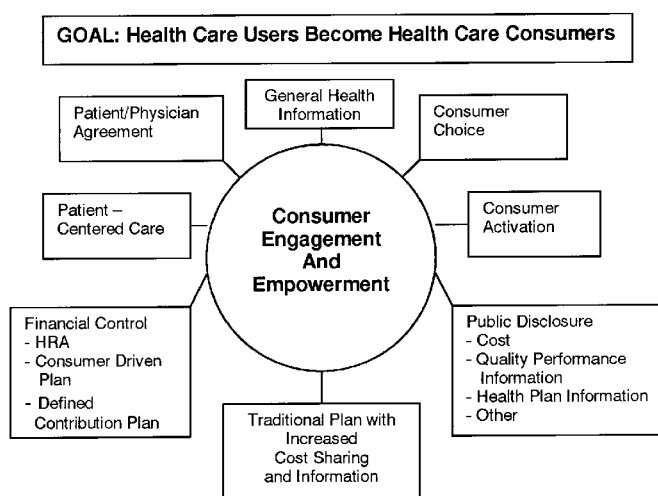
- National standards and local markets: national standards are essential for comparability across markets, credibility, less reporting burden, economies of scale and leverage, and consistent measures for active employees and retirees.
- Help providers improve and report on quality of service and efficiency in consistent ways which (1) gives consumers tools for making better choices and (2) gives employers and other purchasers tools for getting better value for dollars invested in employee medical benefits.
- Leadership and resources:  
Leverage national solutions and resources with leadership from Iowa, regional and national companies supporting and applying national standards in local markets.

### 3. Move toward consumer-centered health care

- Strategy
  - Explore potential options and benefits of emerging consumer centered health care model(s).
  - Identify efforts to address the evolving role and accountabilities for employers, employees (consumers), the health care community, and other stake holders to inform, involve and empower consumers/patients to be more engaged in health care decision making.

*"... The next generation of progress in creating a quality-focused and efficient health care system will require both better understanding of the consumer's needs and new mechanisms for involving consumers directly in their care."* Source: *A New Vision for Health Care: A Leadership Role for Business*, Committee on Economic Development, 2002

- Leadership and resources:  
Joint effort by stakeholders (employers, health care providers, health plans, consumer organizations and government) to inform, empower, and engage consumers/patients.



#### 4. Promote Prevention, Chronic Disease Care Improvement, and Healthy Iowans 2010

- Strategy
  - Pursue improvement in chronic disease care.
  - Familiarize business and community leaders with the contribution of public health activities to the overall health care infrastructure, as well as the cost associated with medical conditions that lend themselves to public health interventions.
- Leadership and resources:
 

The Iowa Chronic Care Consortium was recently created to conduct pilot projects to improve chronic disease care.

Note:

Many of the expenses incurred by the health care system in Iowa are the result of morbidity associated with sociologic and lifestyle factors that cause high utilization of our health care system. Priority attention to public health goals would go a great distance toward addressing that important part of the health care financing equation. Medical expenses for people with diabetes total \$10,071 per person, compared with \$2,669 for people without diabetes, according to Healthy Iowans 2010. Diabetes is closely associated with obesity, and Healthy Iowans 2010 has an aggressive agenda for addressing obesity and diabetes. A collaborative approach to addressing public health goals such as obesity, smoking and violence is a critical component of any effort to improve our health care system.

---

#### STATEMENT OF THE KOSSUTH REGIONAL HEALTH CENTER

[SUBMITTED BY SCOTT CURTIS, ADMINISTRATOR/CEO]

Iowa hospitals have a long tradition of providing quality health care for its patients, communities, and businesses. Kossuth Regional Health Center has been caring for Kossuth County and surrounding area residents for more than 50 years. This health center and its providers employ 155 people with an estimated annual payroll of \$4.5 million boosting the local economy.

Kossuth County has a high proportion of elderly residents who rely heavily on Medicare. Because of our state's low Medicare payments, it is harder for our hospital to buy the latest equipment and compete in recruiting health care workers. Because of Medicare's low payment, Kossuth Regional Health Center is operating at a deficit even though we have had similar volume as last year and a slight increase in total revenue.

**Kossuth County is among the counties in the state with the highest percentage of elderly.** Medicare provides critical health care coverage for our most frail citizens and payment inequity is devastating to Iowa. According to the U.S. Census Bureau, 2000, Iowa has the largest percentage of people more than 85 years of age and has the fifth largest percentage of people more than 65 years of age. More than 20 percent of Kossuth County residents are more than 65 years of age. Kossuth County is also witnessing a decrease in population. According to the U.S. Census Bureau, 2000, Kossuth County had a (-7.7%) change in population from 1990-2000 with only five percent of its residents less than five years of age.

**Kossuth County seniors depend on Medicare.** More than 3,400 Kossuth County residents rely on Medicare for their health care. Kossuth Regional Health Center has come to rely on Medicare for almost 60 percent of its revenue. To make up the difference between what Medicare pays and what it costs to provide care forces our hospital to make up the difference by raising our charges and increasing property taxes to cover unreimbursed Medicare costs. Our residents already pay taxes to fund Medicare and then pay again in the form of increased medical insurance cost and/or property taxes. Our state population is declining which gives our hospital less of a tax base from which to subsidize Iowa's low Medicare payments.

**Disadvantage for recruitment.** Due to our low reimbursement rate, we are losing highly skilled work force. Because Medicare does not pay well, it is harder for our hospital to buy the latest equipment and compete for health care workers. With a national shortage of health care workers, Iowa hospitals struggle to recruit doctors, nurses, and other staff who can easily work in other States or commute to surrounding States. Kossuth Regional Health Center, in Algona, Iowa, is located only 20 miles from the Minnesota state border where reimbursements are higher than Iowa. Over the past few years we have lost countless numbers of professional staff to Southern Minnesota. I am personally aware of nurses who live in Algona and travel to Fairmont, Blue Earth, and even Minneapolis to work in hospitals where the market area pays higher wages. Minnesota receives higher payment for Medicare so it is not surprising that they are able to offer significantly higher wages.

**Kossuth Regional Health Center is operating at a deficit because of Medicare.** There is no greater economic problem facing our state than low Medicare payments. Sixty percent of our revenue comes from Medicare. The problem with the Medicare system is that it assumes it costs less to provide health care in Iowa than in more urban States. But prescriptions, medical equipment, and staffing costs are similar in Iowa. Iowa seniors rely on Medicare and are utilizing health care services 3-4 times the rate of younger patients.

Recent financial analysis by our auditors has helped us to understand the bitter reality of the poor payment that we receive. For the Fiscal Year ended June 30, 2002, of the number of outpatients that we treated we lost more than \$300,000. Medicare regulations, proven burdensome and unclear, resulted in our facility needing to return \$459,000.00 in Medicare Hold Harmless payments.

#### **Current Year**

Kossuth Regional Health Center has had similar volume as last year. We've had a slight increase in total patient revenues, which year-to-date are \$10,914,83. However, higher patient revenues result in higher contractual allowances which year-to-date totals more than \$3 million. Year-to-date, Kossuth Regional Health Center's loss from operations is \$438,000. There are real and significant changes that can be made to Medicare payments now that would begin to make it fair for Iowa.

First, to help hospitals pay their costs, authorize full inflationary updates of Medicare payments. Escalating clinician salaries, pharmaceutical costs, new technology, and soaring professional liability rates simply cannot be ignored. Medicare must pay its fair share.

Second, equalize the Medicare standard payment amount; make the 1.6 percent fix permanent. This provision within the Medicare formula has no basis in sound payment policy, and it needs to be eliminated.

Third, fix the Medicare wage index. This is a major fault in the Medicare payment system. Medicare's wage index is applied to 71 percent of hospital payment, but in reality only about 50 percent of Iowa hospital expenses go to wages and benefits. Kossuth Regional Health Center and every other hospital in Iowa are cheated by this simple lack of reality within the formula. The laborrelated share of Medicare payment must be reduced to reflect reality.

Finally, let's create a Medicare system that really does reward high-quality, costeffective health care. The current nearly inverse relationship between payment and quality is well documented. Studies have shown that States receiving the greatest Medicare payments tend to also have low quality and much wasted spending in their health care systems. Meanwhile, States like Iowa that have proven themselves to be high in both quality and cost efficiency are receiving the lowest payments.

Your Iowa constituents greatly appreciate your leadership and commitment on this issue. We are proud of your chairmanship of the Senate Finance Committee and your relationship with President Bush. Please let us know how we can help.

---

#### STATEMENT OF THE MADISON COUNTY HEALTH CARE SYSTEM

[SUBMITTED BY JILL KORDICK, CHIEF EXECUTIVE OFFICER]

I have prepared this written statement in order to express my concern regarding Medicare reimbursement specific to the Critical Access Hospital program.

The Madison County Health Care System received the Critical Access Hospital reimbursement designation on October 1, 2001. Fundamentally we had no choice, but to seek this designation as the outpatient prospective payment system was contributing to a negative operating margin. Because the Madison County Health Care System offers more than traditional hospital services, our true cost to offer services is not fully being recognized.

The following are examples of how the Critical Access Hospital Reimbursement Program fails to provide adequate payments to our Health System

- We are paid cost for Rehabilitation services for Medicare patients except they are subject to a salary equivalency limit. This is due to the Health System being a rural provider and not able to recruit therapists within the Medicare limits.
- Madison County Home Care is paid under a prospective payment system rather than cost. Costs for these services are expected to exceed payments by \$39,000 for this year.
- Middle River Hospice Services are paid a flat amount per day rather than cost. Cost per Medicare day exceeds reimbursement from Medicare by \$39.00 per day.
- Emergency department physicians; radiologist; and psychiatrist's fees are set by a schedule rather than our cost. The time associated with billing these services for the physician is a non-allowed expense per Medicare.
- Community health outreach is a non-allowed expense by Medicare.
- Not only are services such as home care and hospice paid on a prospective basis rather than cost, general and administrative overhead per Medicare is allocated to these departments which further increases costs that are considered non-allowed by Medicare.

What we are learning is that it is financially not in our best interest to offer service beyond those identified as traditional hospital services. I would echo the sentiments of Mr. Holcomb, who provided testimony at the Field Hearing on April 14, 2003. There are a number of considerations in addressing the inequities in the Medicare payment system, addressing out-dated formulas; inflationary updates, etc. Suffice it to say the challenges we face as a result of the Medicare reimbursement system are many. It is incumbent upon representatives of the Iowa delegation to work together to address this situation.

Thank you, Senator Grassley, for the opportunity to submit information on behalf of the Madison County Health Care System

---

STATEMENT OF THE MARENGO MEMORIAL HOSPITAL

[SUBMITTED BY GENICE A. MAROC, CHIEF EXECUTIVE OFFICER]

Senator Grassley, I appreciate the opportunity to have a written statement accepted into the Senate Finance Committee Field Hearing record of April 14, 2003. I would say that the low Medicare payment in Iowa has become a crisis situation, but, after 20 years of this crime being perpetrated against this state, it is well beyond a crisis. How long can such a situation continue before there is little or no care available to rural Iowans? And why has it continued so long with no relief being offered?

Here at Marengo Memorial Hospital we have another crisis that must be addressed soon. We have an aging facility which is more than 49 years old. The facility must be updated or services will suffer even more than they already have suffered. There is little possibility that we rejuvenate the facility under the current payment system with Iowa receiving half of what some States receive. Please give us the means to continue to provide the excellent care Iowa has been proven to provide. Our ability to provide specialty care, for example, is jeopardized by lack of space to provide exam rooms to visiting outreach specialists. We need to provide care in gastroenterology, otolaryngology, neurology, and, especially, surgery, but cannot because of lack of space. To continue to ask our aging population to travel 75 miles round trip to Cedar Rapids or Iowa City because Iowa receives half of what some States receive goes well beyond inconvenience.

What does Iowa have to offer physicians and nurses to come to our state or to continue to work in Iowa? We do not have the geography. We do not have the weather. We do not have the sports or cultural events or facilities. Add to that the enormous deficit in Medicare reimbursement, and it is easy to see why we lose to nearly everyone. We do not have mountains. We do not have oceans or any large body of water. We do not have perpetual summer. And then we say, please come to Iowa and make much less money. Work hard and provide excellent care, but you will not be fairly reimbursed.

Hospitals and physicians are, however, expected to comply with all the many rules and regulations that everyone else has to follow. Even though everyone knows that compliance is expensive. Iowa hospitals are reimbursed poorly; but they must spend the same dollars to comply. It would seem a bit fairer if Iowa hospitals were asked to comply with one half of the regulations. After all, that is how they are paid.

Medicare has embraced the Critical Access Hospital (CAH) program to help deliver care in rural areas. We are thankful for the Critical Access program. The impact of the poor Medicare payments would be much worse if Marengo Memorial Hospital were not a CAH. In fact, CAH status is the single thing that keeps our doors open. The actual impact in comparison of Medicare payments for PPS v. the CAH cost reimbursed system as of FYE 6/30/2002 is \$1,376,274. It has helped us compared to other non-critical access hospitals in the state, but we are still falling way behind other States, where, by the way, the critical access program exists, also.

The Critical Access Hospital program needs continual refinement. At Marengo Memorial Hospital, the ambulance service is a department of the hospital. Ambulance service, however, is not reimbursed by a cost based method as are other services. It seems that when the ambulance service is a department of the hospital, the payment should be according to the critical access system.

There is no reason at all to pay Louisiana so much and Iowa so little. There is not justification for that. There is not that much difference in the cost of providing care in these two States. That should be easy enough to determine. Iowa provides better care for less. But how much longer can Iowa do that? Not forever. Please stand up for the people of Iowa. Get this system fixed. Please.

---

STATEMENT OF THE MARY GREELEY MEDICAL CENTER

[SUBMITTED BY KIMBERLY A. RUSSEL, PRESIDENT AND CEO]

Mary Greeley Medical Center is a 220-bed community hospital located in Ames, Iowa. Mary Greeley is a regional medical center serving eighteen central Iowa counties. Fifty percent of Mary Greeley's patients are covered by the Medicare program.

Mary Greeley Medical Center has prided itself on being economically self-sufficient. As a cityowned hospital, Mary Greeley receives no tax support. Mary Greeley's margin on Medicare patients is currently -32.69%. It is increasingly difficult for Mary Greeley to continue the services the community expects in the face of ever declining Medicare reimbursement.

The impact on Mary Greeley Medical Center:

1. Mary Greeley Medical Center is losing approximately \$700,000 per year on its 19-bed Skilled Care Unit. This means that the medical center is subsidizing this Medicare program from its reserves. Mary Greeley Medical Center is no longer able to sustain this level of subsidy, and has now reduced the number of beds on this unit from nineteen beds to eleven beds. A new policy has also been implemented in which skilled care patients requesting transfer from other hospitals are not accepted at MGMC.

2. Mary Greeley Medical Center, together with Marshalltown Medical and Surgical Center, McFarland Clinic and the Iowa State Student Health Center, jointly fund the First Nurse call center. This is staffed by specially trained registered nurses who are available to answer health and medical questions from callers on a 24 hour basis. The service is free to callers. The First Nurse service is used by a high percentage of Medicare patients. Often, the First Nurse staff is able to provide callers with self-care advice which allows the caller to avoid a costly visit to a physician's office or to the Emergency Department. The First Nurse service is also used by people in central Iowa who have no health insurance coverage, but need access to services. Due to decreasing Medicare reimbursements, the supporters have had to reduce the annual budget for this service by \$40,000 per year. This means that the number of nurses who staff First Nurse have been reduced; and the callers are experiencing longer wait times and delays in receiving First Nurse advice.

3. Mary Greeley Medical Center is currently recruiting twelve physicians in varying specialties. Progress in physician recruitment has been extremely slow due to knowledge in the medical community of the low Medicare reimbursement in Iowa. Young physicians use this type of information to help them decide on a state in which to practice.

This situation can be rectified by Congress with the following measures:

- Authorize full inflationary updates of Medicare payments.
- Equalize the Medicare standard payment amount, making the 1.6% fix permanent.
- Achieve fairness in the Medicare wage index by applying it to 50% of hospital expenses rather than 71 %.

Iowans are depending on the leadership of the Senate Finance Committee to restore equity to the Medicare system.

---

## STATEMENT OF THE MERCY MEDICAL CENTER (CEDAR RAPIDS, IOWA)

[SUBMITTED BY A. JAMES TINKER, PRESIDENT/CEO]

Dear Senator Grassley:

I am Jim Tinker, President and CEO of Mercy Medical Center in Cedar Rapids, Iowa. I appreciate the opportunity to provide a written statement concerning the Medicare reimbursement issues that impact not only my hospital, Mercy Medical Center, but all health care providers in Iowa.

It is well documented that Iowa hospitals provide some of the highest quality care in the nation for Medicare patients, even while the Medicare payment system reimburses Iowa hospitals and physicians with the lowest payments in the nation. It is also well documented that Iowa is a state that takes care of its people, especially those who are most vulnerable—the elderly, the poor, the disabled. Medicare helps us do that, but it's a flawed system that hurts our hospitals because it rewards inefficient and wasteful providers, while underpaying Iowa and other more efficient States. We must change this system.

The belief that more medical care is better care is deeply entrenched in our system. Findings suggest that if Medicare could achieve spending levels across the country comparable to those in the regions where it pays least for care, it could realize savings of up to 30% over current expenditures without compromising quality of care. That would free up resources to finance a prescription drug benefit for Medicare recipients or to bolster the program's long-term financial position. But, as we all know, winning broad support for these findings and translating them into practice is difficult. There is a lack of information available to assist doctors and patients in deciding which services offer little benefit in specific cases and thus, how to reduce their use without adversely affecting the outcome of care. And, as we have seen so often lately, the backlash of managed care against cost containment tactics shows that many patients are suspicious that any strategies to reduce care would be in their interest.

As I stated earlier, Iowa is ranked high for quality of care provided to Medicare beneficiaries. That is positive news for sure; however, the bad news is that Iowa's high quality of health care that has been so under reimbursed in the past will cause Iowans to be under reimbursed in the future. In other words, even though everyone realizes that Iowa is currently being penalized, there is nothing in place to begin to fix the problem going forward.

The worst side effect of Iowa's high level of health care quality is that because the state is so efficient, sorely needed health care dollars are being sent to States that are far less efficient. Iowans are effectively subsidizing these higher cost States.

Taxpayers here are actually paying for States like Florida that are less efficient. We are not exporters of our Society Security taxes for Medicare. Iowans really should be livid about this. What cools them off is the fact they can still walk into the doctor's office or the emergency room and get good care. While Iowans might not get a good feeling about all the hair pulling we're doing to keep providing that quality care, all they know is that we're able to keep doing it.

But while the quality of care in Iowa's hospitals is recognized as one of the best, the state's Medicare payments remain last in the nation. Surveys examined 22 quality of care indicators abstracted from statewide random samples of medical records for inpatient fee-for-service care, and from Medicare beneficiary surveys or Medicare claims for outpatient care. The highest geographic concentration of high quality-ranking States is in the upper midwest, with North Dakota, Minnesota, Nebraska and Wisconsin joining Iowa in the top quartile of the quality ranking. Notably, four of the ten worst reimbursed States, including Iowa, are ranked among the top 10 for quality.

Let me next mention some facts about my particular hospital. From 1998 to 2000, our Medicare margin went from a gain of \$1.4 million to a loss of \$1.5 million or a \$2.9 million change. We realize the Medicare program was not introduced to make money for the providers, but it should not be costing the providers either.

When I'm asked for real life examples of Medicare reimbursement problems, I often cite the following actual cases, which I will, for purposes of this written statement, identify simply as Mary and John:

Mary was a Medicare patient with Medicaid paying secondary. She first arrived at Mercy as an acute care patient in July 2000. On five separate occasions, Mary was lowered to a skilled level of care following an acute stay. Medicaid paid the SNF portion in the acute care bed. Unfortunately for Mary, she remained hospitalized at Mercy Medical Center until January 2001. During this time, Mercy Medical Center was paid \$173,265 for services that cost us \$276,289, resulting in a loss of \$103,024.



John was also a Medicare patient with Medicaid paying secondary. He first arrived at our facility in January 2001. He left for 17 days in February before returning. During the time he was here, he was classified as acute care on three separate occasions. Following the acute stay, he was dropped to a long-term care level. None of the area nursing homes would initially take him since he was a dialysis patient and had several behavioral problems. He was finally accepted by a care facility in May 2002. During his 16 month stay, our expenses were \$348,520 excluding his dialysis care. We were paid only \$75,231 which resulted in a loss of \$273,289.

Senator Grassley, I have many more examples, but to put it quite simply, Iowans are being cheated. We are penalized for being responsible. The Medicare payment system isn't fair, and it needs to be changed.

In closing, I have one final comment. Iowa loses more money treating seniors than any other state according to a 2001 report to Congress. For every dollar an Iowa hospital spends on health care for a Medicare recipient, it is reimbursed on average only 93.5 cents. That means Iowa hospitals must charge other patients more to make up for being shortchanged by Medicare. This "cost shifting" is unfair and ultimately penalizes Iowa businesses and all of us who must pick up the difference in costs.

Moreover, lower Medicare reimbursement also translates into lower salaries for nurses and others working in the medical profession. For Iowa, it means that an estimated \$1 billion less is coming into the economy of our state than if we were reimbursed at the national average. It means that rural hospitals have to struggle even harder to survive, and if a rural hospital shuts down, the life of the entire community is compromised. We need to change this crazy-quilt system of Medicare payments now or we will soon have even fewer rural hospitals left to serve our citizens.

We in Iowa greatly appreciate your leadership and commitment to improving Medicare payments. Please let us know how we can help you to turn this problem around.

---

STATEMENT OF THE MERCY MEDICAL CENTER (CLINTON, IOWA)

Mercy Medical Center in Clinton provides services to Medicare beneficiaries across a wide spectrum of services including Acute Hospital care, skilled nursing care, ambulatory surgery, home health skilled nursing care, home medical equipment and hospice care. The Medicare program has continually not reimbursed Mercy for the cost of providing these essential services to our community residents.

Medicare Margins: The above noted services to Medicare beneficiaries have generated losses over the past 5 years in excess of **\$19 million**. These losses cause an unfair burden to the economy of the Clinton area and seriously threaten the future of economic development in our community. Specifically:

- the unequalized standard inpatient payment amount results in excess of \$200,000 annually in payment inequity
- the erroneous application of the wage index to payments (71% vs. 50%) has a negative impact of another \$200,000 annually.

The impact of Iowa and the Clinton community receiving reimbursement from Medicare that is dead last is significant.

We are not able to attract the necessary medical staff and clinical staff to provide care to our residents. Current shortages in physician specialties are directly due to low payment to physicians in Iowa. Our community is in desperate need of anesthesiologists and surgeons which requires the use of expensive locum tenens physicians. Physicians are not willing to relocate to a community or state where the payment does not allow them to provide the quality care they can provide in higher paying locations. In addition, we are not able to compete with our border States for critical staff positions that are increasing shortage in our area as well as nationally. Due to our lower reimbursement levels, Iowa facilities cannot provide the same level of salaries and benefits as hospitals in other States.

Payment shortfalls are causing Mercy to evaluate closing programs of benefit to our community. One program at Mercy called Community Case Management is at risk to be eliminated if this problem is not resolved. The Community Case Management program provides monitoring and home visit services to residents that "fall between the cracks". It provides medication management and other health services that are not covered by Medicare and Medicaid so that these residents will maintain their health and avoid becoming so sick as to need expensive emergency room and inpatient care at a cost to those government programs.

We urge the committee to take action to correct the government payment inequities to the Clinton community so that we may continue to provide quality, necessary healthcare services to Clintonians. It is just a matter of being fair.

---

STATEMENT OF THE MERCY MEDICAL CENTER (DES MOINES, IOWA)

[SUBMITTED BY JOSEPH LEVALLEY, SENIOR VICE PRESIDENT AND SUSAN JOHNSON,  
REIMBURSEMENT MANAGER]

Senator Grassley:

Thank you for the opportunity to provide written testimony for the U.S. Senate Committee on Finance hearing regarding “A Fair Deal for Iowa: Fixing Medicare Reimbursement”. In the past—in previous discussions, in testimony during the hearing and in other written testimony—you have heard many compelling arguments for improving the fairness of the Medicare system. On behalf of the more than 6,000 employees, volunteers and medical staff at Mercy-Des Moines, and on behalf of the hundreds of thousands of patients and family members we serve every year, I am writing to urge you to do all you can to improve Medicare reimbursement for our organization and others like us.

As was testified to by J. Michael Earley of the Bankers Trust Company, the reimbursement rate at Mercy-Des Moines, as controlled by the wage index portion of the payment formula, is lower than that of the smallest rural hospital in Minnesota. As you know, Minnesota is a state receiving unfairly low Medicare reimbursements as well. This unfair formula results in Mercy-Des Moines receiving millions of dollars less every year than it would receive if it received the payment rates of rural Minnesota or virtually anywhere else in the nation. Clearly, there is something fundamentally flawed in the Medicare system.

This unfairness impacts every aspect of health care delivery here. It reduces what we are able to pay our staff, thereby limiting our ability to attract and retain the best people. It reduces the amount of capital available for equipment and facilities replacement and modernization. It reduces the resources available to provide needed services that may not be profitable, and to aggressively reach out with all services to the poor and underserved.

As you have heard, unfairly low reimbursement also negatively impacts economic development in our state, particularly in light of the fact that some States are reimbursed so well by Medicare that the hospitals there earn large positive margins on Medicare business. This not only brings money to their States that is used to unfairly compete for professional staff and to enhance services, it provides a large influx of federal money that boosts local economies. In addition, we have been told hospitals in well-reimbursed States use their positive margins to subsidize larger discounts to private payers. This impacts the cost of health insurance for private business—a fact that will take an increasing toll on Iowa’s recruitment of business and industry.

The following more specific information has been prepared in an effort to provide you, the Committee and its staff with additional information that can be used in analyzing, understanding and addressing this issue.

*Measurement Issues*

- Both Ms. DeParle and Ms. Wilensky testified at the April 14 hearing that the average payment per beneficiary is not a good measure of Medicare equity. However, there are disputes with any form of measurement and regardless of the disagreements about how to measure the adequacy of payments to Iowa providers, there are valid concerns with actual payments made to Iowa providers that need to be addressed.
- Ms. DeParle suggests that a better measure is to compare expenditures for beneficiaries in traditional fee-for-service programs to enable capture of healthcare expenses regardless of where they are provided. This may be a better measure of whether or not the beneficiaries are receiving health care services, but it fails to measure whether or not Iowa providers are receiving adequate reimbursement. If payments to non-Iowa providers are included in the calculation, the calculation will be meaningless as far as measuring whether or not payments and services available in the state of Iowa are adequate. In addition, it will mask a potential access problem. If beneficiaries are going out of state for their care, it may be because the care is not available within Iowa and if that is the case, health care availability needs to be addressed as a critical issue. How far are Iowa Medicare residents traveling for their care and is it due to choice or because services are not available closer to home?

- Out-migration by state should be measured to identify States where there are potential access issues.
- Ms. DeParle made the point that removing special payments to hospitals (like medical education payments), results in a rate of service use that varies much less by state. These special payments are “real money” going to hospitals in these States and it doesn’t make sense to remove it for comparison purposes. This is a form of subsidy that these hospitals use to support their overall operations. A similar subsidy could be, and perhaps should be, established for States with high percentages of Medicare patients.

*Beneficiary Out-of-Pocket Expenses*

- Ms. DeParle’s testimony points out that a very high percentage of Iowa Medicare beneficiaries have some form of supplemental coverage. One of the major reasons for this is the coverage provided by the Medicaid program for dually eligible individuals. This is a benefit that has been considered for elimination by the state Medicaid program.
- The point that beneficiaries pay less for Medicare supplemental coverage than beneficiaries in other States makes perfect sense. The major expense of Medicare supplemental plans is for the deductibles and co-pay amounts. Because Medicare payments are lower in Iowa, obviously, co-payments will also be lower, resulting in lower premiums. This is further support for our argument that Iowa providers are underpaid.
- Iowans pay the same percentage of their income in Medicare payroll taxes as other Americans, but Iowans receive fewer benefits. As you know, fewer benefits are available in part because Medicare managed care plans are not offered in Iowa. However, Iowans also receive fewer benefits in the form of older health care facilities, fewer doctors (47th in the nation per capita, according to the Iowa Medical Society.), and fewer available services. Currently in Des Moines, for example, there are long waits for many non-emergent medical services.

*Hospital Wage Index*

- Ms. DeParle stated that Iowa wage indices are “comparable” to other States near Iowa. Comparable is a very broad term and seemingly minor differences in wage indexes can result in significant variances in payment. For example, our wage index of .8827 and Grand Fork, North Dakota’s wage index of .9243 look comparable, but in fact the payment difference is about \$3,000,000 annually.
- In another example, Lincoln, Nebraska, a city approximately the size of Des Moines, located in the middle of Nebraska has a much higher wage index than Des Moines, Iowa. This results in a payment difference of over \$7,000,000 annually. Omaha, Nebraska, less than two hours away, has a wage index that results in payments of nearly \$8,000,000 more annually than the same services provided in Des Moines. These payment variances are computed using strictly the base rate adjusted for area wage indexes and do not include any of the “special payments” to which Ms. DeParle referred.
- In a discussion after the hearing, Ms. DeParle stated that she was surprised to learn that Des Moines’ wage index is lower than many rural areas and lower than communities such as Lincoln, Neb. She noted that this deserves some investigation, a point our organization has been making for a long time.
- Unfortunately, the wage index calculation process has become so complex that CMS cannot possibly anticipate all of the ways that providers can maximize or mis-state the data used to compute the eventual wage index. Medicare utilization and previous payment rates have a dramatic impact on the wage index calculation. It would be far more logical to use regional labor indices to establish wage indexes for regions or States. This may re-establish one of the initial purposes of prospective payment, which was to encourage and reward efficiency. Under the current system, hospitals with higher costs are rewarded with higher payments, a complete reversal of the intent of prospective payment.

*Margins: the Best Indicator of Serious Problems*

- The Medicare margin information should be the most important indicator when looking at the equity of Medicare payments. The negative margins at Iowa hospitals are a warning sign that the current Medicare payment rates cannot sustain an adequate healthcare system in the state for an extended period of time, particularly with the rapidly increasing elderly population.
- According to the Iowa Hospital Association, the average Medicare margin in Iowa is a NEGATIVE 6.5%. This is in a state in which Medicare patients comprise nearly half of the business done by hospitals. Clearly, this is NOT a sustainable financial system.

Thank you again for the opportunity to comment.

STATEMENT OF THE MERRILL PIONEER COMMUNITY HOSPITAL

[SUBMITTED BY GORDON U. SMITH, ADMINISTRATOR]

Chairman Grassley:

Thank you for the opportunity to present this testimony in regard to Medicare payments for the hospitals within the state of Iowa.

Merrill Pioneer Community Hospital is a 25 bed acute care hospital and is the sole hospital within Lyon County. It was previously designated as a Medicare Dependent Hospital (MDH) until two years ago when it obtained Critical Access Hospital (CAH) status. Combined within the hospital's corporate structure is a medical clinic located in Rock Rapids and its two satellite clinics located in George and Doon, Iowa.

I am certain others presenting testimony today will cover their perspectives which will relate to other Medicare payment issues so I will concentrate my comments on the needs of CAHs, and specifically on our facility.

As you know, the enabling legislation for CAHs stated that these facilities are to be reimbursed on a cost basis for the services they provide. Some of us who have been around since before the prospective payment system was adopted for Medicare payments thought that the CAH legislation would truly mean we would be reverting to the system in place until 1982. Unfortunately, we were wrong!

As mentioned above, this hospital is attached to a medical clinic. In many such situations, one may find laboratory and radiology equipment within both the hospital and clinic setting. Our medical clinic does not duplicate radiology or laboratory services as this would be a waste of funds for both equipment and manpower. However, since the laboratory is contained within the hospital, the Medicare statutes deem it to be a "reference" laboratory when performing tests for clinic patients. This means that instead of being paid on a cost basis, we are instead paid on a *fee schedule basis*. By Medicare's definitions, these patients are classified as "nonpatients".

At the same time, the laboratory may be doing this same procedure for a Medicare patient who has not entered into the care system through the clinic and is being treated on an outpatient basis. The Medicare payment for the second patient is made on a *cost basis*. Thus, the same test is being accomplished, by the same personnel, using the same equipment, but the payment method is different. This would be the similar to a farmer having his hog price determined solely on whether or not the purchaser came into the sale barn by the front door or by the back door. It simply makes no sense!

Perhaps the best way to illustrate the payment disparities is through examples of some common laboratory tests. In one instance, the fee schedule reimburses \$4.89 while the outpatient rate is \$21.45. In another case, the fee schedule is \$9.04 and the outpatient payment amounts to \$21.45. In a third test, the fee schedule is \$14.77 as compared to \$39.65. Therefore, you can see that the Medicare payments vary by 169% to 338%. Yet, these are the same procedures, performed by the same personnel, using the same equipment. Additionally, since the CAH reimbursement is based on cost, you can readily see that the laboratory procedures performed for clinic patients are done at a substantial loss, even by Medicare's definition!

We have a second concern and that is with the hospital's ability to maintain its infrastructure. Over the years of operating under the prospective payment system, the facility was forced to use much of its reserves to maintain the operations. Thus, we have a 45 year old facility that is in dire need of upgrading. In other words, we are attempting to provide 2003 patient care in a structure built to meet patient needs in 1958. You can only imagine attempting to provide services that did not even exist in 1958 in such a physical plant.

Additionally, the facility has been cited for numerous fire code deficiencies related to the building. These will consume a substantial amount of the limited reserves onhand.

Simply stated, there are limited reserves to accomplish any upgrades or remodeling to the building. At the present time, the prospect of borrowing the funds is remote since the facility lacks the ability to make payments on the debt. Therefore, we need some form of return on equity to be able to secure the necessary funding to improve the physical plant.

In conclusion, the laboratory reimbursement inequities need to be remedied, (cost based reimbursement for all tests performed for Medicare recipients), and hospitals which serve a high proportion of Medicare recipients need to have a return on equity built into the payment mechanism.

Again, thank you for the opportunity to explain our situation to your committee.

STATEMENT OF THE NORTHWEST IOWA HEALTH CENTER

[SUBMITTED BY BARRY W. WHITSELL, ASSISTANT ADMINISTRATOR/CHIEF FINANCIAL OFFICER]

Dear Senator Grassley:

Thank you for accepting written statements as a supplement to the testimony being provided at the hearing in Des Moines on April 14, 2003. I welcome the opportunity to be a component for change in the Medicare System.

Northwest Iowa Health Center (NIHC) is located in Sheldon, a community of approximately 5,000 people. The service area of NIHC encompasses the health care needs of over 12,000 Iowans. Of this population that we serve, approximately 15% are recipients of Medicare benefits. This population accounts for 46% of the gross revenue generated by NIHC. As you are aware the inequities of the current Medicare reimbursement system greatly penalize Iowa hospitals for the care provided to Medicare patients versus other States. The result of this inequitable payment means that NIHC is losing about 25 cents on the dollar each time we treat a Medicare patient. This shortfall in reimbursement has not prevented these Medicare patients from receiving top quality care compared to other States in the country. It is indeed an irony that the state that receives the lowest reimbursement provides some of the highest quality care and those States that receive the highest reimbursement provide some of the lowest quality care. This inverse relationship must be reversed and I implore you to be the catalyst for change in this endeavor.

The current payment methodology places Iowa hospitals at a disadvantage in terms of employee recruitment and retention. With regard to retention, shortages in the fields of nursing, and laboratory and radiology technicians has put pressure on hospitals like NIHC in Iowa to continue to raise the salary levels of these positions to prevent an exodus of these professionals. Because of the losses that we are experiencing in treating Medicare patients we cannot afford to pay top salaries in our retention and recruitment efforts. This has resulted in vacancies in our hospital and recruitment searches that have lasted in excess of one year. Due to these vacancies an extra burden is placed on existing staff in filling shifts and taking call status and the attrition rate will increase due to burnout thus compounding the existing problems of retention and recruitment. This problem is grounded in the Medicare wage index. Medicare's wage index applies to 71 percent of a hospital's payment when at NIHC 47 percent of our expenses are attributable to wages and benefits. The result is that NIHC is penalized to the tune of about \$200,000 by the lack of reality within this formula. The solution is simple; the labor related share of Medicare payment must be reduced to reflect existing reality.

As one of the largest employers in our community and region the economic impact of NIHC is tremendous. Assuming that each dollar of our \$17 million dollar budget rolls over just three times NIHC has an economic impact in Northwest Iowa of about \$51 million. Ensuring that this vital business continues to be able to meet the health care needs of our patients must result in fundamental changes to the Medicare program while insuring that full inflationary updates to the Medicare payments are authorized. Two fundamental changes that must be pursued are outlined below.

One, the PPS/transitional payment for small rural hospitals must be continued. This payment is scheduled to expire in December 2003 for NIHC and it will result in an additional loss of \$90,000. Currently, NIHC is reimbursed only 41 cents on the dollar for care provided to Medicare recipients on an outpatient basis. The loss of the transitional Payment will further deepen the cost shifting that already takes place due to the shortfall of Medicare payments. This cost shifting places an unfair burden of supplementing the care provided to Medicare patients on employers and employees with private insurance. One could argue this is an additional tax and it is leading to double digit premium increases and partly responsible for the growth in the number of uninsured people.

The second fundamental change must be to equalize the Medicare Standard payment amount; make the 1.6 percent fix permanent. This provision within the Medicare formula must be eliminated. At NIHC such a change would have a positive financial impact and begin to correct the inequities of the current payment methodology.

The health care delivery system of NIHC and the other hospitals in the state of Iowa has been applauded for the quality of the care that is being delivered but the time has come for Congress to pursue avenues to bring Medicare equality to reality.

Iowa and its Medicare patients are being cheated under the current Medicare environment and we need you to be our voice in Congress and bring fairness to the Medicare System.

By your hosting this hearing I recognize that you understand and feel committed to this cause and I thank you for your leadership on our behalf. Iowa can be proud of the record that you have demonstrated in the past and we look forward to the success that you will garner on our behalf in the future.

Thank you for your attention and the opportunity to speak on this very important issue.

---

STATEMENT OF THE PALMER LUTHERAN HEALTH CENTER

[SUBMITTED BY DEBRAH CHENSOLD, PRESIDENT/CEO]

Thank You, Senator Grassley for allowing me to comment on the hearing you recently held on Medicare payments to Hospitals. I am the CEO of Palmer Lutheran Health Center located in West Union, Iowa. Our community has a population of approximately 3000 people. The presence of a hospital in this community is of vital importance to its economic stability and vitality. Certainly West Union is not unique in that fact. I am quite sure that any community that is fortunate enough to have a viable hospital would echo that same sentiment.

Palmer Lutheran Health Center is one of the largest employers in West Union. We draw employees from a number of our neighboring communities. The influx of these people into West Union strengthens our retail market. The economic development committee has shown the importance of our hospital many times as they have recruited new business and industry into our community.

In 2001 Palmer Lutheran Health Center became a critical access hospital. Our Medicare reimbursement has improved dramatically. That change literally saved us from closing our doors and devastating our community. We were experiencing significant losses under the prior Medicare reimbursement methodology. At that time PPS had not even been implemented which was sure to reduce our payments even further. We would not have survived under that payment methodology. Thankfully, our financial situation has improved and critical access has made it possible to maintain access to vital health care services.

I believe there are still some improvements that need to be made to the critical access program. I believe all services that a critical access hospital provides should be cost based reimbursed. Home care services are especially important to us. We have the only Home care, Hospice and Community Health Services available in our community so it is vitally important that we be able to maintain these services. Another service that needs to be looked at is our local EMS. It would be most beneficial if the 30-mile limit for ambulance services was dropped so those services could also be cost based reimbursed. It goes without saying how devastating it would be if we lost our local EMS services in rural Iowa.

Prior to becoming a critical access hospital we were receiving 40% of our charges for 60% of our patients. I often asked business owners if they would accept 40% of their charges for the merchandise they sold or the services they rendered. They would laugh and say, "no way." I then asked them what would happen if they were mandated to do so or the majority of their customers would go away. Their answer was always the same; "We could not keep our doors open." Yet that is exactly what we are asking Iowa Hospital to do!

My fear is that if the current inequities of the Medicare program are not corrected, more Iowa hospitals will be facing the same bleak financial picture that we were, prior to critical access. Small hospitals such as ours suffered sooner because we did not have the mix of private pay patients to offset the Medicare reimbursement. There are many hospitals in Iowa that do not nor will they ever meet the requirements to become a critical access hospital. They are suffering and they will, at a minimum, be forced to cut services and in the worst case scenario some may be forced to close their doors. Something must be done soon to correct the inequity of the Medicare reimbursement system so we do not have to experience that loss.

We need to ask ourselves some serious questions. How long will the private sector accept responsibility to subsidize the Medicare program? How long will Iowa hospitals be able to maintain services when they cannot recruit or retain quality staff because they cannot pay the same wages as our neighboring States? How long will Iowa be able to maintain our quality rating of number 6 in the nation when physicians are not even considering locating in Iowa because of our low Medicare reimbursement? How long will Iowa Hospitals be able to sustain the losses that they are experiencing due to the inequity of the Medicare program? How do we explain to

our fellow Iowans why it is OK that they are being treated unfairly? How long will Iowans accept the fact that nothing can be done about the inequity because it is a difficult problem?

I am extremely grateful for what the critical access program has done for Palmer Lutheran Health Center and other small rural hospitals. Senator Grassley, I want to thank you personally for being such an integral part in helping make this become a reality in Iowa. But, I must look at our entire health care system in Iowa because I know that if *all* hospitals are not healthy we will *all* pay the price in the end. Thank you for allowing me an opportunity to respond to this important issue.

---

STATEMENT OF THE TRINITY REGIONAL MEDICAL CENTER

[SUBMITTED BY TOM TIBBITTS, CHIEF EXECUTIVE OFFICER]

The purpose of this letter is to inform your committee of the hardships that the current Medicare reimbursement methodology is causing for our community hospital. Trinity Regional Medical Center is a Rural Referral Center serving north central Iowa. The hospital is licensed for 200 beds and currently has 170 staffed beds. Approximately 65% of our business are Medicare patients.

*Medicare Margins*

Our Medicare margin is no different than the statewide average. We currently receive reimbursement from Medicare that is below our cost of providing those services. At present we receive approximately 93 cents for every dollar of cost we incur for providing services for Medicare patients. How can we continue to provide services below our cost? Our costs continue to increase and our hospital continues to receive declining reimbursement.

*Standard Amount*

The current standard amount hospitals receive from Medicare is not even close to the current labor and non-labor portions of our expenses. At present the labor portion of the standardized amount is 71 %. In reality our hospital's labor portion of our total expenses is 46%. It is unfair to adjust 71 % of the standardized amount by our wage index when our labor portion is 46% of our total costs.

*Employee/Physician Recruitment*

The hardships caused by the unfair reimbursement are too numerous to mention in this summary. However one of the major hardships is employee/physician recruitment. In light of the nation wide nursing shortage, maintaining competitive nursing and other staff salaries is extremely important. This hardship also puts extreme pressure on physician recruitment. Physicians are reluctant to come to Iowa because of the low reimbursement.

*Services Offered/Community Benefit*

Trinity is currently reviewing the various services offered and may have to cease some of the current services. Trinity also has tithed 10% of its system-operating margin for community needs and has established a committee of community leaders to administer the program. This program may have to be terminated in light of the current reimbursement.

Thank you for the opportunity to voice our concerns. Please use this letter as a testimonial to the seriousness of the current Medicare reimbursement situation.

