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EXECUTIVE SESSION

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TUESDAY, JUNE 20, 1978

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United States Senate,  
Committee on Finance,  
Washington, D.C.

The Committee met, pursuant to notice, at 10:10 a.m. in room 2221, Dirksen Senate Office Building, Hon.-Russell B. Long, Chairman of the Committee, presiding.

Present: Senators Long, Talmadge, Byrd, Bentsen, Hathaway, Moynihan, Curtis, Hansen, Dole, Packwood, Roth and Danforth.

The Chairman. The Committee will come to order.

Let me just cover a thing or two that maybe we can dispose of in short order, and I would suggest also that Senator Moynihan -- we do not have any indication of what Senators will be here. Senator Ribicoff cannot be here. You might want to slide over toward the head of the table.

Let me ask you, the first order of business on this proposed agenda is a matter dealing with the nomination of Donald C. Lubick. Is there any remaining opposition to that nomination? Does anybody want to hold that nomination up any longer?

I do not think there is any, to my knowledge.

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1 If this is no objection, without objection we will report  
2 that nomination of Donald C. Lubick to be Treasury Assistant  
3 Secretary for Tax Policy.

4 Next, waiver of Budget Act point of order. Explain that.

5 Mr. Stern. Yes, sir.

6 The Committee acted on the International Trade Commission  
7 authorization bill about two and a half weeks before the May  
8 15th deadline for reporting out authorizing legislation.  
9 However, the Committee agreed that it would do it in the form  
10 of amending the House bill when it came over. In fact, the  
11 House bill did not come over until after May 15th, so the  
12 bill reported by the Committee would be subject to a point of  
13 order because it is an authorizing bill reported out after  
14 May 15th.

15 What is needed is a fairly routine waiver of the point  
16 of order, which is reported in the form of a resolution. The  
17 Budget Committee then approves that, and then the bill can be  
18 taken up on the Floor.

19 I do not know of any Budget Committee opposition to this.  
20 This is simply a procedural step.

21 Senator Curtis. It does not involve any amount?

22 Mr. Stern. No. The resolution permits the Senate to  
23 take up the bill that already has been recorded. It is rather  
24 like a rule in the House, in that sense.

25 The Chairman. I do not know of any reason why we should

1 not take up that matter.

2 Without objection, we will act for a waiver of the point  
3 of order.

4 The thought was we could have reported this measure out,  
5 the authorization for the International Trade Commission. We  
6 thought the House would send us a bill and we waited for the  
7 House bill to get here and we thought it would be here soon.  
8 But now it is subject to a point of order on the budget proce-  
9 dure.

10 They should waive it. Without objection, we will ask for  
11 that waiver, then.

12 Now, tell us about this: Budget Act allocation by the  
13 Finance Committee?

14 Mr. Stern. Under the Budget Act, after the resolution  
15 is agreed to by the Congress, each Committee is given an over-  
16 all allocation and the Committee must then file a report show-  
17 ing how they distribute that allocation of spending amounts  
18 by categories, such as income security, health and so forth.

19 The amount allocated by the Budget Committee is shown in  
20 your Attachment B here on the table on the back. Basically,  
21 we do not foresee any problem with their proposed allocation  
22 or the assumptions upon which they derive their figure. We  
23 think that that allows for the kind of new legislation that  
24 we understand that the Committee contemplates in the spending  
25 area.

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1 The Chairman. You think that is something we can live  
2 with?

3 Mr. Stern. Yes, sir.

4 So we would simply propose using the numbers.

5 The Chairman. If there is no objection, then, we will  
6 approve that then.

7 Now, number 4. Older Americans Act provision affecting  
8 social security, document C.

9 Mr. Stern. When the Human Resources Committee reported  
10 out the Older Americans Act, their bill included a provision  
11 which was quite sweeping.

12 The Chairman. What?

13 Mr. Stern. The bill that the Human Resources Committee  
14 reported out -- let me start again.

15 When the Human Resources Committee reported out a bill  
16 extending the Older Americans Act and amending it, they inclu-  
17 ded a rather sweeping provision that said no part of the cost  
18 of any project under any Title of this Act may be treated as  
19 income or benefits under any Title of this Act for the purpose  
20 of any other program or provision of state or Federal law.

21 This would mean that anything received under the Older  
22 Americans Act would now be treated as income for purposes of  
23 taxation, Social Security retirement test, Supplemental  
24 Security Income, or anything else.

25 This was something that we wanted to raise with you,

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1 because we were quite concerned about its sweeping effect.

2 Since the materials were sent out, the Human Resources  
3 Committee has suggested that they would propose an amendment  
4 which instead would say that the wages and salaries would be  
5 treated as income just as it is now, but that the other benefits  
6 that people might get, such as a free meal or transportation,  
7 those kinds of things would not be considered income for  
8 purposes of other Federal programs. And the staff feels that  
9 would be an acceptable compromise.

10 It was mainly the cash income that we were concerned  
11 about.

12 Senator Curtis. May I ask you a question there?

13 Was it our concern how these things are treated or whether  
14 or not this Committee has the right to determine tax matters  
15 as well as what shall be counted as income for various welfare  
16 programs?

17 Mr. Stern. I think it is partly jurisdictional, but  
18 mostly substantive. I do not think that you would have a  
19 situation that anyone with a particular program that they thought  
20 was worthwhile would then want to say, well, the income from  
21 this program would not be treated as income for purposes of  
22 any Federal law.

23 That kind of thing could proliferate easily.

24 Senator Curtis. They are still doing it?

25 Mr. Stern. Even under the compromise, they would be doing

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1 it with respect to benefits in kind, such as transportation  
2 or meals provided, things like that. They would not be  
3 treating cash income differently under the Older Americans  
4 Act than under any other law.

5 Senator Curtis. Is it your contention that we would  
6 have a different rule for different categories of people as  
7 to whether or not fringe benefits were taxable income? Could  
8 the Congress maintain that free meals were not income to older  
9 Americans but they were income to workers who got a subsidized  
10 meal at noon?

11 Mr. Stern. I think the question is pretty much academic  
12 in this case because, in order to be eligible to be in these  
13 programs, you have to have a pretty low income and I guess  
14 that most older people participating in this program are not  
15 taxed at all. But, in theory, it would set up a difference.

16 Senator Curtis. I am not going to prolong it, but I do  
17 think we have a jurisdictional thing here that is rather  
18 important. A good portion of the bills that are submitted  
19 to this Committee we are told that we must hurry to enact  
20 because the Human Resources Committee has already enacted, and  
21 has the bill on the Floor.

22 If they make the same progress that they made in the last  
23 three or four years, they have considerable jurisdiction. But  
24 I will not press the matter any farther.

25 Senator Dole. You are suggesting that we adopt the

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1 compromise, strike out the language and not include "in  
2 kind"?

3 Mr. Stern. Yes.

4 Senator Curtis. Is the Act before us?

5 Mr. Stern. No, sir. It is on the Senate calendar. It  
6 was reported out by the Human Resources Committee. What I  
7 am suggesting is that the Human Resources Committee is going  
8 to propose this amendment anyway, but that ought to take care  
9 of the matter.

10 Senator Dole. That is what Senator Eagleton has in mind?

11 Mr. Stern. Yes, sir.

12 I may have spoke too broadly before, but the jobs program  
13 under the Older American Act, that is the one we are most con-  
14 cerned about and that is the one where you have to be low  
15 income. So that I do not think that the question of taxing  
16 fringe benefits would have much meaning here.

17 So basically, at this point, is to be decided what the  
18 Human Resources Committee has proposed to do. We are not  
19 recommending any action.

20 Mr. Stern. You are recommending it be deleted?

21 The Chairman. We are not recommending that, since they  
22 are going to take action anyway to restrict their provision,  
23 so that it does not affect salaries and wages. Salaries and  
24 wages will be treated just as they are under Finance Committee  
25 law now, that their proposal is acceptable.

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1 The Chairman. Are they going to undertake to say,  
2 though, that now these fringe benefits that they propose  
3 would be taxable?

4 Mr. Stern. In effect, yes, although I do not think  
5 that the people involved -- I think very few of the people  
6 involved would be paying taxes anyway.

7 The Chairman. If you do not watch out, that is where you  
8 get into trouble. You find some person has \$200,000 a year  
9 and then you say none of this will be taxed. Then you have  
10 some wealthy person not paying any taxes. Just like the  
11 unemployment insurance.

12 We have situations where some person makes a large amount  
13 of money in the year, during some period he is employed. So  
14 you have a very wealthy person getting a lot of money, maybe  
15 wealthy in his own right, and drawing unemployment, food  
16 stamps, or something like that, even though it was never  
17 intended for that person.

18 I would think that that should be considered before the  
19 fact, rather than after the fact.

20 What do you do if somebody is very wealthy? Are you  
21 going to say, all right, nobody pays any taxes on this income?

22 If you do not watch out, further on down the road that  
23 will be seized upon by some very wise people to make a good  
24 thing out of it for their clients. You cannot blame them for  
25 doing it.

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1 Senator Hansen. I agree with you, Mr. Chairman.

2 The Chairman. Why do you not at least suggest that they  
3 consider that question: assuming a person is extremely wealth,  
4 would they, nevertheless, have all of these benefits without  
5 paying any tax at all?

6 Mr. Stern. Would you like us to draft a letter from you  
7 to Senator Williams more or less expressing the concern that  
8 this could lead to that kind of a situation and they might  
9 want to consider some form of limitation so that that would  
10 not happen?

11 The Chairman. Someone may come before this Committee  
12 saying here is a person who made \$500,000 a year and paid  
13 no income tax, or some additional benefit that they are adding  
14 on right now, where someone gets by without paying their fair  
15 share. Then you are going to seek response to the same thing  
16 that they accused us of.

17 Senator Hathaway. What is the revenue loss on this,  
18 Mike?

19 Mr. Stern. In connection with that provision, I do not  
20 know. I think it would be very small.

21 Senator Hathaway. A lot of it is compensated for anyway  
22 because the wealthy person would go to the Senior Center and  
23 pay for his meals anyway.

24 Mr. Stern. My impression was that these programs were  
25 not means-tested.



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1 Senator Hathaway. No, but on a voluntary basis, most  
 2 of them pay in anyway. It may be an academic question.  
 3 The Chairman. What you are talking about is sending them  
 4 a letter?

5 Mr. Stern. Yes, sir.

6 The Chairman. Why do you not do that, that they, by all  
 7 means, do something about a case of a further tax exemption  
 8 of someone who has too much already.

9 Mr. Stern. Yes, sir.

10 The Chairman. If there is no objection, let us go to  
 11 the next point, approval of the Hungarian Trade Agreement.

12 Mr. Cassidy. The next item on the agenda is the U.S.-  
 13 Hungarian Trade Agreement, Attachment D in the pamphlet for  
 14 you, under Title IV of the Trade Act. No trade agreement  
 15 between the United States and a Communist country can take  
 16 effect for the United States unless it is affirmatively approved  
 17 by the majority vote of both the House and the Senate.

18 The Finance Committee has 45 working days to consider  
 19 such a resolution. The House passed H. Con. Res. 555 on  
 20 May 22, that is now before the Committee, approving the U.S.-  
 21 Hungarian Trade Agreement. The Subcommittee on International  
 22 Trade of the Finance Committee held hearings on the Senate  
 23 version of this resolution, S. Con. Res. 76, on May 9, and  
 24 the Committee now has, by our best estimate, about four more  
 25 days before the procedures in the Trade Act will automatically



1 distract the Committee from consideration of this resolution,  
2 regardless of the way that this Committee wishes to report.

3 We estimate that would be next Tuesday.

4 Senator Curtis. What happens Tuesday?

5 Mr. Cassidy. Automatic discharge. It goes to the Floor,  
6 and the Floor has 15 working days to consider the resolution.

7 Senator Curtis. May I ask a couple of questions about  
8 the agreement?

9 Mr. Cassidy. Yes.

10 Senator Curtis. I have a copy in my hand of Public Law  
11 93-618. That is the one?

12 Mr. Cassidy. That is correct.

13 Senator Curtis. On page 87, it provides that no non-  
14 market economy country shall participate in the program of  
15 grants and loans and the like if it is found that they are  
16 violating certain human rights. Is that right?

17 Mr. Cassidy. That is correct.

18 Senator Curtis. One of those is to deny citizens the  
19 right or opportunity to join persons permanently through  
20 emigration, very close relatives in the United States, spouse,  
21 child, brother or sister. Two imposes more of a nominal  
22 tax on the visas or other documents required for immigration  
23 described in paragraph one or imposes more than a nominal tax,  
24 levy, fine, fee or other charge on any citizen as a consequence  
25 of the desires of such citizen to emigrate described in

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1 paragraph one.

2 The Act also provides that the President can waive that,  
3 is that right?

4 Mr. Cassidy. That is correct.

5 Senator Curtis. If he does waive it, those provisions  
6 would not apply?

7 Mr. Cassidy. Assuming that the President gives assurances  
8 to the Congress that that waiver will promote the policy of  
9 those sections.

10 Senator Curtis. Referring again to Public Law, page 88,  
11 D of that Section, it says, "During any period that a waiver  
12 is in effect with respect to any non-market country under  
13 Section 402(C) the provisions of Sections A and B will not  
14 apply with respect to such country."

15 Just in a word, tell us what that means?

16 Mr. Cassidy. That means if the President waives the  
17 application of 402, which is the so-called Jackson-Vanik  
18 amendment on freedom of emigration, then he will automatically,  
19 by reason of subsection D, waive the restrictions of Section  
20 409, which is freedom to emigrate to join a very close relative.

21 Senator Curtis. What sort of resolution is before us at  
22 this time?

23 Mr. Cassidy. The resolution before you at this time  
24 solely deals with approval of the U.S.-Hungarian Trade Agree-  
25 ment. This emigration waiver issue will have to come before

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1 the Committee sometime this summer, probably in July. The  
2 Subcommittee on International Trade, the President has already  
3 sent a second message recommending the continuation of the  
4 President's authority to waive these sections, 402 and 409,  
5 and the Subcommittee on International Trade will hold hearings  
6 on this Presidential recommendatnion on July 12th.

7 Senator Curtis. But the resolution before us today, what  
8 does it say? Just approval?

9 Mr. Cassidy. Just approval of the trade agreement.

10 Senator Curtis. Is it subject to amendment?

11 Mr. Cassidy. To amendment, no.

12 Senator Curtis. An amendment to strike out D from the  
13 existing law would not be in order today?

14 Mr. Cassidy. I do not believe so, but let me check the  
15 procedures, sir.

16 (Pause)

17 We are checking the procedures, but it is also a Concur-  
18 rent Resolution which will not go to the President, therefore  
19 it is not legally binding. It is just a Congressional action,  
20 House and Senate action.

21 You would have to have an original that went to the  
22 President for signature.

23 Senator Curtis. I am inquiring now primarily about the  
24 procedures, but there will be a subsequent matter coming before  
25 this Committee that this issue can be raised, if someone so

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1 chooses?

2 Mr. Cassidy. The issue specifically -- the issue of  
3 freedom of emigration restrictions will be raised in July and  
4 at that time the Committee has two options. It can, by  
5 affirmative action, order reported a resolution disapproving  
6 the continuation of the President's authority to waive these  
7 restrictions which would mean, in effect, that the Trade  
8 Agreement with Hungary which is now in existence, and if you  
9 believe this Trade Agreement -- excuse me. The Trade Agree-  
10 ment with Romania now in existence. And if you approve this  
11 Trade Agreement with Hungary then the most favored nation  
12 treatment under those trade agreements would stop as of the  
13 day the Congress adopted the disapproval resolution of the  
14 waiver.

15 You could -- and certainly the issue you are talking  
16 about is appropriate to raise at that time.

17 Senator Curtis. What kind of resolution will be before  
18 us then?

19 Mr. Cassidy. No resolution, unless you want to disapprove  
20 the President's authority to waive. If the Congress wants to  
21 allow the President to continue to waive this Jackson-Vanik  
22 provision and your amendment to Section 409, the Congress does  
23 nothing. The waiver authority continues for one year.

24 Senator Curtis. They have no authority to approve, subject  
25 to amendment?

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1 Mr. Cassidy. No. Not under the procedures as written.

2 Senator Curtis. What is the effect, if we approve what  
3 is before us today?

4 Mr. Cassidy. The effect if you approve the resolution  
5 before you today will be to implement the United States-  
6 Hungarian Trade Agreement. That means that imports of  
7 Hungarian products into the United States will get most favored  
8 nation treatment and exports from the United States to Hungary  
9 will get their most favored nation treatment.

10 There are also business facilitation agreements, and so  
11 on.

12 Senator Curtis. These two sections relate to guarantees  
13 and loans and so on?

14 Mr. Cassidy. They do, yes. They relate to MFN, tariff  
15 treatments, CCC and Exim Bank financing, et cetera. All forms  
16 of financial arrangements.

17 They prohibit financial assistance and MFN treatment as  
18 long as the country in question does not comply with emigra-  
19 tion requirements unless the President waives those restric-  
20 tions.

21 Senator Curtis. I want to make sure I understand it.  
22 When will these further bills come to us?

23 Mr. Cassidy. The President has already sent us a letter  
24 recommending that his authority to waive Jackson-Vanik be  
25 extended for one year, and the Subcommittee on Trade --

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1 Senator Curtis. His authority as represented by the  
2 Section D as I read?

3 Mr. Cassidy. Correct.

4 Senator Curtis. We are confined to that issue?

5 Mr. Cassidy. The issue that the Subcommittee is holding  
6 hearings on is that issue, presuming that the Committee can  
7 take up any aspect of it that it wishes to take up.

8 Senator Curtis. Have you arrived at an answer, whether  
9 an amendment is in order today?

10 Mr. Cassidy. An amendment is out of order. Under the  
11 rules, it is not in order.

12 Senator Curtis. Then I am out of order, Mr. Chairman.  
13 I yield the floor.

14 The Chairman. Senator Dole?

15 Senator Dole. If it goes to the Senate Floor, then we  
16 have 15 days to do what?

17 Mr. Cassidy. Working days, with no more than 20 hours  
18 of debate to vote up or down on this resolution.

19 Senator Dole. We have to take it up in 15 days?

20 Mr. Cassidy. It is a privileged matter, et cetera, so  
21 it is almost impossible to avoid.

22 Senator Dole. If we wanted to get at the question raised  
23 by Senator Curtis, then we could introduce a resolution of  
24 disapproval?

25 Mr. Cassidy. Well, technically, the point that is being

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1 raised by Senator Curtis is not before the Committee.  
 2 Technically, you have two tracks -- the labor business on  
 3 one side, and straight approval of the Trade Agreement which  
 4 is before you today.

5 In theory, the approval of the Trade Agreement has nothing  
 6 to do with Jackson-Vanik. That is a separate procedural  
 7 issue.

8 If you wanted to oppose the Hungarian Trade Agreement,  
 9 you would essentially report -- one thing you could do is  
 10 report this bill unfavorably and then tell the Senate to vote  
 11 no, in which case there would be no trade agreement with  
 12 Hungary. But the technical issue is the substance of the  
 13 Trade Agreement with Hungary, not the Jackson-Vanik provisions.

14 Politically, of course, whatever is at issue is at issue.  
 15 Procedurally, we are only talking about the Hungarian Trade  
 16 Agreement today.

17 Senator Dole. You said a few moments ago if we took  
 18 something up in July, then everything that we had done today  
 19 would stop?

20 Mr. Cassidy. If, in July, the Committee orders reported  
 21 a resolution disapproving the extension of the President's  
 22 waiver authority, then MFN, tariff treatment for Romania which  
 23 now exists, and if this resolution is approved, then tariff  
 24 treatment for Hungary would terminate.

25 Senator Curtis. It would be possible -- I am not proposing

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1 any action on this -- but it would be possible for the  
2 Committee to do as they do on many other fields, if they had  
3 a majority vote to disapprove this waiver, because they can  
4 attach it on any bill over which we have jurisdiction.

5 Mr. Cassidy. Sure, just like any other legislation.

6 Senator Dole. I want to put into the record, I asked  
7 a couple of questions at the hearing and Senator Ribicoff  
8 addressed to Mr. Vance, Assistant Secretary for European  
9 Affairs. One of them was in reference to whether or not those  
10 who leave Hungary can take any property with them, and they  
11 are not divested, or required to divest themselves of property  
12 as a condition for being permitted to leave, but if they do  
13 not sell their property, they must leave it in the hands of a  
14 designated administrator, who may be a relative. If the  
15 property is sold, the emigrants may receive the proceeds which  
16 are placed in a block account in Hungary which means they  
17 cannot take them with them, but they can spend them if they  
18 ever go back to Hungary for a visit. Which, to me, seems some  
19 impediment on the right to emigrate and secondly, we were  
20 concerned about the mix of those who were permitted to emigrate  
21 and I think they gave us the cases from October '77 and  
22 April '78, between that time, a breakdown of those who were  
23 permitted, number and occupation.

24 I ask that that statement be made a part of the record.

25 Finally, I guess the point I want to make, I want to

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1 address the other problem, the waiver by the President with  
2 reference to Hungary or Romania. We do that through a disap-  
3 proval resolution?

4 Mr. Cassidy. Correct.

5 Senator Dole. Thank you.

6 The Chairman. Mr. Moynihan?

7 Senator Moynihan. May I simply express the view that  
8 the President's waiver with respect to the Hungarian trade  
9 arrangements has, in the view of many of us, been very much in  
10 the spirit of the Jackson-Vanik amendment, the object of which  
11 is to encourage freedom of emigration and to offer, in a sense,  
12 inducements to it and we believe that this is substantially the  
13 case in Hungary as it has been in Romania and would look upon  
14 this as evidence of the successful working of this policy --  
15 not to suggest that Hungary has done this, has adopted his  
16 policies because of ours, but certainly our objects have been  
17 harmonious with theirs.

18 The Chairman. What is the will of the Committee now?  
19 May I ask if this is correct?

20 If we report out a resolution of approval and that is voted  
21 down by the Senate, would that not work out the same way if we  
22 reported out a resolution of disapproval and the resolution of  
23 disapproval were agreed to?

24 Mr. Cassidy. Under these peculiar Trade Act procedures,  
25 the only vehicle that you have available is a resolution of

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1 approval. If you report the resolution of approval unfavorably,  
2 or report it favorably and the Senate votes it down, either way,  
3 assuming --

4 The Chairman. Even if we reported it favorably and it  
5 is voted down by the Senate?

6 Mr. Cassidy. There is no Hungarian Trade Agreement.

7 The Chairman. Is there any opposition to this agreement?  
8 If there is not, I propose --

9 Mr. Cassidy. We have not heard from anyone who has opposed  
10 the agreement, as such. We have heard from a number of people  
11 who have various commercial problems with Hungary, but so far,  
12 none of them have indicated they want to oppose the agreement.

13 The Chairman. Then I would propose then that we just  
14 report the amendment out favorably. Otherwise, it goes out  
15 automatically.

16 Mr. Cassidy. Yes.

17 The Chairman. Without objection, we will report it.

18 Senator Dole. We can still raise the questions most of  
19 us have in July?

20 Mr. Cassidy. Correct. That is when the waiver issue will  
21 be before the Committee.

22 The Chairman. Let us take the next issue.

23 I would suggest we skip over that for a moment. Senator  
24 Curtis is not here, and he wishes to be heard on that.

25 Why do we not take this matter of -- let me see, Senator

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1 Haskell had a private relief bill.

2 Senator Byrd. Mr. Chairman, the Subcommittee on Taxation  
3 held a hearing on Senator Haskell's bill some time ago. I do  
4 not remember the exact detail, but I think it is an appropriate  
5 bill for the Committee to approve. I have heard of no opposi-  
6 tion to it. Mike can probably give a little more detail.

7 The Chairman. Why do you not tell us a little bit more  
8 about it?

9 Mr. Humphreys. What happened was that this Jefferson  
10 County Mental Health Center, a nonprofit organization, was told  
11 by the Internal Revenue Service that it had been improperly  
12 paying Social Security taxes because it had not waived its  
13 immunity from Social Security taxes, and consequently, they went  
14 ahead and refunded the taxes to their employees in some years  
15 past and after that happened, the Internal Revenue Service  
16 found that it indeed did have a waiver of the immunity and told  
17 the organization that it would now have to repay those taxes  
18 that it had already refunded to its employees.

19 What the organization is asking is not that it be relieved  
20 of its own liability but simply of the liability to pay these  
21 to the Internal Revenue Service, these Social Security taxes  
22 that they had already given back to their employees. The  
23 amount is \$74,000. And the employees would lose any Social  
24 Security coverage that they might have for that period, but  
25 they could regain it if they wanted to pay back the taxes that

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1 had been refunded to them.

2 At the hearing, the Administration indicated no objection  
3 to this.

4 The Chairman. The Administration favors this?

5 Mr. Humphreys. They made no objection to it.

6 The Chairman. No objection, and the Department has no  
7 objection to it, and the Subcommittee has no objection to it?

8 Senator Byrd. I move its adoption.

9 The Chairman. All in favor, say aye.

10 (A chorus of ayes.)

11 The Chairman. Opposed, no?

12 (No response)

13 The Chairman. The ayes have it.

14 Mr. Stern. Mr. Chairman, in terms of form, since it is a  
15 revenue measure, I would just amend that that be a Committee  
16 amendment that you could offer to an appropriate revenue bil  
17 when you get any of the revenue bills up on the Floor?

18 The Chairman. All right. We will approve it and it can  
19 be offered when we have something up that can be passed.

20 Now that Senator Curtis is here, I would like to just  
21 briefly discuss Item No. 6, Medicare and Medicaid Administra-  
22 tive and Reimbursement Reform Act, just to have a chance to  
23 discuss the problem somewhat.

24 Senator Curtis sent me a letter that he would like for us  
25 to postpone consideration of this measure and I do think that

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1 we ought to talk about the overall problem.

2 Senator Talmadge is Chairment of that Subcommittee. My  
3 concern is that the Labor Committee has reported a bill in  
4 this area, is that not correct?

5 Senator Talmadge. A year ago.

6 The Chairman. They reported it a year ago and I would  
7 assume that they are going to want to act on their bill?

8 Senator Talmadge. And the Commerce Committee, on the  
9 House side, has been working on it and will meet to try to mark  
10 it up tomorrow, and this bill has been kicking around now for  
11 about three years. The President endorsed it a number of  
12 times during his campaign while he was running for President.

13 We have had two hearings on the bill. We think that it  
14 has considerable support throughout the country. We have 19  
15 co-sponsors. Staff has worked extremely hard on it for about  
16 three years.

17 Our Subcommittee has been working on it. Some of the  
18 measures that may be proposed by the staff may be controversial.  
19 I would suggest that we take up the bill that we originally  
20 introduced, go into that with the staff suggestions for  
21 improvements. Those that we think are wise, we can tentatively  
22 agree to them. Those that we think are unwise, we can reject  
23 them, and then, after we complete action on marking up the bill  
24 put it in legislative language, let the Committee take another  
25 look at it at that time.

1 I think that it is imperative that this Committee take  
2 action to report a bill. Otherwise, we will be accused of  
3 foot-dragging. This has been one of the President's primary  
4 objectives in urging action on it now for more than a year.

5 The Human Resources Committee has acted. We think that  
6 our bill is a vast improvement over the bill reported by the  
7 Human Resources Committee.

8 We have no idea of what the House will do tomorrow. I  
9 understand a vote in the Commerce Committee is very close as  
10 to whether to put this 9 percent cap on. We think that our  
11 plan is more practical, more realistic, more equitable than  
12 a flat 9 percent cap.

13 What we propose to do is try to evaluate hospitals  
14 according to types of hospitals, penalize the inefficient  
15 hospitals, reward the efficient hospitals through prospective  
16 payments.

17 We think that it has substantial support in the Committee  
18 and in the Senate, hopefully in the Congress.

19 The Chairman. Senator Curtis, would it be all right if  
20 we discussed the bill?

21 Senator Curtis. I have no objection to discussing it.  
22 I am faced with this problem.

23 Seventeen pages of material was sent around discussing  
24 this, and analysis of it shows that there are 40 changes in the  
25 Talmadge bill and some more since it was typed up. The Minority

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1 have been excluded. There have been staff meetings where  
2 an invitation was extended to the Minority members of the  
3 staffs on Human Relations, the Minority members of staff on  
4 Ways and Means, and the Minority staff of this Committee found  
5 out about it afterwards.

6 My suggestion was that in light of all of these changes,  
7 we have, in all probability a material change from the Talmadge  
8 bill on which hearings were held and I merely ask that they  
9 be reduced in writing so that we have a bill before us.

10 But I have no objection to considering that. I do expect  
11 to ask Mr. Constantine about each one of these changes that  
12 appear here and have them explained, because this Committee  
13 has run into trouble many times before. We have had explana-  
14 tions here. We have had Medicaid explained to us as costing  
15 less than a half million dollars and now I do not know that  
16 anybody can count how much.

17 There are some changes in here that appear material.  
18 I have no objection to spending what time we have talking  
19 about them, but I seriously object to the procedure as far as  
20 the staff level is concerned. It is not a matter of pride or  
21 power of the minority. It is just a bad way to legislate.

22 The Chairman. Let me ask this question, since this matter  
23 has come up. I did not hear about it before.

24 Is it true that this bill was put together without the  
25 Minority staff having an opportunity to consult and participate.

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1 in the work that was done? Is that correct, Mr. Constantine?

2 Mr. Constantine. Yes and no, Senator. Yes in the  
3 sense that a meeting was held to discuss possible changes, that  
4 was a staff workpaper about two months ago -- possible  
5 suggested changes in the hospital portions of the Talmadge  
6 bill and it was discussed with the staff of both Senators  
7 and Committees which had either approved various hospital  
8 cost containment materials or were sponsors of the material.  
9 That is number one.

10 As far as this bill is concerned, Senator Curtis, the  
11 17-page summary, the 17-page document, in large part consists  
12 of 16 of the 24 sections without changes, not been changed,  
13 and the bill is introduced. There are six with relatively in-  
14 substantial changes, or minor changes, to which we would regard  
15 as having a substantial change from the bill as introduced.

16 In that regard, last Monday, for example, we had a meeting  
17 with the Congressional Research Service to discuss the  
18 proposal and your staff member was invited to that meeting.

19 On Tuesday there was another meeting with Mr. Hoyer who  
20 works with us and on Thursday, we had a briefing session that  
21 lasted almost three hours to which all staffs of all Senators  
22 were invited and that was an extensive and detailed discussion  
23 of each of the provisions with quite a few questions and  
24 answers.

25 I think that is about as far as that goes. The bill was

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1 drafted, really, quite awhile ago. Its predecessor was in the  
2 last Congress, S. 3205, and the Committee held five days of  
3 hearings on that in 1976. In S. 1470, you had four days of  
4 hearings in June of last year.

5 So the bill was essentially, the hospital reimbursement  
6 segments, the practitioner reimbursement and the administra-  
7 tive sections have been changed, but the structure has  
8 remained the same. There has not been an overwhelming change.

9 The point is that the bill was Senator Talmadge's bill.  
10 At this point, it is now a Committee bill. At the time it  
11 was introduced it was prepared, and we, over the years, just  
12 as we work on any bill -- for example, Mr. Chairman, when we  
13 worked on the Long-Ribicoff-Talmadge proposal --

14 The Chairman. Long-Ribicoff-Talmadge-Dole proposal.

15 Mr. Constantine. We had prepared amendments for individual  
16 Senators at their request. It is the normal procedure.

17 What we were going to suggest is that the Committee in the  
18 past has generally proceeded along the lines of a description  
19 of a provision with suggested changes, and then if those  
20 changes are approved or not, then proceeding to draft, we  
21 come back to the Committee and would draft language and then  
22 you are free to raise it again, discuss it, disapprove it  
23 once more. Ordinarily we have not drafted suggested changes  
24 until the Committee has acted on those changes, made a  
25 decision.

1 Senator Bentsen. Mr. Chairman, let me understand.  
2 Were any substantive changes made by staff that had not been  
3 discussed in Subcommittee?

4 Mr. Constantine. The changes were not made, Senator  
5 Bentsen, in the bill. They have been made in terms of this  
6 document in terms of suggested changes in the bill, suggested  
7 improvements along the lines which Senator Talmadge indicated  
8 in statements and speeches that he desired to make.

9 I am just focussing on the hospital portion. Basically  
10 the Talmadge bill, as introduced, was a system of classifying  
11 and comparing like hospitals and establishing a means of cost  
12 centers, which were reasonable and which were not.

13 The changes are suggested changes only, Senator. In  
14 other words, the text of the bill has not been changed. That  
15 is for the Committee, the suggested changes along the lines  
16 that Senator Talmadge suggested. And when the Administration  
17 testified at the hearing, they strongly objected. They said  
18 that the Talmadge bill did not go far enough, it only covered  
19 initially adjusted routine costs, the hospital's room and  
20 board, routine nursing costs. The suggested approach  
21 Senator Talmadge indicated, let's see if we can develop an  
22 approach to potentially cover ancillary services. That is  
23 included as a suggested change.

24 Senator Bentsen. What about Section 30 now in providing  
25 statutory base? Was that discussed in the Subcommittee before

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1 the members?

2 Mr. Constantine. Not these. These are all suggestions.  
3 The HCFA was established under the Talmadge bill. The  
4 Department then proceeded to implement that administratively.  
5 There was the GAO report, critical --

6 Senator Bentsen. I understand that it is with some  
7 specificity now that you have set out certain positions to  
8 accomplish this. Were those things discussed before the  
9 Subcommittee?

10 Mr. Constantine. Within --

11 Senator Bentsen. Before the members?

12 Mr. Constantine. The suggestions here, no, sir, they  
13 were not discussed. The issues were discussed.

14 Senator Curtis. May I ask something? You answered the  
15 Chairman yes and no. You elaborated on the no part. I want  
16 to find out something about the yes part.

17 You mentioned that within the last week or so the Minority  
18 staff of the Finance Committee had been called in, but that  
19 was after these changes had been formulated.

20 Mr. Constantine. Senator, this document here was prepared  
21 Wednesday evening of last week.

22 Senator Curtis. So this was after they were prepared?

23 Mr. Constantine. No, we met Monday of last week to discuss  
24 these things and we outlined them to describe the suggested  
25 changes and again, Mr. Hoyer met on Tuesday before this was

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1 prepared.

2 Senator Curtis. Your meeting where you thrashed out and  
3 arrived at these changes was held at a considerable time before  
4 that.

5 Mr. Constantine. Some of these suggested changes obviously  
6 we had discussed months ago. Others were discussed, were  
7 agreed upon in terms of staff recommendations, now, Senator,  
8 were discussed and arrived at as late as last week.

9 Mr. Swoap. If I may resond in terms of minority staff to  
10 place in where I believe is the context of events that occurred,  
11 was, as you recall, the bill was introduced last spring, the  
12 original Talmadge bill, S. 1470, and at that time there were  
13 hearings held, there were one and a half days of hearings  
14 held in the fall that covered a statement of principle in addi-  
15 tion to the original Talmadge bill and the Administration bill.

16 But from that time forward, from last fall until this  
17 last Monday, the Minority staff was not included in any of the  
18 discussions, any of the briefings, any of the considerations  
19 and the preparations of what have turned out to be rather  
20 substantive and major changes in the proposal.

21 We had two briefings, one on Monday and one on Tuesday on,  
22 as Mr. Constantine has indicated, a proposal that even then  
23 was changing, so that it was not solidified until Thursday and  
24 it was not until Thursday that we were able to get this 17-page  
25 document which I understand has now changed in some respects.

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1 So that it has been very difficult for Minority staff to  
2 even determine what is being proposed, let alone to analyze  
3 it, or to present recommendations to you. So that the document  
4 that was just given to the Minority is my best effort to give  
5 you an analysis of what is in the proposal, given five days of  
6 lead time.

7 The Chairman. Let me make this suggestion.

8 The last thing on earth I want to do is take advantage of  
9 Minority on this Committee. The Minority is most considered  
10 and they deserve the same kind of thought and consideration  
11 that are given to us -- fair, cooperative and helpful, and  
12 every last one of them are good members of the Committee.

13 The fact is, although it would have been good to have more  
14 communication with the Minority staff, I would think that the  
15 Minority staff knows a lot more about what is in this document  
16 than I do, because I have not read it. Nobody has explained  
17 what these proposed amendments are to me, and I would think  
18 that we might just discuss the principal points at issue and  
19 see whether we can reach a conclusion on some of them, and  
20 then after we conclude that, then I would suggest, between now  
21 and the next meeting, that the Minority staff work with the  
22 other staff members and see if they can make some constructive  
23 suggestions of ways that they think that the bill should best  
24 be tailored, and then we can meet at a subsequent meeting  
25 and hopefully conclude our deliberations on this matter.

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1 Senator Curtis. Mr. Chairman, I have no desire to be  
2 an obstructionist. I have no objection to proceeding this  
3 morning. When my turn comes, I expect to ask Mr. Constantine  
4 about these changes, whether it is a minor change, major  
5 change is a matter of opinion.

6 I would like to go down the list of them and have him  
7 explain them.

8 Mr. Constantine. Senator, if you do not mind, we would  
9 prefer to defer Sections 2, 3 and 4, the Hospital Reimbursement  
10 Sections, until the meeting on Thursday, because that is one  
11 that will take the most time. Those are the sections that  
12 take the most time. And proceed to the Section 10 and continue  
13 there, if that is all right.

14 Senator Curtis. In other words, you are skipping every-  
15 thing about hospital containment costs?

16 Mr. Constantine. Not totally, Senator, but the basic  
17 stuff in Sections 2, 3 and 4; the essential hospital reimburse-  
18 ment reform in Medicare and Medicaid is contained in Sections  
19 2, 3 and 4. The bill includes practitioner reimbursement  
20 reforms, longterm care, administrative and miscellaneous,  
21 and it would be easier to carry over until Thursday morning  
22 on Sections 2, 3 and 4 if that is all right.

23 Senator Curtis. Sections 2, 3 and 4 of the Talmadge  
24 bill?

25 Mr. Constantine. Yes, sir.



1           These sections -- for example, in the practitioner reim-  
2           bursement reform, Sections 10 through 15 are either identical  
3           or virtually identical with the bill as introduced. Sections  
4           10 through 15.

5           The Chairman. It seems to me if we just skip over  
6           Sections 2, 3 and 4 and discuss the other items that are here,  
7           then if we can come to agreement on what we are trying to do  
8           on these others, we still have plenty of work to do in trying  
9           to reach agreement on language and along with our usual  
10          procedure, that does not prejudice anyone.

11          Senator Curtis. Could we have a copy of the bill?

12          Mr. Constantine. Starting with Section 10.

13          Senator Curtis. Section 10.

14          Does that have to do with agreements of physicians to  
15          accept assignments?

16          Mr. Constantine. Yes, sir.

17          Senator Curtis. Is that changed from the Talmadge bill?

18          Mr. Constantine. No, sir.

19          Senator Curtis. It does provide for incentives?

20          Mr. Constantine. Yes, sir.

21          Senator Curtis. What are the expected costs of those  
22          incentives?

23          Mr. Constantine. It depends on the assumptions. I might  
24          as well explain that the problem of Part B of Medicare is the  
25          declining rate of physician acceptance of assignments where

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1 the physician agrees to accept the Medicare reasonable as  
2 a charge, billing the patient only for deductible or co-  
3 insurance. There are reasons for it, including the lag  
4 and increases in Medicare reimbursement, philosophic objection  
5 to taking apayment from the government directly.

6 The proposal is designed -- there is no more money, really,  
7 in Part B of Medicare. The premium keeps coming up. The  
8 Federal government, the general revenue financing is \$6.5  
9 billion to several billion a year for Part B, the physicians'  
10 part. The premium the beneficiary pays goes up to \$8.20 on  
11 July 1 that the older person pays.

12 What the Talmadge bill sought to do was devise a means to  
13 encourage physicians to accept assignments voluntarily without  
14 increasing the cost of the program. The idea was that when a  
15 physician takes an assignment that is a direct payment from the  
16 government rather than going through a beneficiary, the  
17 government saves money.

18 Prudential has done studies that it takes 27 minutes to  
19 process an unassigned claim because of the paperwork -- the  
20 older person, you have to go back and forth with mail as  
21 opposed to doing it thorough the physician's offices where  
22 the clerks are properly trained and that kind of thing. Four  
23 and a half minutes in those kinds of cases.

24 Senator Curtis. What are the incentives?

25 Mr. Constantine. The incentives are these, sir. If the

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1 physician agrees to become a participating physician volun-  
2 tarily and accept the Medicare reasonable charge as a full  
3 payment for his visit, he will receive essentially for every  
4 claim on every Medicare beneficiary a \$1 additional allowance,  
5 a claims savings allowance, an administrative cost savings  
6 allowance, plus in our conversations with private practitioners  
7 in Colorado, Mississippi, around the country and in Georgia,  
8 they maintain they probably save at least another \$1 in  
9 overhead costs.

10 There are some additional benefits apart from the straight  
11 dollar -- simplified claims procedures. He could submit his  
12 claims on a multiple basis rather than individually.

13 The physician today has to get a patient's signature on  
14 every claim. This would permit him to have a signature on  
15 file and you just simply validate that to cut down on the  
16 paperwork in the doctor's office.

17 Senator Curtis. He would get \$1 for accepting the  
18 assignment rather than saying to the patient, you file your  
19 claim?

20 Mr. Constantine. Plus a lower overhead as well.

21 Senator Curtis. How much would that save the government.

22 Mr. Constantine. Excuse me?

23 Senator Packwood. Let me ask a question. If a doctor  
24 charges \$15, what does he do with it in this proposal?

25 Mr. Constantine. For the sake of argument, the patient

1 has a \$60 deductible, pays the first \$60; under this proposal  
 2 the doctor agrees -- say it is \$15 in Medicare allowance,  
 3 \$14, today he is getting \$14 and his charge is \$15, his normal  
 4 charge. Under this proposal he would get 80 percent of the  
 5 \$14 from Medicare plus \$1 and he would submit that claim on  
 6 a simplified billing form with a lot less paperwork in his  
 7 office.

8 Senator Packwood. To who?

9 Mr. Constantine. To the doctor.

10 Senator Packwood. I thought the doctor -- the doctor  
 11 has the bill. He is charging the patient.

12 Mr. Constantine. Right.

13 Senator Packwood. Who does the doctor submit the bill  
 14 to?

15 Mr. Constantine. To the government, to the insurer,  
 16 to the carrier under Part B of Medicare.

17 Senator Packwood. I thought you were having it submitted  
 18 directly. It is still to the carrier, not to the Division  
 19 of Direct Reimbursement?

20 Mr. Constantine. No, sir, not ordinarily. It would go  
 21 to the carrier. No, there is no change in that. It is just  
 22 that they keep a list of them and he submits his claims on a  
 23 multiple listing basis.

24 Senator Packwood. He accepts assignment of full payment?

25 Mr. Constantine. Yes, sir. The idea being a rural doctor

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1 who gets \$10 for a routine office visit, for example, in  
2 Colorado, this is not uncommon. These are people who discussed  
3 this. That dollar in administrative allowance plus saving  
4 another dollar in overhead means, in effect, that his net  
5 from his practice from that visit increases by 20 percent.

6 The government, the estimated cost savings is about \$1.50  
7 to \$2.00 per assigned claim as opposed to an unassigned claim  
8 in Medicare today. There obviously would be savings.

9 In answer to Senator Curtis' direct question, if there  
10 were no change at all in the people taking assignments, that  
11 is, if the same number of people who take assignments today  
12 on claims did not change, we are simply paying another dollar  
13 for each of those claims. We estimate the cost of that  
14 initially at about \$50 million more.

15 If, however, additional physicians accept assignment  
16 who are not taking it today, obviously there would be offsets  
17 against that cost.

18 Apart from that one on one effect, if the effect of this  
19 is to hold at least constant and curb the deterioration in the  
20 numbers of physicians who now take assignments and who are  
21 growingly refusing to accept them, then it will serve its  
22 purpose also in that regard.

23 Frankly, in our opinion, it is the best you can do without  
24 decreasing the direct payments of the cost of the program.

25 Senator Packwood. Will the payments be a percentage of



1 the usual and customary fee in each area so it will vary from  
2 area to area?

3 Mr. Constantine. No, sir. It is a flat dollar adminis-  
4 trative cost savings allowance.

5 Senator Packwood. I understand that, the percentage of  
6 the fee that is going to be paid. You said Medicare paid  
7 \$14. You paid 80 percent, plus a dollar.

8 Is the 80 percent a constant, or will it vary?

9 Mr. Constantine. The 80 percent is a constant.

10 Senator Packwood. Of the percent Medicare will pay?

11 Mr. Constantine. Reasonable charge.

12 Senator Packwood. What is the reasonable charge based  
13 on?

14 Mr. Constantine. In some cases, quite a lot of data; in  
15 some cases, not very much. Theoretically, it was based on  
16 the customary physician's charges in an area that were in  
17 effect when Medicare began and those were distilled into a  
18 prevailing -- today, for example, they pick the 75th percen-  
19 tile. That is, for a given procedure, say an appendectomy,  
20 75 percent of the charges for appendectomies come in at \$400  
21 or less. That is the 75th percentile some years back. That  
22 was frozen in time, and the payment is limited to a percentage  
23 factor, annually permitted to rise on a percentage factor,  
24 based on general practice and wage level increases.  
25

Medicare uses that. There is a lag in that. Those vary

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1 all over the lot, all over the country.

2 Senator Packwood. Do you have a provision in this bill  
3 where, in future years, we will try to hold costs down by  
4 paying a lower and lower percentage to the physician?

5 Mr. Constantine. No, sir.

6 Senator Packwood. No administrative discretion to do  
7 that?

8 Mr. Constantine. To pay a lesser percentage than 75  
9 percent?

10 Senator Packwood. Yes.

11 Mr. Constantine. I believe that was first in law in 1972.  
12 It was prior to 1972 and H.R. 1, the 75th percentile was  
13 incorporated into law.

14 Senator Packwood. No discretion to change the 80 percent  
15 figure that you cite?

16 Mr. Constantine. No, sir. That is statutory.

17 Senator Curtis. Will this procedure simplify things for  
18 both the patient and the government?

19 Mr. Constantine. It certainly would simplify it for the  
20 government and certainly for the patients, particularly. If  
21 the physician accepts assignment, it means that there is less  
22 paperwork and hopefully less cost to the patient, and with  
23 the physicians' practice expenses reduced.

24 Senator Curtis. In other words, it would be an inducement  
25 to go to the physician, that I will accept an assignment, rather

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1 than to select a physician on the basis of choice or  
2 recommendation for expertise?

3 Mr. Constantine. Senator, that situation is what pre-  
4 vails today. We do not believe that this changes -- this  
5 provisions change today. Today, you have the same it  
6 should be between the physicians to do, to accept assignments  
7 and those who do not. This does not flag anyone.

8 Senator Dole. You would not have to accept Medicare  
9 patients?

10 Mr. Constantine. Yes, you do not have to accept assign-  
11 ments. It does not have to accept Medicare patients. This  
12 is the third alternative.

13 Senator Dole. As I understand it, the Administration  
14 opposes this proposal, and we have an estimate of the cost at  
15 \$115 million, rather than \$50 million.

16 Mr. Constantine. I know that. Two things. The Adminis-  
17 tration is opposed to this proposal because they say that they  
18 are going to have their own proposals next year for fee schedules  
19 and so on, and other approaches. The \$115 million estimate was  
20 in error. That covers claims to all claims submitted by  
21 physicians. Only half of the claims submitted are taking  
22 assignments today on those claims and of those, a number of  
23 those would not be eligible for this \$1 payment.

24 For example, under the bill, the physician could not get  
25 more than \$1 for a claim a week. If he submitted two claims

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1 in a week, there still would only be a \$1 cost savings  
2 allowance and the claims Medicare receives --

3 Senator Packwood. Claims, or claims per patient?

4 Mr. Constantine. Claims per patient per week, one cost  
5 saving. There are certain exclusions for certain hospital  
6 claims which are counted in the total of the Part B plans and  
7 so on.

8 That is why we distilled that to the \$50 million claims  
9 that would be subject to the cost savings allowance.

10 Senator Bentsen. Does the Administration have any sub-  
11 stantive objection to this provision or are they saying we  
12 do not have a particular proposal yet, and we want to wait for  
13 ours?

14 Senator Dole. I think it is going to cause problems. If  
15 you change the formula, you are going to cause problems.

16 Mr. Constantine. We are not changing the formula, Senator.  
17 It does not touch this formula at all. It gives the physician  
18 an option -- Mr. Fulberton, administrator of the Health Care  
19 Finance Administration, he may want to respond as to any  
20 substantive things.

21 Mr. Filberton. The Administration's position, essentially,  
22 is we want to see some major changes in the way physicians  
23 are reimbursed under Medicare. We are now engaged in a very  
24 active consideration of proposals to do that.

25 I think the proposals, when they come out, will differ

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1 in substantial ways from those you are discussing this morning,  
2 but I think we are after the same objectives, considering that  
3 as a part of our fiscal 1980 legislative program.

4 Senator Curtis. How would you like to reimburse posi-  
5 tions?

6 Mr. Filberton. I have to say, Senator Curtis, we have  
7 not actually approved any kind of proposal in this Department  
8 yet; it is under active consideration. We are getting comments  
9 from a lot of people inside the Department. If I were to  
10 speak personally, I would think that what I would propose inside  
11 the Department is a negotiated fee schedule, state by state,  
12 at this point, with some other changes to bring in some things  
13 that you have in this bill.

14 For example, requiring that physicians take assignment  
15 in all cases or not; some incentives for them to get into  
16 the system and take assignment. We have a situation where  
17 over half a billion dollars that Medicare patients have to pay  
18 out of pocket are the differences between the reasonable charge  
19 that Medicare will pay and the physician's actual charge.  
20 We are very concerned about that.

21 Senator Hansen. If I could ask a question, you say you  
22 would like to make some major changes in the way physicians are  
23 to be reimbursed or paid, is that right?

24 Mr. Filberton. Yes, sir.

25 Senator Hansen. Does the Administration have detailed

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1 the specific proposals that it wants to implement, or does  
2 it just think that it needs to be changed?

3 Mr. Filberton. We are in the process right now, Senator,  
4 of considering some very substantial changes. We have pro-  
5 posals that are being circulated for comment. We will have to  
6 get approval from OMB at some point. We are in an active  
7 process at this moment.

8 Senator Hansen. It would be accurate to say no, you have  
9 not finalized the proposals that you are going to make to the  
10 Congress?

11 Mr. Filberton. We have not finalized them; that is an  
12 accurate statement.

13 Senator Bentsen. How many years have we been working on  
14 this?

15 Mr. Constantine. Senator, this bill, I guess, is the  
16 product of a lot of years. It was formally introduced three  
17 years ago, over two and a half years ago.

18 Senator Bentsen. So that there has been some time during  
19 which suggested changes by the Executive Branch could have  
20 been made?

21 Mr. Constantine. Yes, sir.

22 Senator Dole. I move that we adopt this section.

23 The Chairman. All in favor, say aye.

24 (A chorus of ayes.)

25 The Chairman. Opposed, no?



1 (No response)

2 The Chairman. The ayes have it. That is Section 10.  
3 Now, Section 11.

4 Mr. Constantine. There are two sections to this bill.  
5 This provision is as it is in S. 1470, as it is in the bill  
6 without suggesting any change.

7 A number of the rural states have indicated to Senator  
8 Talmadge and others the difficulty of getting physicians in  
9 shortage areas, and one of the problems they indicated was  
10 Medicare brought a new doctor in at the 50th percentile, a  
11 new doctor could establish his customary charges only at the  
12 50th percentile as opposed to what he could get in the city,  
13 where he could come in at considerably greater money.

14 He could, over time, increase up to the maximum, the  
15 75th percentile that we discussed.

16 The purpose of this provision is fairly simple. Senator  
17 Eastland raised it, this segment of the provision, and that  
18 is to permit new doctors and other doctors, present doctors,  
19 doctors within a physician-shortage area, to come in just at  
20 the top, at the 50th percentile, so whatever deterrent, to  
21 whatever extent Medicare deters doctors moving into physician  
22 shortage areas it will not be because we would just underpay  
23 them at a little higher level. That is essentially what this  
24 is.

25 The Administration has a cost estimate here on that

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section of \$5 million in 1980 under Medicare.

Senator Curtis. At the present time, it works just the opposite, does it not? If a physician now is in a rural area and he moves to a larger metropolitan area, the chances are he can be reimbursed more for Medicare than for the same services.

Mr. Constantine. Considerably more.

Senator Curtis. This reverses it.

Mr. Constantine. It does not quite reverse it, Senator. It simply says -- this is primarily directed towards getting new doctors in the areas. It says that if the 75th percentile for an office visit in a given area might be -- routine office visit -- might be \$10 at the 75th percentile, by the 50th percentile, because the doctors in that area have always had lower fees, it would be \$8, so he could come in at \$10. He can establish his customary fee at \$10 instead of being locked in at \$8 initially.

Senator Curtis. These are real problems. Suppose you have two rural counties. One does not have any doctor, but the nearest area that the people can go to had a charge of \$8 for an office call, but you got somebody to come in there and this were enacted, what would be the basis of his fee?

Mr. Constantine. What would they use? The statewide prevailing. He could come in on the 75th percentile.

Senator Curtis. He could come in higher than that local



1 fee?

2 Mr. Constantine. Yes.

3 Senator Curtis. Suppose the adjoining county has a  
4 doctor who has been there for years and he has served the  
5 whole community and answered their calls, and answered their  
6 calls when they did not have the money and everything else?  
7 If this is adopted, he still would be subject to a lower fee,  
8 would he not?

9 Mr. Constantine. No. What this says is that they can  
10 both go up to the 75th percentile. It is nondiscriminatory  
11 in that regard.

12 Senator Curtis. It says this proposal calls for increased  
13 payments to physicians who set up practices in low-fee,  
14 physician-shortage areas.

15 Mr. Constantine. That is correct. It also indicates,  
16 Senator, that if a physician is presently there who is below  
17 the 75th percentile he, too, can go up to that level. In  
18 other words, if the 75th percentile is \$10 and the 50th percen-  
19 tile is \$8, if a physician presently there is at \$8, he can  
20 go up to \$10.

21 Senator Curtis. They are two different communities.

22 Mr. Constantine. In the shortage area, yes, but they  
23 are both shortage communities. That is what you are saying.

24 Senator Curtis. Two different communities. One has a  
25 doctor who has served a long time. The other one has a doctor

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1 who has come in. Will they be paid the same?

2 Mr. Constantine. It depends on the prevailing charges  
3 in the area. Assuming that they are both physician shortage  
4 areas, assuming that they are in this same area -- and I think  
5 Nebraska has probably one for the rural areas -- they could  
6 probably move up to the same thing.

7 The problem you have there, you have the one man with a  
8 lot more experience being paid the same as a new man.

9 Senator Curtis. What page is this on?

10 I received complaints in rural doctors in Nebraska that  
11 if they moved to a city they would get paid more for render-  
12 ing the same service and yet we are begging people to stay,  
13 to serve the rural community.

14 All my question is is will this set up a preferred  
15 situation for a new doctor and deny it to the practitioner  
16 who has been there a long time, if they are in different  
17 communities?

18 Mr. Constantine. No, sir, basically not, Senator. We  
19 would have to see.

20 Senator Curtis. What page is that language on?

21 Mr. Constantine. Page 27.

22 Senator Curtis. -- The language I have is physicians  
23 who set up practices.

24 Senator Dole. Who are presently serving in shortage  
25 areas.

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1 Mr. Swoap. As long as it was the same area, if they  
2 were two different communities and one was not deemed a  
3 shortage area, then the doctor moving in the new area that  
4 was a shortage area would get a higher reimbursement.

5 Senator Hanse. Let me ask on that point, I suppose the  
6 fact that the doctor is present in an area would tend to  
7 incline persons charged with the responsibility of determining  
8 doctor shortage areas to include one which was not a doctor  
9 shortage area. Would not that, in effect, tend to penalize  
10 the doctor who, as Senator Curtis says, is in an area, trying  
11 to do a job, and yet would he not be denied an opportunity  
12 for a raise in remuneration because of the fact that he was  
13 there?

14 Mr. Swoap. To the extent that it caused that area to be  
15 deemed not to be a shortage area, that would be correct.

16 Senator Hansen. I would hope that we would not get into  
17 that. I do not think that anyone would want to penalize  
18 making it tougher for a doctor to get what he otherwise would  
19 be able to receive if he were moving in and if he were there.

20 How can we get around that situation?

21 Mr. Constantine. A physician shortage area, until some-  
22 one moves in there? (

23 Senator Hansen. I think we could find cases where a  
24 doctor, especially the older physicians, are staying in an area  
25 and they are staying with the patients, and if there were

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1 doctors in several places, that would not be a place that  
2 a doctor would go to.

3 I could foresee a situation where a doctor is staying in  
4 an area and he might be right alongside another area that  
5 would be without a physician. I would hope the application of  
6 this concept would not result in penalizing the doctor who  
7 was already there. How may we insure that that would not  
8 happen?

9 Mr. Constantine. The suggestion is, Senator, that they  
10 can all go, assuming they are in the area, to that same 75th  
11 percentile. But what you are getting at, suppose you have a  
12 physician in an adjoining area, not a shortage area?

13 Senator Hansen. Not a shortage area, because one doctor  
14 is already there.

15 Mr. Constantine. This does not deal -- frankly, Senator,  
16 this does not deal with the non-physician shortage area.  
17 The probability is that the disparity will not be that great.

18 This particularly hits the older physicians in an area  
19 who are usually in the 75th percentile by that time anyway,  
20 so this is not much in it for them. It is occasionally where  
21 they are somewhat below that.

22 This is a case for a new doctor moving in who today can  
23 only come in at the 50 percentile.

24 Senator Hansen. The reason I ask the question, we have  
25 a burgeoning population in Wyoming. A number of communities

1 are without doctors, or are inadequately staffed as far as  
2 doctors are concerned.

3 I know of a number of counties that have made a Herculean  
4 effort trying to establish hospitals or health centers of  
5 some kind where the doctors have patients, and you get one  
6 man down in and he is there for a year and he goes on to  
7 greener pastures. So there are a lot of doctors -- I am  
8 concerned about that situation in Wyoming. I suspect that it  
9 could be duplicated in other areas, but certainly it is true  
10 out there, because our population has been very mobile and  
11 we have had people move in in other areas where, frankly,  
12 doctors do not like to move into.

13 There are the obvious advantages that you can find in  
14 large communities. They do not want to be in an area where  
15 there is a real need, yet not having the other amenities of  
16 life.

17 Mr. Constantine. If you have a young doctor who can make  
18 \$15 an office visit for a routine office visit in Cheyenne,  
19 say, and he goes out to rural Wyoming where they charge the  
20 75th percentile, \$9 or \$10, and Medicare says the 50th  
21 percentile is at \$8, at least to bring him up to \$10, give  
22 him a whack at that so that the disparity is not as great,  
23 that is essentially as far as this goes on that portion of  
24 it.

25 Senator Curtis. What is the answer then? What happens



1 to the one doctor in the adjoining community who is there  
2 and it is not a shortage area, but it would be if he left.

3 Does he get a different fee than the newfellow coming  
4 in?

5 Mr. Constantine. He would get the fee that is ordinarily  
6 calculated. I guess you could have an anticipated shortage  
7 area, but this just deals with those areas that have been  
8 designated as physician shortage areas.

9 The probability is if he is in an adjoining community,  
10 particularly in a state with a large rural area, there will  
11 not be any great difference. The disparities come in in  
12 terms of the city mice and the country mice. That is where  
13 it really gets wild.

14 This is one that Mississippi was particularly concerned  
15 about in terms of attracting doctors.

16 Mr. Swoap. There is the further aspect, Senator Curtis,  
17 of the second component of this section, because that has a  
18 very marked distinction between the city and the rural  
19 physicians.

20 Mr. Constantine. This is the first segment and I pointed  
21 that out. This deals with that.

22 There is a second segment to the section without change  
23 from the original, the bill as introduced, which deals with  
24 large states that have multiple areas for determining  
25 Medicare prevailing charges -- California, New York. California

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1 has 20 areas, that sort of thing, 20 different localities  
2 that we compute customary and prevailing charges.

3 The disparity in some of the large states is completely  
4 unjustified by the cost of practice differences. For example,  
5 a couple of years ago, a hemorrhoidectomy, the Medicare  
6 prevailing charge was \$280 in San Francisco and \$450 in  
7 Los Angeles, both very high-cost areas and so on.

8 You have that disparity essentially in large states,  
9 New York, California. It does not particularly exist in  
10 Ohio nor Pennsylvania, but it is primarily in New York and  
11 California.

12 What this amendment does -- there are some other states;  
13 I do not want to be guilty of that -- what this amendment does  
14 is says that you calculate for all those 20 localities in  
15 the state a statewide average charge. You take all of the  
16 hemorrhoidectomies and average them out through the state of  
17 California and it says that in any locality, you take those  
18 hemorrhodectomies and you get the seatewide average for the  
19 procedure.

20 In any one locality, you would not automatically increase  
21 the prevailing charge to the extent that it was more than  
22 one-third above the statewide average. By way of example,  
23 as I explained earlier, there is an annual adjustment in the  
24 prevailing, depending on cost of practice changes and increases  
25 in prevailing wage levels.

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1 That means that in the example I gave you in Los Angeles  
2 and San Francisco, both of those, the \$280 goes up 5  
3 percent and the \$450 goes up 5 percent. The dollar disparity  
4 between the two widens. Instead of \$170, it may be \$177.  
5 That kind of thing.

6 What this section says is that you get the statewide  
7 average. That to the extent that any locality exceeds the  
8 statewide average by more than a third, do not reduce the  
9 charge there; you do not automatically increase it.

10 Under the example I gave you, if the statewide average  
11 for hemorrhoidectomies in California was \$300, that is all  
12 throughout the state, including Los Angeles and San Francisco,  
13 to the extent that a given area's prevailing charge exceeded  
14 \$390 a third above that -- \$400 -- a third above that, we  
15 would continue to pay the \$450 in Los Angeles but we would not  
16 increase it by 5 percent until such time as it did not exceed  
17 the statewide average by more than one-third.

18 That provision, this portion is estimated to save \$95  
19 million in fiscal 1980 by moderating the increase to the  
20 people at the extreme ends of the rates.

21 Mr. Swopa. A concern that the Committee may want to  
22 explore, in those states where you have particularly one urban  
23 area or two urban areas and the rest of the state is predominantly  
24 rural, in that event, over time, the effect will be to limit  
25 the urban practitioners to one-third above what the rural

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1 practitioners would receive.

2 The question is, is that a fair or equitable ratio  
3 between what may be demonstrably higher costs in urban areas.

4 Mr. Constantine. That is not quite true. The urban  
5 areas tend to weight the average because it is a statewide  
6 average including the urban areas. They charge more and they  
7 often do more of the procedures. It does have some effect.  
8 But the point is, it does not mean --

9 The Chairman. Let me ask a question. I am no expert  
10 about this; I am just trying to learn as I go along. If I  
11 learn one thing every day, I have 365 more items than I did  
12 a year ago.

13 Let me get one point straight in this whole bill. If we  
14 assume that we are going to charge the same price no matter  
15 whom you go to see, does that mean you have two doctors, one  
16 of whom has performed this operation a thousand times and he  
17 is right in the prime of his practice. He is in his mid-40's  
18 and he has done the operation a thousand times. Here is  
19 another doctor who is available to the operation and he is  
20 getting a little old. He trembles a little bit. He has  
21 performed the operation once in his whole lifetime.

22 Do you mean I have to pay the same price in either event?

23 Mr. Constantine. The way Medicare is, that is not what  
24 this is. We just take an allowance. There is no rhyme or  
25 reason. We may be paying with the trembling hands today under

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1 Medicare than the other fellow just because of their billing  
2 practices and their customary charges. It just developed  
3 that way.

4 There is the whole issue of specialists versus GP, those  
5 kinds of arguments where both today Medicare distinguishes  
6 between specialists and GP's, where they both may be rendering  
7 the identical service.

8 The Chairman. Do they pay the general practitioner less  
9 than they pay the specialist for the operation?

10 Mr. Constantine. Not always under Medicare's prevailing  
11 charge system. We have states where we pay the specialists  
12 less than the GP gets for certain procedures and services.

13 There is no real logic. It sort of grew like Topsy.

14 At the beginning of Medicare, when it started, we had  
15 a poor data base and there were a lot of things that evolved  
16 that are anomalous, inconsistent.

17 The Chairman. As a practical matter, there are a lot of  
18 these surgical procedures that should never be performed by  
19 a general practitioner, never, never. It is a risk of the  
20 person's life to have a general practitioner do a procedure  
21 that he has never done before, and a good specialist, I would  
22 say, improves the person's chance of surviving that operation  
23 three to one.

24 Do you mean to tell me that for all we know the general  
25 practitioner may be paid even more to perform an operation than

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1 the specialist?

2 Mr. Constantine. Yes, sir.

3 The Chairman. We ought to have a law against a general  
4 practitioner even doing it, if a specialist can be found.

5 I know a little about what I am talking about. I know people  
6 who have died just because the person who performed the opera-  
7 tion, as best he could with what he had to work with, but did  
8 not have the skill, competence and know-how on how to handle  
9 that type of operation.

10 Senator Hansen. Mr. Chairman, I have to make this obser-  
11 vation. How does a person become a specialist? He has to  
12 start someplace, does he not?

13 You lose a few.

14 The Chairman. My impression is that he is supposed to  
15 operate on cadavers. You are supposed to practice on these  
16 people who have already lost out before he starts cutting up  
17 those who have a chance.

18 Senator Danforth. I am curious about why the geographical  
19 unit used to do the averaging is the state? Has any thought  
20 been given to, say, wider geographical areas, regions, or  
21 even national averages?

22 Mr. Constantine. There are a fair number of states which  
23 are single areas. You pretty much then result in a national  
24 or regional fee schedule over time.

25 This was essentially designed to deal with rather gross

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1 differences within a single state. It was not a movement  
2 towards a regional or national fee schedule.

3 Obviously, you can combine states and apply a statewide  
4 test. Then you would be moving towards regional and national  
5 fee schedules where the difference is, say, one-third, from  
6 one end of the country -- a hemorrhoidectomy in California to  
7 a hemorrhoidectomy in New York.

8 Senator Danforth. If we are setting the fee schedule,  
9 why is it preferable to do it on a state basis? It seems to  
10 me that we have crossed the bridge, in effect, of setting fee  
11 schedules. So if we are going to do that, why not do it on  
12 the most frugal basis?

13 Mr. Constantine. I do not believe we have crossed the  
14 bridge yet in setting fee schedules. Usually within a state,  
15 more often than not, obviously there is equity within a state,  
16 doing it within the boundary of a state. Very often the same  
17 carrier operates, makes the determinations in most of those  
18 localities.

19 In California, we have two carriers, Blue Shield and  
20 Occidental, and they handle it, whereas in Idaho we may have  
21 a different one, or in Nevada a different carrier. It makes  
22 it awkward to coordinate those data systems.

23 Mr. Fulbertson. If I may interject, that is one of the  
24 issues that HEW is now considering very actively, whether we  
25 should have statewide schedules or whether there should be a

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1 national fee schedule or something in between. There are  
2 some difficult issues in that area, as I am sure you know.  
3 It is one of the things that has taken us a little while to  
4 come up with a proposal.

5 Mr. Constantine. This segment of the bill is estimated  
6 to save \$95 million the first full year and in 1980 -- the  
7 first part is an additional \$5 million. The estimated savings  
8 in 1980 -- I am sorry, assuming fiscal '80, would be \$110  
9 million for Medicare and \$13 million under Medicaid savings,  
10 a total of \$123 million.

11 The Chairman. Let me make a suggestion. We are not  
12 going to be able to finish our work on this bill this morning,  
13 even the parts that Mr. Constantine suggested that we work on.

14 I would like to suggest that between now and the time that  
15 we meet on this again that if you can work it out that you hold  
16 a meeting, hopefully the Subcommittee or such Senators or staff  
17 who would like to sit in with you, and sit down and go over  
18 this with those who are particularly interested in it, as  
19 Senator Curtis is. He will make himself available.

20 Go over it and talk about this and see if you can narrow  
21 the areas where there is a difference of opinion, so that  
22 hopefully when we meet Thursday we will make better progress.

23 Then we can turn to some of these other things that  
24 otherwise we are not going to be able to get to this morning,  
25 such as what Senator Moynihan is interested in, and see if we

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1 can reach a decision on some of those items. At least we  
2 can discuss them.

3 There is one item that I particularly want to bring to  
4 the attention of the Committee, but I do not want to preclude  
5 others. I would like to give them a chance to bring up their  
6 points as well.

7 Senator Dole. In other words, our different staff people  
8 can all get together and we meet again on Thursday?

9 Senator Talmadge. May I make this suggestion, Mr. Chair-  
10 man? Members of the Health Subcommittee, Talmadge, Ribicoff,  
11 Nelson, Bentsen, Matsunaga, Dole, Laxalt and Danforth.  
12 Senator Curtis is very much interested.

13 I would suggest that, Jay, you get all of the staff  
14 together and brief them thoroughly this afternoon and let's  
15 have a meeting of the Health Subcommittee tomorrow morning  
16 at 9:00 a.m.

17 Senator Curtis, will you be here at that time?

18 Senator Curtis. Yes, I will try to be here.

19 Senator Dole. I cannot be here.

20 Senator Curtis. There are things, like pathologists,  
21 the next section, it is a very major change from what we are  
22 doing now. They regard a pathologist as a physician in the  
23 hospital, therefore, he should be handled differently than  
24 a physician someplace else.

25 Now, to my mind, a pathologist is one of the most important

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1 guys around. Probably the most dreaded thing at the present  
2 time is cancer, and the pathologist, the accuracy of his  
3 ability and so on, his training, his reputation -- just because  
4 he is in the hospital, I am not in favor of reimbursing him  
5 on a different pattern than this does, and as I read it, it is  
6 different than what was in the Talmadge bill. And I would  
7 like to ask Mr. Constantine, have the pathologists, radiolo-  
8 gists and anaesthesiologists seen the proposed changes?

9 Mr. Constantine. Senator, the provision as it is is as  
10 it was in the Talmadge bill as introduced. What is just there  
11 is the staff suggestion which the pathologists asked for,  
12 which they were trying to work out, for example, to cover  
13 autopsies, which are not paid for, and they have been unable  
14 to come up with information that they tried to get for a year  
15 and a half to justify professional component.

16 We met with them to try to justify a basis to say that  
17 there was a professional component in the clinical laboratory  
18 services. We asked the College of Pathology and the Chairman  
19 of departments to indicate those functions that pathology  
20 would normally perform, and must perform in order to deem that  
21 he is involved with the hospital's laboratory and the minimum  
22 amount of time.

23 So you have what he does and the timeframe, in which  
24 he does it, and we suggest that we be able to come back and  
25 recommend an alternative to what was in the Talmadge bill.

1 They went to work. They have not been able to come up with  
2 that information, but the meetings we held with them were in  
3 good faith and all the staff is suggesting here is the  
4 original Talmadge amendment as it is there, plus at such time  
5 as the pathologist can come up with what the pathologist must  
6 actually do and the minimum amount of time that he must do this  
7 in order to say that he has done these thousands of laboratory  
8 tests.

9 There is a personal component, a personal professional  
10 component that, at such time that they can come up with that  
11 that the Secretary is authorized to then proceed.

12 It was simply a good faith suggestion. We would be glad  
13 to delete it.

14 Senator Curtis. Have they seen the changes?

15 Mr. Constantine. We discussed it yesterday. We discussed  
16 it with Mr. Colley who represents the pathologists, and the  
17 change is essentially that we would just recommend to the  
18 Committee, you have not been able to come up with it so far.  
19 If and when you do, we would recommend to the Committee that  
20 they authorize the Secretary to proceed.

21 Senator Curtis. What change would take place in the  
22 interim? Would the pathologist, radiologist and anaesthesiolo-  
23 gist, would their reimbursement be handled exactly as it is  
24 now?

25 Mr. Constantine. Oh, no, sir. Senator, what I was getting

1 at was the bill -- I'm simply saying that the provision that  
2 we have here before you is identical with that in S. 1470.

3 Senator Curtis. The pathologists do not agree with that.

4 Mr. Constantine. No, sir, they do not. That is right.

5 Senator Curtis. What you are saying is we will put it  
6 into effect and we will come in with something. Is that  
7 right?

8 Mr. Constantine. That is right. The option is there.  
9 That provision is endorsed by the radiologists and the anaes-  
10 thesiologists. It is the pathologists, and they are the ones  
11 most directly affected, no question about it. They are the  
12 ones who stand the most to lose or gain.

13 Senator Curtis. In other words, it is a proposal they  
14 do not like and what you have done here is say we will put  
15 this proposal in effect until you can bring in some proof why  
16 we should not?

17 Mr. Constantine. Yes and no, Senator. The proposal here  
18 is the amendment as introduced, which they do not like. What  
19 they have been unable to come up with is an alternative -- the  
20 information on which an alternative approach might be offered  
21 and the staff 's suggestion is essentially to at least leave  
22 the door open if they can come in with that later on.

23 Senator Curtis. Who approves that alternative?

24 Mr. Constantine. The Secretary of HEW.

25 Senator Curtis. Neither the Congress nor the pathologists?

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Mr. Constantine. Senator, what you could do is delete the staff suggestion. Then Congress has an opportunity to vote on it later to decide what they want to do.

Senator Curtis. Then the change is made.

Mr. Constantine. Yes, sir. That is the point.

Senator Curtis. Why not delete the section?

Mr. Constantine. Senator, because this is an area where there was a substantial amount of testimony showing very excessive payments unrelated to professional time and effort based upon the ability of the pathologists to work on a percentage arrangement, work on a percentage contract with the hospital.

We have letters from certain pathologists who are embarrassed. Quite a few people in medicine are upset, quite excessive costs. The provision is endorsed by the Administration.

Both the Health Subcommittee of Ways and Means and the Health Subcommittee of Interstate Commerce have expressed concern and voted amendments to amend the law to deal with the excessive payments on a percentage arrangement. They have no relationship at all to professional time and effort.

Mr. Swoap. Senator, two further observations. I discussed the two sections at issue, Sections 12 and 15, with the College of American Pathologists on Friday. They had not seen the changes which were made under the staff proposals, so I do not



1 know what their position is on the changes that have been  
2 made. I do know that they are in opposition to the original  
3 language in S. 1470. Also, you should focus, as well, on  
4 Section 15 in addition to Section 12, because Section 15 does  
5 give the Secretary significant new powers to establish what  
6 are called RVS's -- Relative Value Schedules -- and that, in  
7 my opinion, has some rather broad-reaching implications for  
8 the determination of physician's fees generally across the  
9 country. That is a significant new power given to the  
10 Secretary under Section 15.

11 Mr. Constantine. Senator, just to get the record  
12 straight, the staff suggestion was not really -- it was an  
13 added option for the pathologists rather than -- what we are  
14 saying, if you are to consider the provision as it is in the  
15 bill, they are unhappy. No question about that. The staff's  
16 suggestion was a softening position to give them another  
17 alternative.

18 Subsequently Mr. Colley was in here the week before last.  
19 He represents the pathologists. We discussed it and told him  
20 that they had been able to come up with it, we were going to  
21 suggest to the Committee at least leaving the door open.  
22 Additionally, Mr. Ergalano talked to Mr. Stern.

23 It is simply a liberalization and keeping the door open.

24 I am not saying for a moment that they like the provision.  
25 The staff is perfectly willing to withdraw its suggestion and

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1 the staff can just act -- we thought this would be helpful  
2 to the pathologists rather than harmful in the longrun. This  
3 is what they have been trying to do for a year and a half and  
4 have not been able to successfully come up with it.

5 There is nothing mysterious about it, or devious. It  
6 simply says that when you can come up with that information,  
7 fine.

8 Senator Curtis. In whose opinion?

9 Mr. Constantine. In terms of the Secretary.

10 Senator, the staff suggested that because we do not know  
11 who else. If you give us an acceptable reference point other  
12 than the Secretary to determine that we have nonacceptable  
13 basis to determine what a pathologist must do and how much time  
14 he must spend in doing it in order for the Congress to deem that  
15 there is a professional component in every year and specimens,  
16 blood tests, and so on.

17 If NIH could do it or someone -- it is the lack of another  
18 reference point, Senator, that is the problem.

19 Mr. Swoap. An alternative, however, is not to implement  
20 the original language in S. 1470, Sections 12 and 15, until  
21 such time as the pathologists are able to provide the data that  
22 Jay is describing.

23 Senator Dole. Then we do not take care of the problem.  
24 We have these very excessive fees being made by pathologists.

25 Mr. Swoap. Senator, that may be correct.

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1 Senator Dole. They have the hospital by the throat.  
2 If you have to have a pathologist, they can extract any amount  
3 they want -- and do.

4 Mr. Swoap. To date, I have not seen any evidence of the  
5 incidence of this problem. I have heard isolated examples  
6 but I have not seen any data presented on the incidence of  
7 the problem generally.

8 Senator Talmadge. Let's hear from Mr. Fulberton.

9 Mr. Fulberton. Mr. Chairman, we had a study of 1975  
10 incomes of hospital-based physicians, pathologists, the group  
11 you are talking about right now, where they got their money  
12 on percentage of departmental revenue. 1975 money averaged  
13 \$138,000 a year; pathologists on salary doing the same kind  
14 of work is \$49,000.

15 Senator Talmadge. We had instances, I believe, of one  
16 pathologist who had two, three rural hospitals. He would  
17 spend part-time, and his take would be the percentage of  
18 the gross and would run up to \$150,000, \$200,000. Is that not  
19 correct?

20 Mr. Fulberton. Yes, sir. The figures I am giving are  
21 averages. There were figures in excess and below, of course.  
22 The Administration does favor the provision in the Talmadge  
23 bill as drafted, with a couple of technical modifications.

24 Senator Talmadge. Was there not a hospital with a 147-  
25 odd beds in Maryland where the pathologist's take was in

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1 excess of \$250,000?

2 Mr. Constantine. It was more than that; I think it was  
3 close to a half a million.

4 Senator Talmadge. That is the problem we are aiming at  
5 here. I do not think any physician ought to be paid on a  
6 percentage of the gross of that particular hospital. What we  
7 are trying to do is pay all physicians on a fee-for-service  
8 rendered.

9 Mr. Constantine. Senator, the hearing had an extensive  
10 listing submitted by the states of New York, New Jersey and  
11 other examples and then we had one report in California of  
12 almost \$200,000 out of a 33-bed rural hospital using laboratories  
13 60 percent of the time for out-of-hospital patients, paying  
14 the hospital \$750 a month.

15 Senator Curtis. Will you explain how the percentage of  
16 hospitals bill?

17 Mr. Constantine. Yes, sir. Under this section, the  
18 percentage contract works where the pathologist or radiologist  
19 says, I will get a percentage of the departmental revenue,  
20 the pathology department, whether gross or net in return for  
21 this contract to do this work in the hospital.

22 Often the work is done by medical technologists. There  
23 was extensive testimony from them on that point. The way that  
24 this bill works, this does not affect the direct personal  
25 services of a pathologist in anatomic pathology. He can still

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1 bill his fee for tissue studies and so on. This deals with  
 2 the clinical laboratory work. It says that where he is not  
 3 rendering a personal service for his educational, supervisory  
 4 and administrative responsibilities, an equivalent amount will  
 5 be paid to him by the hospital which a full-time specialist  
 6 of similar competence and training would have got on a salary  
 7 basis for those nondirect services.

8 For his personal patients, he can bill his fee. This  
 9 only deals simply because he has a laboratory contract. The  
 10 percentage arrangement may not yield excessive amounts.

11 Senator Curtis. The percentage of what?

12 Mr. Constantine. Ordinarily it is the gross of the gross  
 13 billings of the laboratory, the clinical laboratory.

14 Senator Curtis. Gross billings of the laboratory?

15 Mr. Constantine. Yes, sir.

16 Senator Curtis. Not the total hospital?

17 Mr. Constantine. No, sir.

18 Senator Curtis. How would that change the total laboratory  
 19 billings?

20 Mr. Constantine. What this does, Senator, it changes -- the  
 21 total laboratory billings for the sake of argument might be

22 \$5 million --

23 Senator Curtis. Let's talk about an individual patient.

24 Mr. Constantine. Today, ordinarily, he does not bill the  
 25 patient. The patient is billed by the hospital and the hospital

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1 bills for the laboratory charges and pays the physician his  
2 percentage, you know, of the laboratory gross.

3 What I think you are getting at, will this change the  
4 charge to the patient?

5 Mr. Constantine. Probably not, Senator. What it does  
6 do is that Medicare and Medicaid and Blue Cross generally do  
7 not pay the hospitals on a charge basis, they pay on a cost  
8 basis, so that what it changes, if the \$2 charge, instead of  
9 20 percent of \$2, the pathologist wants to put the equivalent  
10 of 10 percent, the hospital retains more and that is an offset  
11 against its cost which leaves a lesser amount for Medicare to  
12 have to pay Blue Cross. More goes to the hospital and less  
13 to the pathologist.

14 As the revenues of the hospital increase, it serves to  
15 reduce the cost.

16 Senator Curtis. You mean even if they adopt this proposal,  
17 the patient, when he pays his own bill, or an insurer does,  
18 or Medicare and Medicaid, that the charge will remain the  
19 same for certain laboratory work?

20 Mr. Constantine. The probability is that it will remain  
21 the same, but the reimbursement costs will decrease.

22 Senator Curtis. By lessening the amount that the pathologist  
23 gets, you increase the net of the hospital and therefore you  
24 can use that as a means to lower the general cost to the  
25 government?

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1 Mr. Constantine. Yes, sir. The estimated savings of  
2 this provision, I think, is \$32 million in 1980.

3 Senator Curtis. It seems to me that that is a very cir-  
4 cuitous way of saving money. If a patient is going to have to  
5 pay a fixed fee for laboratory services in the hospital and  
6 all you do is say to the hospital you cannot pay the amount  
7 to the pathologist, but it does not lower the cost to the  
8 patient, I cannot see the equity.

9 Mr. Constantine. Senator, it does, in effect. Remember  
10 that most patients do not pay. They are paid for by third  
11 parties, government, Blue Cross, private health insurance.  
12 But to the extent that hospital costs -- and admittedly, this  
13 is only \$13 million a year in Medicare and Medicaid -- in  
14 1980 to the extent that hospital costs and revenues are increased  
15 and the balance to be reimbursed to insurers is modified, it  
16 should be presumably reflected in lower premiums or premiums  
17 not increasing, the cost to the government not increasing that  
18 otherwise would increase.

19 The large carriers do not pay on a charge as a charge  
20 basis.

21 Senator Curtis. Does the bill, as written, apply to a  
22 case where somebody is in the hospital and they pay their own  
23 bill?

24 Mr. Constantine. No, sir, it does not.

25 Senator Curtis. No part of this bill?

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1 Mr. Constantine. No, sir.

2 Senator Curtis. Now, the Administration proposal does?

3 Mr. Constantine. The Administration proposal, the whole  
4 cost containment, that is everyone.

5 Mr. Fulberton. This provision, as I read this bill, would  
6 apply only to Medicare and Medicaid. It would save on the  
7 order of at least \$30 million on Medicare next year. The  
8 Administration supports it, and I might say that our analysis  
9 would suggest that if the hospitals are paying less to the  
10 pathologists they are going to be able to save money for all  
11 of their patients because they would not have to need that  
12 income to pay the pathologists those inflated amounts so there  
13 will be savings. If the hospital changes its systems to comply  
14 with Medicare and Medicaid, there may be some automatic changes  
15 in the private system, but that is how the hospital has its  
16 arrangements with the pathologists.

17 Senator Curtis. It still seems to be a strange procedure  
18 that the hospital will continue to charge the patient the same  
19 fee, that the government says it is going to regulate the  
20 amount that the pathologist gets.

21 Mr. Fulberton. Our analysis suggests that actually, if  
22 the hospital pays less, the pathologist may very well be able  
23 to keep down the amounts of billings for laboratory services.  
24 It may, in some cases, be able to decrease them, if inflation  
25 is not working at the same time. If they pay the pathologist

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1 \$50,000 or \$75,000 less, they may be able to decrease the fees  
2 in total.

3 Senator Curtis. In reference to excessive costs in Medi-  
4 care and Medicaid, we read in the paper and we had some testi-  
5 mony about certain cases -- I think there were some in Florida,  
6 some in Chicago -- where individual physicians -- I am not  
7 talking about pathologists alone -- received fraudulent and  
8 outrageous fees, and some of them have been indicted.

9 Have any of those cases been cases of pathologists?

10 Mr. Constantine. I do not know.

11 Senator Curtis. I do not recall any of them.

12 Mr. Fulberton. We would be glad to get that information  
13 for the record.

14 Mr. Constantine. Most of the cases of the pathologists  
15 being discussed here are essentially the hospital-based ones  
16 who are ordinarily not, except for an anatomic pathology  
17 tissue and so on, not billing the patient directly, so any  
18 fraudulent activity, any activity, would have to be in relation  
19 to the hospital's inflating some sort of manipulation of figures  
20 with the hospital.

21 I have not heard of any of that kind of thing. I think  
22 the issue on this one is whether the reimbursement under  
23 Medicare and Medicaid is excessive in the absence of demonstrated  
24 professional time and effort.

25 Mr. Fulberton. With these kinds of amounts, I do not see



1 too much evidence for fraud.

2 Senator Moynihan. Mr. Chairman, I do not wish to inter-  
3 rupt, but I would like to make a statement which I, at least,  
4 take very seriously, which is to say, Senator Talmadge knows  
5 how much I admire the principals that he sets down in sections  
6 2, 3 and 4 of the bill and then Section 46.

7 These are large legislative principles, incentive payments  
8 and rates of return. I would like to say, I do not think that  
9 we have any business involving ourselves in any of the issues  
10 between Sections 4 and 46.

11 Now, we have to, because we got started, but these are  
12 basically administrative matters. They do not respond to  
13 legislative direction, and they account for the administrative  
14 disaster of this program.

15 We sit in this Committee deploring the outrageous increase  
16 in costs of this program, but we do nothing about it because  
17 we impose such administrative restraint on the administrators  
18 that, in fact, they know what they do is what they have been  
19 told to do and they cannot be held responsible for it.

20 I think, if our social programs are going to respond at  
21 all to the fury the public has about their costs we are going  
22 to have to learn to make the distinction between legislation  
23 and administration, and it is an increasingly -- it is a  
24 certain kind of cowardice among administrators who ask for  
25 legislation in order that they not be blamed for the decisions

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1 they make, but they are wrong. We need the administrators  
2 to take the heat and make decisions.

3 We are fundamentally incapacitating administrative when  
4 we give it this much detailed instruction. It is none of our  
5 business how much pathologists get paid. Our business is that  
6 there should be a certain provision of medical care at a certain  
7 level of cost, and unless we keep our task simple, we will  
8 never perform it.

9 That is all I meant to say, sir.

10 The Chairman. Mr. Fulberton wants to comment on that.

11 Mr. Fulberton. Mr. Chairman, I hope this will not come as  
12 a surprise to Senator Moynihan, but I agree 100 percent with  
13 his position, and so does the Administration. As a matter of  
14 fact, we testified before the Health Subcommittee on Ways  
15 and Means yesterday morning, which was also taking up some  
16 relatively minor and technical proposals, and we suggested that  
17 we work with them so that we can have some more administrative  
18 flexibility built into the system so we can handle the  
19 problems without taking up your valuable time.

20 Senator Moynihan. Why do you think it would come as a  
21 surprise to me? Do you think I think you are all a bunch of  
22 numbskulls?

23 Mr. Fulberton. You indicated that perhaps, Senator, there  
24 was some cowardice on our part and we wanted to get the  
25 blessings of the Congress for these.



1 Senator Moynihan. No, no, no. The general point is  
2 that, in the main, administrators, because they are faced with  
3 so much adversary action against them are beginning to prefer  
4 legislative determinations of administrative issues.

5 Mr. Fulberton. We are resisting that, sir.

6 Senator Moynihan. I think you are all smart fellows and  
7 am not surprised that you agree with me.

8 The Chairman. Sometimes that is right and sometimes  
9 that is not right. I have seen some of these situations where  
10 we pass a law -- someone showed me a situation where we passed  
11 a law and we had one little line in it, one simple little  
12 point. I guess it gave the Secretary the right to make a  
13 regulation in this particular area, an innocuous little thing.

14 Here the hospitals could have 500 pages of regulations,  
15 500 pages of it, to be complying on this one little line, a  
16 very simple proposition. And it will lead you to believe that  
17 maybe we would have been better off if we had been a little  
18 more explicit in saying precisely what we wanted done rather  
19 than leave this open.

20 In the state of California, they say that an application  
21 for a person to go on AFDC, laid end to end, is 70 feet long.  
22 And so the people out there tried their hand at writing up  
23 what they thought would be a better application form and it  
24 works out to three pages. Anything that might be relevant  
25 that is not encompassed in the information which is on the

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1 first page, any explanation that might seem relevant and  
 2 helpful can be filled in on the fourth page, or you can even  
 3 add a page to it if you needed to, rather than a 70-page form.

4 What is your reaction to that, Mr. Constantine.

5 Mr. Constantine. Senator, we certainly agree on the  
 6 administrative stuff, but there are problems that we have  
 7 created which are legislative in nature and which require  
 8 legislative remedy; if you want to correct the situation,  
 9 the administrative discretion is not there.

10 For example, to put a limit on statewide prevailance  
 11 requires a statute. There is no administrative discretion in  
 12 that to moderate the payments on percentage arrangements to  
 13 save that money requires legislative arrangement. They cannot  
 14 do it administratively.

15 Some things require legislation.

16 I know Senators Talmadge, Dole and Nunn wrote a letter  
 17 to the Comptroller General asking for a complete review of all  
 18 regulations, laws, Federal, state and local, affecting hospi-  
 19 tals, with recommendations knocking out everything that is  
 20 duplicative in the paperwork wherever possible. And the first  
 21 reports that are coming back in, we will be back with legisla-  
 22 tive recommendations, because the first report is on the  
 23 certification of hospitals for compliance.

24 GAO is going to recommend that we just dump our governmen-  
 25 tal operations and contract with the Joint Commission.

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1 The Chairman. I was the manager of the Medicaid bill  
2 when that became law -- the Medicare bill too, for that matter.  
3 I would have thought that Medicare bill could have been written  
4 in the same number of pages that you have right here. Instead,  
5 it must have been ten times that and I know that we on the  
6 Committee did not write much of that. Most of that was some-  
7 thing that was sent to us.

8 It had plenty of provisions in there. Everytime you  
9 turned around, once every second or third or fourth page,  
10 you found something according to regulations to be written by  
11 the Secretary. So even that left a tremendous amount of room.

12 It should be said on both sides of the argument, all I  
13 know is that what we can do is look at each one of these sections  
14 and say, is this something where we need legislation or can you  
15 do it by regulation. I think that it creates problems both  
16 ways.

17 I believe that time has proved me right, we are not going  
18 to report this bill today. I said that about 45 minutes ago.

19 Senator Danforth?

20 Senator Danforth. Mr. Chairman, I am sorry. I was not  
21 here for consideration of the Hungarian Trade Agreement.

22 Senator Ribicoff received a letter from a Dr. Jack D.  
23 Early who is President of the National Agricultural Chemical  
24 Association who was addressing the practices in Hungary in  
25 respect to the infringement of patent rights of U.S. companies,

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1 and the letter concludes by saying that we believe that these  
2 concerns should be made a matter of record and that the  
3 Committee and the Senate should carefully monitor Hungarian  
4 compliance with both the letter and the spirit of the agree-  
5 ment, if it is approved.

6 We would also urge the Committee to take appropriate  
7 action in the event of noncompliance.

8 I ask unanimous consent, Mr. Chairman, that the letter  
9 to Senator Ribicoff be made a part of the record with respect  
10 to the Hungarian Trade Agreement and that the staff be instruc-  
11 ted to include in the report appropriate language pointing out  
12 this problem.

13 The Chairman. Without objection, that is agreed.

14 Senator Dole. Could I put a statement in the record?  
15 It is not often that I disagree with Senator Moynihan; today,  
16 I do. I would like to put my statement on the record as to  
17 how I view the problem we have in this area.

18 Senator Curtis. In the field of government costs, how  
19 much is the government having to pay because of malpractice  
20 insurance?

21 Mr. Constantine. You mean in Medicare and Medicaid?

22 Senator Curtis. Yes. How much because of increasing  
23 costs because of that?

24 Mr. Constantine. Not an enormous amount. It is a lot of  
25 money, but not in proportion to the total.

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1 Mr. Fulberton. I think, Senator -- I will have to check  
2 the figures to be certain -- I found 3 percent of hospital  
3 costs. As I recall, a little less than that goes to malpractice  
4 insurance. As a matter of fact, we are looking at this ques-  
5 tion a little more deeply. There is some indication that we  
6 have been paying more than our share of the malpractice cost of  
7 hospitals since our beneficiaries, the aged and the poor, tend  
8 by substantial margins to sue people less than the balance of the  
9 population, so we may be paying an inordinate share.

10 Senator Curtis. Of the overall costs of hospital and  
11 medical service, it is a big item?

12 Mr. Fulberton. Something less than 3 percent.

13 The Chairman. Senator Talmadge had announced that he  
14 was going to hold a meeting starting at 9:00 o'clock tomorrow.  
15 I hope staff will talk to Minority staff between now and that  
16 time and communicate on this bill in so far as something that  
17 might be achieved in that regard, as best you can, and that  
18 those who have a particular interest in this bill talk about  
19 it tomorrow morning at 9:00 o'clock and hope that that will  
20 help to reduce the time it will take to act on it in the full  
21 Committee when it meets again on Thursday.

22 I want to turn to another matter or two.

23 Senator Talmadge. If you would yield at that point,  
24 Mr. Chairman?

25 The Chairman. Yes.



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1 Senator Talmadge. Let me urge, at this point, that all  
 2 members of the Subcommittee on Health who can possibly be  
 3 present be here tomorrow morning, and also Senator Curtis.  
 4 This is a very important bill, and it is time that we got  
 5 moving on it.

6 We have already been accused of foot-dragging. It is  
 7 imperative that this bill be reported to the Senate as soon as  
 8 we can.

9 The Chairman. I wish I could have gotten to the subject  
 10 I wanted to talk to at this moment when there were more  
 11 Senators here, but I was concerned about what could happen  
 12 sometime soon. We are going to have the Sunset Bill brought  
 13 before the Senate sometime soon. The Rules Committee is going  
 14 to be reporting that out.

15 As I understand it, the bill does not have a proposal with  
 16 regard to tax expenditures, but I am led to believe that the  
 17 Government Operations Committee and perhaps Mr. Muskie and  
 18 his friends on the Budget Committee, some or all, propose to  
 19 include tax expenditures in those things that would expire  
 20 unless renewed.

21 That could amount to an automatic increase in taxes of  
 22 \$120 billion.

23 Take state and municipal bonds. As I understand it, that  
 24 provision could make all that taxable unless the Congress  
 25 passed a law to say it would not be taxable. There would be





1 a situation where a tax never existed at all on the income  
2 of all of those items, yet it would be enacted in the generos-  
3 ity of that legislation, by a mere 40 percent.

4 The Senators could, in effect, by preventing Congress  
5 from acting, using their rights under the rules of the Senate,  
6 prevent us from continuing the exemption of taxes on these  
7 state and municipal bonds just by resisting any legislation  
8 to extent the tax exemption that exists now.

9 Senator Curtis. In other words, 40 percent of the  
10 Senate could impose a tax?

11 The Chairman. Yes. Even though perhaps 100 percent of  
12 the House members might not favor that tax and even though  
13 60 percent of the Senate -- say 59 percent of the Senate --  
14 may not favor that tax.

15 Senator Moynihan. If I may ask a question, you raised  
16 the question of municipal bonds which frequently are sold in  
17 time lengths of 20 and 25 and 30 and even 40 years. The  
18 Sunset provision would come into effect after a ten-year period.

19 Mr. Stern. Ten years at the most. Actually, over a  
20 cycle.

21 Senator Moynihan. So nobody could sell a municipal bond  
22 with any guarantee beyond ten years. That would double the  
23 price of municipal bonds.

24 The Chairman. There is another problem involved in that.  
25 For example, take the provision on capital gains. Congress

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1 has voted to tax capital gains, but at a lesser rate than  
2 ordinary income. Such a provision would cause capital gains  
3 to be taxes as ordinary income, even though the trend, the way  
4 people are thinking, seems to be in the other direction at  
5 this point.

6 Once that law is in effect, it will only require 41  
7 percent of the votes in the Senate to keep it that way, to make  
8 that expire and to keep it from being re-enacted, to provide  
9 they will not exercise their right to conduct a filibuster  
10 and if they feel strongly about it, they can do that.

11 Furthermore, it would only require the President and  
12 one-third of either House to enact a big tax increase.

13 It seems to me that the approach that our staff has  
14 suggested would be far better on the whole Sunset approach,  
15 to take the view that each Committee would study each item  
16 subject to their jurisdiction and recommend what should be  
17 done about it in terms of hopefully on the spending items,  
18 in terms of the economy, and I would think that the taxpayers  
19 out of a Sunset bill, which theoretically is going to terminate  
20 some of the spending functions, would expect a tax cut, not a  
21 tax increase.

22 And it seems to me that if we are going to proceed on the  
23 theory that the Sunset law applies to the tax laws -- and I am  
24 not sure that it does, but if we are going to proceed, that  
25 laws are going to automatically expire, it should be the tax,

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1 not the deduction that expires, or the result would be a tax  
2 cut, not a tax increase.

3 Senator Curtis. Does the statute define a tax expenditure?

4 Mr. Stern. The Congressional Budget Act has a definition  
5 of a tax expenditure, yes, sir.

6 Senator Roth. Mr. Chairman, the Sunset legislation does  
7 not contain provisions applying to tax expenditures. A number  
8 of us thought that in Government Operations, for the reasons  
9 that you do point out. You are dealing with an entirely differ-  
10 ent situation.

11 In the case of spending programs, we are talking about  
12 turning on or off government spending. In the case of taxes,  
13 you are dealing with the private sector and I think the point  
14 that Pat Moynihan made is very appropriate. It would bring  
15 uncertainty to the private sector and cause the economy to go  
16 down.

17 As of now, tax expenditure is not a part of the Sunset  
18 legislation. I am sure the amendment will be offered again on  
19 the Floor, however.

20 The Chairman. The point that I have in mind is that it  
21 seems to me that if this is to be amended to say that tax  
22 expenditures will expire, then we should sponsor an amendment  
23 to go one better and make the whole thing expire -- let the  
24 whole Internal Revenue Code expire, the whole thing.

25 Senator Moynihan. I so move, Mr. Chairman.



1 The Chairman. Instead of starting out with a proposal,  
2 for example, that you tax capital gains at 70 percent, you  
3 start out at a point where you tax nothing, starting at zero  
4 working up, rather than down.

5 Senator Roth. May I raise another tax matter, that we  
6 are having additional taxes imposed upon the American people  
7 only in this case, by the bureaucracy, by the Internal Revenue  
8 and I am talking about -- you recall, six, eight months ago;  
9 I guess even longer than that, Larry Woodworth, in answer to a  
10 question of mine, agreed that they would not change the taxing  
11 of fringe benefits until July 1st.

12 As you well know, there is a proposal now to issue a  
13 regulation that is going to mean very substantial taxes and  
14 a number of us in this Committee have issued resolutions that  
15 require the cancellation. I am as concerned about the timing  
16 when we could arrange this. This is something we ought to  
17 deal with because, there again, you have not the Congress  
18 raising taxes but the bureaucracy. That seems to be just as  
19 serious.

20 The Chairman. Mr. Moynihan?

21 Senator Moynihan. Mr. Chairman, I believe I introduced  
22 that measure. It is S. 3145, and I think Mr. Stern hoped to  
23 put it on the agenda for our Thursday meeting.

24 Mr. Stern. Yes.

25 Senator Curtis. Have the laws that created the departments

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1 expired in the Sunset law? I think it should be included.

2 I think it should be included.

3 Mr. Stern. I believe that is done through a funding  
4 determination, not the laws themselves.

5 Senator Curtis. Why not? Why not have them come in and  
6 prove their worth? And some of them who are suffering from  
7 obesity could have a new birth of normal weight.

8 Senator Roth. We will be able to deal with that problem.

9 The Chairman. I would like to ask the staff to get and  
10 make available to every member what I thought was one of the  
11 most thoughtful articles written on this subject this year,  
12 an article by Art Pine. Sometime back he started out talking  
13 about a situation where a salesman in his store bought --  
14 the salesman in a store bought at a discount because he  
15 ~~bought at~~ the store.

16 The point is, if you follow the logic of the Internal  
17 Revenue, anytime that the salesman buys something from the  
18 store at a discount, that can be assessed as income against  
19 the salesman.

20 Some years ago it was my good fortune to find a fellow  
21 who thought he could buy something at a discount for me. He  
22 once earned a furniture store in New Orleans. He does not  
23 own it any more, but he once did, so he had the fraternity --  
24 he told me he could help me buy some furniture. And it was  
25 amazing to me, you can go with someone, how he can buy it for

1 you at a discount.

2 If you take the Treasury regulation, the Treasury will  
3 come in and tax you on the difference between the stated price  
4 and the discount on the theory that even though they sold it  
5 to you at a more reasonable price than they were asking, that  
6 you had been gifted with income for the difference. And it  
7 creates all kinds of problems.

8 I would like the Senators to take a look at this. Read  
9 Mr. Pine's article on our subject. This is a very, very broad  
10 subject and it leads you into all kinds of directions. I  
11 am not disparaging some fine things that other people have  
12 written in this area, but all that is involved in taxing these  
13 so-called fringe benefits, taxing a little hostess because she  
14 goes somewhere to eat free or at a discount.

15 There are so many things. The Wall Street Journal had  
16 this ad just the other day -- all this talk about the three  
17 martini lunch, that would not concern the average man, but  
18 now they are going to tax your baloney sandwich at the  
19 company cafeteria.

20 Senator Moynihan. On-the-job training may be taxable  
21 income; Mr. Kurtz has suggested that.

22 May I say, Mr. Chairman, that Senator Dole and Senator Roth  
23 have both introduced a bill similar to the one I have intro-  
24 duced. Forgive me for not making that clear.

25 I just wanted to make clear that Mr. Stern hopes to bring

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1 the matter up on Thursday.

2 Senator Long. Thank you very much, gentlemen. We will  
3 plan to meet again on Thursday.

4 Senator Moynihan. One thing. Senator Bentsen suggested  
5 that on Thursday we will have to deal with this New York City  
6 measure. It is a very simple one, so we wonder if it could  
7 be put at the beginning of the agenda? It will not take us  
8 too much time, I think, but we need to get it out.

9 The Chairman. All right.

10 (Thereupon, the Committee recessed, to reconvene  
11 Thursday, June 22, 1978.)

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June 15, 1978

MEDICARE-MEDICAID ADMINISTRATIVE AND REIMBURSEMENT REFORM ACT (S. 1470)  
 (Prepared by the Staff of the Committee on Finance)

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Section 2. -- Criteria for Determining Reasonable Cost of Hospital Services

Background

The rapid growth in the costs of hospital care has focused increasing attention on hospitals and the present methods currently used to reimburse hospitals. Cost-based reimbursement such as that utilized by Medicare and Medicaid, in particular, has been widely criticized as inflationary. There is little in the way of pressure on hospitals so paid to contain their costs, since, generally, any increases are simply passed along to the third party payors. The present "reasonable costs" procedures under the Medicare program are not only inherently inflationary--because there are no effective limits on what costs will be recognized as reasonable--but also contain neither incentives for efficient performance nor true disincentives to inefficient operation.

Summary of Proposal Including Modifications

Section 2 of the bill would establish new methods of reimbursement for hospitals under the Medicare and Medicaid programs. The new methods, to be effective with hospital reporting periods that begin after June 30, 1979, would be implemented in two stages: (1) During an initial, transitional stage, which is expected to cover the first two years, most of a hospital's routine costs (essentially costs other than ancillary expenses such as laboratory, X-ray, pharmacy, etc.) would be subject to a target rate based on similar costs incurred by comparable hospitals. Those hospitals whose routine operating costs were below the average for comparable hospitals would be rewarded with incentive payments, and payments to those hospitals with routine operating costs are substantially above the average would be reduced. If during this initial period it is determined that non-routine in-patient hospital costs are rising at excessive rates, annual increases in these ancillary costs would be limited, on an interim basis, by an index related to changes in the prices and wages hospitals pay and in the services hospitals provide. (2) The initial system would be studied and refined, based on recommendations of a Health Facilities Costs Commission, until a permanent system could be established which would establish payment rates and provide incentive payments with respect to both routine and ancillary costs. Continuing efforts would be undertaken by the Commission to refine and improve the system of classification and comparison so as to achieve the greatest equity possible.

Reimbursement for routine costs. -- Comparisons among hospitals would be made by:

1. Classifying hospitals in groups by bed size, type of hospital, rural or urban location, or other criteria recommended by the Health Facilities Cost Commission;
2. Utilizing a uniform cost reporting system; and
3. Including all routine costs and excluding variable costs such as capital and related costs; costs of education and training programs; costs of interns, residents and non-administrative physicians; energy costs; and malpractice insurance costs.

A per diem rate for routine operating costs would be determined for each hospital by:

1. Calculating the average per diem routine operating cost within each group of hospitals under the classification system, and
2. Determining the per diem rate for each hospital in the group by adjusting the labor cost component of each hospital's per diem routine cost for area prevailing wage differentials.

Hospitals whose actual routine operating costs fell below their payment rate would receive one-half of the difference between their costs and their payment rate, with the incentive payment limited to five percent of their payment rate. Hospitals whose actual costs exceeded their payment rate, but were no more than 115 percent of that rate, would be paid their actual costs. Those with costs above 115 percent of their payment rate would have their reimbursement limited to that amount. Adjustments would be made to take into account wage and price changes, subject to certain limits.

In the second and subsequent years the maximum payment rate would be increased by the actual dollar increase in the average rate for a group during the preceding year. In calculating the group averages, one-half of costs found excessive would be excluded from the calculation.

Exceptions to the target rates would be made for hospitals which demonstrate that their costs exceed their rates because of: (1) unusually high standby costs necessary to meet the needs of a particular area; (2) atypical cost and revenue patterns of newly-opened hospitals; (3) increases or decreases in services for such reasons as consolidation, sharing, and approved addition of services among hospitals; (4) evidence which demonstrates that they paid their employees larger wage increases than those received by other workers in the area because the hospital employees' wages were below the level prevailing locally for comparable or reasonably comparable work. Also, in the first year only, an exception would be made where a hospital can demonstrate that the wages paid to its employees are significantly higher (in relation to the wage level prevailing in its area) than other hospitals in its group.

Hospitals would be exempted from the proposed cost limits if: (a) the hospital is located in a State which has a cost control program which applies at least to the same hospitals and costs as the Federal program; and (b) the State requests use of their own program and demonstrates to the satisfaction of the Secretary that, using the State's program, total reimbursable costs of hospitals in the State can reasonably be anticipated not to exceed those under the national program. Hospitals in States which obtain a waiver would be reimbursed for the Medicare program's proportionate share of the cost of operating its cost control program. A State which exceeds, in the aggregate, the costs which would otherwise have been paid under the Federal programs, for any two-year period would be covered under the Federal limits beginning with the subsequent year and have the amount of the payments overrun recouped over subsequent periods through appropriate reduction (not in excess of one percent annually) in the routine and ancillary cost limits otherwise applicable.

Reimbursement for ancillary costs. -- The Health Facilities Cost Commission, until such time as they are able to develop and implement classification and comparison for hospital ancillary costs (in whole or part), would monitor increases in Medicare-Medicaid reimbursement for ancillary services, to determine whether the increase exceeds the rate that can be justified by changes in general earnings levels and changes in the prices of goods that hospitals pay in order to provide ancillary services.

If it was determined by the Commission that increases in ancillary costs were excessive, an interim limit on such costs could be applied. Under the interim method, increases in each hospital's ancillary costs per stay would be updated annually to take account of changes in general wage levels in the hospital's locality and national changes in a weighted index of prices which hospitals pay for a market basket of key items and supplies reasonably representative of ancillary departments' purchasing patterns and overall costs.

There would also be an adjustment to take account of the marginal costs or savings attributable to changes in admissions volume, varied to take account of the individual hospital's size, location and prior occupancy level. In the first year the relative impact of these factors would be estimated based on National data. In subsequent years the relative impact would be based on surveys.

The allowable percentage increase for ancillary costs could be further increased for hospitals whose routine costs, by an intensity factor to be recommended by the Commission as appropriate for some or all hospitals.

The ancillary service cost limit would be combined with the routine service cost limit into a single overall limit on reimbursable costs per stay.

Permanent reform. -- Reimbursement for Medicare and Medicaid hospital costs would be refined by the Commission on an ongoing basis by improving on the routine cost method described above and by extending the technique of classification and comparison or applying other equitable procedures for determining reasonableness of costs, to ancillary costs, to outpatient hospital services, and other provider costs.

For example, the Commission could recommend whether a warranted change in the provision of hospital services will have a significant effect on the cost of hospital care which the market basket index and earnings adjustment do not reflect. The Commission would determine what additional costs, if any, the affected hospitals should appropriately bear and would adjust the hospital's target rate accordingly.

The exceptions process described for the routine cost rates would also be subject to refinement under the permanent program.

Health Facilities Costs Commission. -- On or before January 1, 1979, the Secretary would appoint the members of a new Health Facilities Costs Commission. The Commission would consist of 15 persons who are expert in the health facilities reimbursement area. Three members would be representatives of hospitals, and 12 members would represent public (including Federal, State and local governmental programs) and private third-party programs committed to cost control objectives in their own programs. A majority would be selected from governmental programs. The members would serve staggered four-year terms.

The Commission would constitute the primary source of policy guidance on all matters concerning the reimbursement reform program. The Secretary could reject a decision of the Commission.

The Commission would monitor and study all aspects of the interim and permanent reform program and propose such changes and refinements as it found appropriate. Such changes would be implemented unless specifically rejected by the Secretary. The Commission would be directed to also develop more equitable and cost-effective reimbursement in the following specific areas:

1. Expanding the program to include: one or more of the excluded inpatient costs; outpatient hospital costs; the costs of other providers of services (such as skilled nursing facilities, ICF's, home health agencies, and renal dialysis facilities, etc.).
2. A refined method of adjusting reimbursement to inpatient facilities that takes account of the changes in marginal costs or savings attributable to changes in admissions volume and other factors.
3. The desirability of waiving applicability of the Federal reimbursement limits in the case of hospital clusters.
4. The equity, cost and efficiency of applying the exceptions provided by the bill, and improved means of timely determination of such requests.
5. Refinement of classifications, cost comparisons and procedures for updating cost information.
6. Review the industry's voluntary program and made recommendation concerning the triggering of the limits on ancillary costs it believes to be warranted.

The Secretary, taking account of the proposals and advice of the Commission, would modify the reimbursement system by regulation.

Section 3 -- Payments to Promote Closing and Conversion of Underutilized Facilities

Background

Studies have pointed to a national surplus of short-term general hospital beds ranging as high as 100,000 or roughly 10 percent of total available beds. Excess capacity contributes significantly to hospital costs since the initial construction and financing expenses have to be recovered through the hospital charge structure. In addition there are the continuing expenses associated with maintenance and non-patient services involved in keeping an empty bed ready for use.

Summary

Section 3 provides for including in hospital reasonable cost payment, reimbursement for capital and increased operating costs associated with the closing down or conversion to approved use of underutilized bed capacity or services in nonprofit short-term hospitals, (limited to increased operating costs in for-profit short-term hospitals). This would include costs which might not be otherwise reimbursable because of payment "ceilings", such as severance pay, "mothballing" and related expenses. In addition, payments could be continued for reasonable cost capital allowances in the form of depreciation or interest which would ordinarily be applied toward payment of debt outstanding and incurred in connection with the terminated beds. In the case of complete closing down of a hospital, payments would continue toward repayment of any debt, to the extent previously recognized by the program, and actually outstanding.

A commission would approve requests for such payments. Appropriate safeguards are to be developed to forestall any abuse or speculation. During the first two years, not more than 50 hospitals could be paid these transitional allowances in order to permit full development of procedures and safeguards. This limited application will also provide Congress with an opportunity to assess the effectiveness and economic effect of this approach in encouraging hospitals to close or modify excess and costly capacity without suffering financial penalty.

Section 4 -- Federal Participation in Hospital Capital Expenditures

Background

Under section 1122 of the 1972 Amendments, the Secretary is required to seek contract agreements with the States for their review of capital investment in hospital and other health care facilities which exceed \$100,000, change the bed capacity, or substantially change the services in the facility. HEW may deny Medicare and Medicaid reimbursement for depreciation or interest costs if they were incurred without prior State approval.

Summary

Section 4 provides for changes to be made in the current law limitations on Medicare and Medicaid payments related to certain hospital capital expenditures. These changes link the procedure directly to the health planning law (P.L. 93-641) and require that the designated planning agency (the so-called State Health Planning and Development Agency as designated under Section 1521 of the Public Health Service Act) approve capital expenditures in excess of \$100,000 as a condition of Medicare and Medicaid reimbursement for both capital and direct operating costs associated with those expenditures. A special procedure is established for proposed capital expenditures in metropolitan areas which include more than one State or jurisdiction. States or jurisdictions in the area must approve the expenditure, or it would be considered disapproved for purposes of reimbursement, subject to review and reversal by the Secretary.

## Section 10 -- Agreements of Physicians to Accept Assignment of Claims

### Background

Payments for physicians' services under Medicare may be made directly to the beneficiary or to the physician furnishing the service depending upon whether the itemized bill method or assignment method is used when requesting payment from the carrier. An assignment is an agreement between the physician and the Medicare beneficiary under which the beneficiary "assigns" to the physician his rights to benefits for covered services included in the claim. In return, the physician must agree to accept the reasonable charge determined by the carrier as his full charge for the items or services rendered. A physician may accept or refuse requests for assignments on a bill-by-bill basis.

Total assignment rates and net assignment rates (which excludes claims from hospital-based physicians and group practice prepayment plans) have been declining steadily. In calendar year 1977 the net assignment rate was 50.5 percent.

### Summary

Section 10 provides incentives for physicians to accept assignments for all their Medicare claims. Under the bill there would be "participating" physicians, a concept employed by many Blue Shield plans. A "participating" physician is an M.D. or D.O. who voluntarily and by formal agreement agrees to accept the Medicare reasonable charge determination on an assignment basis, as the full billing amount for all services to all Medicare patients. Agreements would be cancelable or concluded on the basis of 30 days' notice. "Nonparticipating" physicians could continue to elect to use the assignment method of billing on a claim-by-claim basis, as under present law.

In the case of a participating physician: (1) the Secretary would establish appropriate procedures and forms whereby such physician may submit his claims on one of various simplified bases and these claims would be given priority handling by the Part B agent.

An "administrative" cost-saving allowance of \$1 per eligible patient would be payable to a participating physician covering all services provided and billed for with respect to an eligible patient which were included in a multiple billing listing.

No administrative allowance would be payable in the case of claims solely for laboratory tests and X-rays undertaken outside of the office of the billing physician.

As an example of how this would operate, take the case of a physician who does not accept assignments today and whose routine office visit charge is \$10. If he became a "participating" physician, he would receive an extra \$1 allowance for that visit plus probably save at least another \$1 in billing, collection and office paperwork costs. In effect, his net practice income would increase by 20 percent as a result of "participation". The physicians with the lowest charges (often those in rural or ghetto areas) would benefit proportionately most from participation, as the cost-savings allowance and the office cost cutting would represent a greater percentage of their charges.

## Section 11 -- Criteria for Determining Reasonable Charge for Physicians' Services

### Background

Medicare presently allows a new doctor to establish his customary charge at not greater than the 50th percentile of prevailing charges in the locality.

Medicare currently utilizes more than 200 different "localities" throughout the country for purposes of determining Part B "reasonable" charges. In some States there are as many as 15 different localities. This has led to marked disparities in areas of the same State in the prevailing charges for the same service. For example, the prevailing charge under Medicare was \$450 in Los Angeles for a hemorrhoidectomy but only \$280 in San Francisco for the same procedure. Additionally, under present law, all prevailing charges are annually adjusted upward by a fixed percentage to reflect changes in the costs of practice and wage levels. The effect of present law is to further widen the dollar gap between prevailing charges in different localities.

### Summary

Section 11 would permit new physicians setting up practices in localities with lower fee levels to establish their customary charges at the 75th percentile of prevailing charges (rather than the 50th) as a means of encouraging doctors to move into low-fee, physician-shortage areas. It would also permit doctors presently practicing in shortage areas to move up to the 75th percentile.

Section 11 would require calculation of Statewide prevailing charges (in any State with more than one locality) in addition to the locality prevailing charges. To the extent that any prevailing charge in a locality was more than one-third higher than the Statewide average charge for a given service, it would not be automatically increased each year. This provision would not reduce any prevailing charges currently in effect -- it would operate, to the extent given charges exceed the Statewide average by more than one-third -- to preclude raising them.

## Section 12 -- Hospital Associated Physicians

### Background

Many physicians in the fields of radiology, anesthesiology, and pathology generally engage in a variety of professional activities including teaching, research, administration, and other hospital activities in addition to furnishing or supervising medical services for individual patients.

Under present law, a variety of payment mechanisms are recognized for reimbursement purposes. One form involves an arrangement between physicians and the hospitals under which the physicians' compensation is based on a percentage of departmental gross charges or of net collections. These percentage arrangements generate substantially higher costs to Medicare and Medicaid than other forms of compensation more directly related to personally rendered professional time and effort.

Summary

The section provides that reimbursement for the portion of his services which the physician may perform for the hospital as an executive, educator, or supervisor would be paid, by the hospital, on a basis related to what would be paid in the case of a salaried physician performing similar work for an institution. Percentage arrangements would ordinarily not be recognized for Medicare and Medicaid reimbursement purposes to the extent those arrangements yield amounts in excess of what would have otherwise been paid to a physician performing similar functions in an employment relationship.

The provision in present law which permits 100 percent payment for inpatient radiology and pathology tests, instead of 80 percent as is the case with all other physician services under Medicare, would be retained only for those physicians who agree to become "participating physicians." The section preserves the eligibility of radiologists, pathologists, and anesthesiologists to be paid by Medicare and Medicaid on a fee-for-service basis for patient care services which they personally perform or personally direct.

Suggestion

The staff suggests additional language authorizing the Secretary to establish regional schedules of allowances for the professional services of physicians at such time as adequate criteria specifying the minimum range of professional activity and time actually undertaken and spent in clinical laboratory supervision and administration in a hospital become available.

Such allowances for "professional components" may utilize a relative value approach in weighting one test or procedure as opposed to another. The amounts would be collected by the hospital in behalf of the physician(s) concerned and then paid to them.

Appropriate modifications depending upon volume of tests, would also be made in the schedule of allowances. It is also suggested that, to the extent not otherwise compensated, reasonable allowances be established under Part A for professional services in the performance of autopsies.



Section 13. -- Payment for Certain Antigens Under Part B of Medicare

Background

It is common for a doctor to refer a patient to an allergist who prepares a supply of antigens for the referring doctor's use. Under current Medicare law, the allergist cannot be reimbursed directly for the antigen unless he also administers it.

Summary

Section 13 would amend current law to provide that allergists may be paid directly for preparation of a reasonable supply of antigens which are dispensed or administered by or under the supervision of another physician.

Section 14. -- Payments on Behalf of Deceased Individuals

Background

Under present law, Medicare can only pay a claim on behalf of a deceased beneficiary where the physician accepts an assignment or where the family has actually paid the bill. Where a physician refuses an assignment, families have encountered difficulty in raising sufficient cash to pay the bill in order to be eligible for payment by Medicare.

Summary

Section 14 would permit payment by Medicare on the basis of a non-receipted bill for care directly to the spouse or other legal representative of a deceased Medicare beneficiary.

Section 15. -- Use of Approved Relative Value Schedules

Background

Third-party payors have often employed relative value schedules to determine payment rates for the many different services and procedures which physicians perform. These are lists of medical procedures and services which set forth comparative numerical values for each. These useful mechanisms for assessing reasonableness of physicians' fees have recently been cited by the FTC and the Department of Justice as being conducive to price fixing by the physician groups that have traditionally been responsible for their development.

Summary

Section 15 authorizes the use of procedural terminology systems and relative value schedules for use under Medicare, Medicaid and other non-public programs where approved by the Secretary of H.E.W. The Secretary would approve the terminology and relative values only if he has been advised by the H.E.W. Health Care Financing Administration that: (a) all interested parties have been given the opportunity to comment; (b) economic impact of the relative values have been analyzed through statistical analysis; (c) the system is practical to use and reflects the time, effort and other factors required to perform the various listed procedures; and (d) the use of the system will enhance the administration of Medicare and Medicaid.

## Section 20 -- Hospital Providers of Long-term Care Services

### Background

Under present law, a hospital-based skilled nursing facility can participate in Medicare and Medicaid only if the facility is a "distinct part" of the institution. To be a distinct-part SNF, the facility must be an identifiable, separate unit within the institution. All beds within the unit must be separated physically from units housing all other patients in the hospital. Various beds scattered throughout the hospital may not comprise a distinct-part for purposes of program participation.

### Summary

The bill would authorize Medicare and Medicaid reimbursement to small rural hospitals that use the facility's beds on a "swing" basis as either acute or long-term care beds, depending on need. The bill would allow reimbursement to a hospital which (1) has less than 50 beds; (2) has an average daily occupancy rate of less than 60 percent; and (3) has been granted a certificate of need for the provision of long-term care services.

A simplified cost reimbursement formula would avoid the current requirement for separate patient placement within the facility and separate cost finding.

Within three years after enactment, the Secretary would provide a report to Congress concerning whether a similar provision should be extended to other hospitals where there is a shortage of long-term care beds, regardless of number of beds or geographic location.

## Section 21 -- Reimbursement Rates Under Medicaid for Skilled Nursing Facilities and Intermediate Care Facilities

### Background

Present law requires States participating in Medicaid to pay skilled nursing facilities (SNF's) and intermediate care facilities (ICF's) on a reasonable cost-related basis. This requirement, added by section 249 of the Social Security Amendments of 1972, gives States the option of using Medicare's reasonable cost reimbursement formula for purposes of reimbursing SNF's and ICF's or developing other reasonable cost-related methods of reimbursement acceptable to the Secretary.

There has been considerable controversy over whether the reimbursement mechanisms developed under section 249 may include an allowance in the form of incentive payments related to efficient performances by providers.

### Summary with Modifications

The bill would allow States the option, when computing reimbursement rates under Medicaid to a SNF or ICF, to include reasonable allowances for the facility in the form of incentive payments related to efficient performance.

Section 22. -- Medicaid Certification and Approval of Skilled Nursing and Intermediate Care Facilities

Background

At present, the decision as to whether a skilled nursing facility (SNF) or an intermediate care facility (ICF) is qualified to participate in the Medicaid (Title XIX) program is made by State agencies.

However, for skilled nursing facilities participating under Medicare only, or both Medicare and Medicaid, the Secretary of HEW is the final certifying officer.

State certification of SNF's and ICF's results in lack of uniformity in the application of the Federal standards to which all such facilities are subject and lack of timely termination of facilities with serious deficiencies.

Use of provider agreements without fixed expiration dates has in the past caused serious difficulties and delays in decertifying a facility with deficiencies.

Summary

The bill provides that final determinations of basic eligibility of skilled nursing facilities and intermediate care facilities under title XIX be made by the Secretary of HEW. The Secretary would enter into an agreement with the State whereby the appropriate State health agency would survey facilities wishing to participate in either (or both) the Medicare or Medicaid programs and report its findings and recommendations to the Secretary. The Secretary would make a determination as to eligibility and advise the State if a facility meets the basic requirements for participation as a SNF or ICF. The Secretary would specify the length of time (not to exceed 12 months) for which approval could be granted.

The State could accept as a participant in the Medicaid program any facility certified by the Secretary. A State could not receive Federal matching funds for services provided by any facility not approved by the Secretary.

Facilities dissatisfied with the findings of the Secretary would be entitled to a hearing by the Secretary and to judicial review of the Secretary's final decision following the hearing.

The purpose of the provision is to assure more uniform application of health and safety standards and timely termination of facilities with serious deficiencies. The provision is comparable to an amendment approved by the Finance Committee and Senate in 1972.

Section 23. -- Visits Away from Institution by Patients of Skilled Nursing or Intermediate Care Facilities

Background

Until recently, HEW policy has limited Federal contributions to the cost of reserving beds in skilled nursing facilities (SNF's) and intermediate care facilities (ICF's) for Medicaid patients temporarily away from the institution. The regulations permitted Federal funds to be used to reserve a bed for 15 days each time a patient was in a hospital for acute care. It also permitted Federal contributions for a total of 18 days during a 12-month period when patients were visiting their homes or other places for therapeutic reasons.

Last year, the Health Care Financing Administration issued regulations that removed all limitations on Federal funding of therapeutic absences as long as they are authorized.

Currently, however, there are no requirements in existing law setting forth policies with respect to reserving beds in SNF's and ICF's for Medicaid patients who are temporarily away from the institution.

#### Summary

The bill would prohibit the Secretary from imposing numerical limits on the number of home visits which might be made by SNF or ICF patients.

### Section 30. -- Establishment of Health Care Financing Administration

#### Background

S. 3205 (94th Congress) included a provision which provided for the establishment of a Health Care Financing Administration (HCFA) in HEW. This proposal was directed toward promoting uniform policy-making and enhanced accountability in the Medicare and Medicaid programs. In early 1977, the Administration adopted administratively the structured changes which were included in S. 3205. HCFA includes the old Bureau of Health Insurance, Bureau of Quality Assurance, Medical Services Administration, and the Office of Long Term Care.

#### Summary

Section 30 provides statutory authority for the combination of the Medicare, Medicaid, Office of Long Term Care and Bureau of Quality Assurance agencies into a single Administration for Health Care Financing headed by an Assistant Secretary.

#### Suggestion

Because the administrative reorganization has, instead of simplicity and consolidation, led to increased complexity, staffing, budget and fragmentation, it is suggested that the amendment be modified so as to provide only:

1. A statutory basis for HCFA.
2. Statutory positions of: (a) Administrator, (b) Deputy Administrator, (c) Deputy Administrator for Medicare, and (d) Deputy Administrator for Medicaid.
3. For a complete report by the Comptroller General (within 6 months) evaluating the organization to date as well as recommended improvements.
4. Committee recommends that further permanent appointments to principal positions and reclassification actions (with respect to the Bureau of Health Insurance) be suspended pending the G.A.O. report).

### Section 31. -- State Medicaid Administration

#### Background

The efficiency of State Medicaid programs varies widely. In a number of instances the administration is lax and does not meet Federal requirements for proper program operation. While some improvements have recently been noted, serious deficiencies still exist in a number of States. This is due principally to the general lack of uniform program performance standards and the absence of effective sanctions on poor-performing States.

#### Summary

Section 31 establishes specific performance criteria with respect to State administration of Medicaid. These would require timely determination and redeterminations of eligibility; effective review of those providing services and the services provided; and timely development and submission of program operating data. The Secretary would review, on site, each State's compliance, with these criteria, as well as with the requirements for prompt claims payment established in P.L. 95-142.

The Comptroller General would certify the methodology used by the Secretary. Deficiencies would be required to be corrected within periods not exceeding six months. At Federal expense, States would be provided any necessary technical or professional assistance they requested to improve their systems or correct deficiencies. Graded penalties relating to Federal matching for administrative costs would be assessed for uncorrected deficiencies. States which perform in a superior manner would be rewarded by a higher Federal matching rate for administrative costs. All review reports and findings would be made available to Governors and State legislatures on a routine basis.

#### Suggestion

Because of the coordination of AFDC and Medicaid eligibility determinations, it is suggested that the eligibility element, as a test of State performance, be taken out of the amendment.

#### Section 32. -- Regulations of the Secretary

##### Background

Under the Administrative Procedures Act (5 U.S.C. 553), the Secretary is required to publish a general notice of proposed rulemaking in the Federal Register. After providing the public with an opportunity to comment, he then publishes a final rule which ordinarily can become effective no earlier than 30 days after publication. Present law permits the Secretary, for good cause, to dispense with both the requirements for the notice of proposed rulemaking and public participation, and the delayed effective date. In a number of instances, HEW has failed to promulgate both proposed and final rule-making on a timely basis.

##### Summary

Section 32 would provide that all regulations implementing the Social Security Act, determined by the Secretary to be urgent, would become effective within 60 days after publication in the Federal Register. In addition, all regulations relating to this bill would have to be promulgated so as to become effective no later than one year after enactment.

#### Section 33. -- Repeal of Section 1867

##### Background

The "Social Security Amendments of 1965" provided for the establishment of the Health Insurance Benefits Advisory Council (HIBAC) under the new Section 1867 of the Act. This Council was to provide advice to the Secretary on matters of general policy with respect to the administration of Medicare. The "Social Security Amendments of 1972" modified the role of the Advisory Council so that its role would be that of offering suggestions for the consideration of the Secretary on matters of general policy in both the Medicare and Medicaid programs. Questions have been raised regarding the continuing effectiveness of this body.

##### Summary

Section 33 would terminate HIBAC upon enactment.

Section 40. -- Procedure for Determining Reasonable Cost or Reasonable Charge

Background

The concepts of "reasonable cost" and "reasonable charge" are incorporated into the reimbursement policies of the Medicare and Medicaid programs to assure that only items reasonably related to and necessary for the efficient delivery of quality health services are recognized for payment purposes. Present law and current regulations prescribe a variety of rules for establishing the "reasonableness" of both costs and charges. However, there are at present no rules to test the reasonableness of costs or charges calculated or derived from a percentage, fraction or proportion of patient service revenues. For example, business contracts for support services such as computer and data processing, financial and management consulting, or for the furnishing of equipment and supplies to providers of health services may provide remuneration to the suppliers based on a percentage of the gross or net billings of the health care facilities or of individual departments. Similarly, landlords may receive a percentage of provider gross (or net) income in return for office space, equipment, shared waiting rooms, laboratory services, custodial and office help and administrative services. Such arrangements can be highly inflationary and add costs to the Medicare and Medicaid programs which may not reflect actual efforts expended or costs incurred.

Summary

Section 40 provides that reimbursement to contractors, employees or related organizations, consultants, or subcontractors would not be recognized where compensation or payments (in whole or part, in cash or kind) were based upon percentage arrangements. This would include payment of commissions and/or finders' fees and lease or rental arrangements on a percentage basis, as well as management or other service contracts or provision of services by collateral suppliers such as pharmacies, laboratories, etc. The percentage prohibition would flow both ways either from the supplier or service agency back to the provider or organization or from the original provider or organization to the supplier or service agency.

Suggestion

The staff suggests that the Secretary be granted authority to permit reimbursement for normal business practices (such as real estate brokerage) which do not result in excessive costs to the Medicare program.

Section 41. -- Ambulance Service

Background

Under present law, Medicare will pay for ambulance services where the use of other means of transportation is contraindicated by the individual's condition and the individual is transported to the nearest participating institution with appropriate facilities. The term "appropriate" facilities means that the institution is generally equipped to provide the needed hospital or skilled nursing care for the illness or injury involved. The individual physician who practices in a hospital is not a consideration.

On rare occasions, the nearest hospital with appropriate facilities does not have a physician available to undertake the required specialized care. The present alternatives are to bring the physician to the patient, a possible misuse of physician time, or to transport the patient to the more distant facility at his own expense.

Summary

Section 41 would provide reimbursement for ambulance service to a more distant hospital when the nearest hospital does not have staff qualified to undertake the required care.

Section 42 -- Grants to Regional Pediatric Pulmonary Centers

Background

In 1972 the Senate approved an amendment which would authorize up to \$5 million annually for grants to public or nonprofit private regional pediatric respiratory centers which are part of (or affiliated with) institutions of higher learning. These grants were to assist institutions in the training of health care personnel in the prevention, diagnosis, and treatment of respiratory diseases and providing needed services for children and young adults suffering from such diseases.

Summary

Section 42 is identical (except for effective dates) to the amendment approved by the Senate in 1972.

Section 43 -- Waiver of Human Experimentation Provision for Medicare and Medicaid

Background

Under current law, State Medicaid programs may impose nominal cost-sharing requirements on Medicaid eligibles. Recently, a cost-sharing experiment was challenged as violations of regulations implementing the Human Experimentation statute. The challenge would effectively prevent any cost-sharing experiments under the Medicaid program, and could seriously hinder other Medicaid and Medicare research.

Summary

Section 43 waives the requirements of the Human Experimentation statute otherwise held applicable for purposes of Medicare and Medicaid.

Section 44 -- Disclosure of Aggregate Payments to Physicians

Background

Recent disclosures of physicians receiving large payments under Medicare have served to unjustifiably embarrass honest physicians who serve a large number of elderly patients. The disclosures have also been characterized by a high degree of inaccuracy which has not only embarrassed the physicians concerned but also the Government.

Summary

Section 44 would ordinarily prohibit the release of the names and the amounts paid to physicians on behalf of Medicare patients. Similar information on Medicaid payments could be released by a State if it chose to do so.

Section 45 -- Resources of Medicaid Applicant to Include Certain Property Previously Disposed of to Applicant's Relative for Less than Market Value

Background

Under present law, States which use the SSI criteria in determining Medicaid eligibility for the aged, blind, and disabled may not impose transfer of assets restrictions on those applicants. Thus, an applicant who needs Medicaid coverage can transfer assets which could be applied to the cost of Medicaid-financed services and become immediately eligible for Medicaid. This situation increases program costs, especially for expenditures for skilled nursing and intermediate care facility services, and damages program credibility by allowing relatively well-off people to become eligible for Medicaid.

Some 25-30 States are currently imposing restrictions on the transfer of assets on some Medicaid groups but not on others. Title IV-A of the Act does not prohibit such State eligibility conditions. Further, those States which choose to use the more restrictive standards for Medicaid eligibility for the aged, blind, and disabled rather than the SSI criteria can impose this eligibility condition if they did so in January 1972.

Summary

Section 45 would allow States to deny Medicaid benefits for up to a year in the case of aged, blind, or disabled individuals who disposed of their property to relatives for less than fair market value.

Suggestion

The staff suggests that the amendment be broadened to include transfers to any person not just a relative, and that the term "property" be changed to "assets."

Further, that the provision be a requirement of a State plan rather than a compliance question.

Section 46 -- Rate of Return on Net Equity for For-Profit Hospitals

Background

Under current law for-profit institutions are allowed a rate-of-return on their net equity equal to one and one-half the current rate-of-return on Social Security investments. This rate is not regarded as a fair return.

Summary (as modified)

Section 46 would increase the rate of return for for-profit institutions to two times the Social Security investment rate.



STATEMENT OF SENATOR BOB DOLE

MR. CHAIRMAN, THE DISCUSSION WE ARE ABOUT TO BEGIN COMES AT A DIFFICULT TIME FOR OUR HEALTH DELIVERY SYSTEM. WE ARE FACED BY STAGGERING COSTS, DEBATE ABOUT THE EFFECTIVENESS OF THE SYSTEM ITSELF, AND GROWING CONCERN THAT WE HAVE BUILT A MONSTER THROUGH OUR CENTRALIZED APPROACH TO DIRECTING AND REGULATING THAT VERY SYSTEM FOR WHICH WE STILL HOLD SO MUCH HOPE. WE ARE TODAY WATCHING THE MEDICAID AND MEDICARE PROGRAMS PAY OUR HOSPITALS AN AVERAGE OF 19 PERCENT MORE EACH YEAR OVER THE PAST TEN YEARS. OUR CITIZENS PAY MORE THAN \$700 EACH FOR HEALTH CARE ANNUALLY; OUR NATION WILL SOON COMMIT MORE THAN NINE PERCENT OF THE GROSS NATIONAL PRODUCT TO HEALTH CARE.

HOW DO WE RESPOND? THE ADMINISTRATION CRIES OUT FOR MORE AND MORE CONTROL, FORGETTING ONCE AGAIN THE PAINFUL LESSONS WE THOUGHT WE LEARNED WHEN PRICE CONTROLS FAILED IN THE PAST. "CUT IT OFF AT THE TOP - PUT ON THE CAP, EVERYTHING WILL BE OK!" IT CRIES. WHEN WILL WE LEARN? DO WE WANT MORE CHAOS? A "CAP" THAT MAY WELL FALL AND BECOME A FLOOR? A CAP THAT WILL LEAD TO SO MANY "EXCEPTIONS" THAT THEY WILL PROVE THE RULE? A CAP THAT COVERS A 50 BED RURAL HOSPITAL AS IF IT WERE THE SAME AS A 1000 BED HOSPITAL IN ONE OF OUR BLIGHTED CITIES!

THIS MAKES NO SENSE TO ME, AND THE AMERICAN PEOPLE WITH THEIR RECENT VOTES SAY THAT THE BIG BROTHER APPROACH MAKES NO SENSE TO THEM EITHER. WE CANNOT LOOK AT OUR HEALTH CARE SYSTEM AS IF IT IS ALL THE SAME. WE CANNOT FORGET THAT OUR STATES CAN JUDGE THEIR OWN NEEDS MUCH BETTER THAN WE SO MUCH OF THE TIME. WE CANNOT CONTINUE WITH THE FANTASY THAT MORE AND MORE MEDDLING IS THE ANSWER.

THAT IS WHY I HAVE JOINED WITH MY COLLEAGUES IN SPONSORING S. 1470. IN THIS BILL WE PROMOTE CHANGE THROUGH INCENTIVE, NOT PUNISHMENT. WE SAY THAT IF THE STATES KNOW BEST, LET US RECOGNIZE THAT AND INDEED HELP THEM IN DEVELOPING AN EQUITABLE AND MANAGEABLE DELIVERY SYSTEM. WE REALIZE THAT ALL IS NOT THE SAME AND RESPOND BY BEGINNING TO CLASSIFY, TO STOP TREATING APPLES AS IF THEY WERE ORANGES.

THERE ARE ELEMENTS OF THE BILL THAT NEED FULL DISCUSSION, IN MY VIEW. ARE WE PLACING SOME OF THE NON-FEDERAL, THIRD PARTIES AT RISK FROM HOSPITAL CONTROLLERS WHO MAY BE MOVED TO SHIFT COSTS AWAY FROM THE MEDICARE - MEDICAID PROGRAMS? HAVE WE THOUGHT THROUGH IMPLICATIONS OF THE HEALTH FACILITIES COSTS COMMISSION THAT HAS BEEN PROPOSED? WHO WILL SERVE? HOW WILL IT RELATE TO THE SECRETARY OF HEW? PERHAPS MOST IMPORTANTLY, HOW CAN WE IN THE CONGRESS ENSURE AN ONGOING VOICE AND CHANCE TO JUDGE FOR OURSELVES? MR. CHAIRMAN, I LOOK FORWARD TO AN ACTIVE PART IN THE DEBATE THAT FOLLOWS. AS YOU WELL KNOW, THESE ISSUES HAVE BEEN OF VITAL CONCERN TO ME IN THE PAST, AND I WELCOME THE OPPORTUNITY TO ADDRESS THEM ONCE AGAIN.

A G E N D A

SENATE FINANCE COMMITTEE

Thursday, June 22, 1978, 10:00 A.M.

1. Legislation extending the expiring law which permits the New York City employee pension funds to purchase and hold New York City and Municipal Acceptance Corporation (MAC) obligations (see staff document J)
2. Medicare-Medicaid Administrative and Reimbursement Reform Act (S. 1470) (see staff document E)

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Additional matters which may be brought up by Senators:

Senator Roth                      S. Res. 475, expressing the sense of the Senate that the Internal Revenue Service proposal to reorganize District Offices in 12 States not be implemented (see staff document G)

Senator Ribicoff                  Request for additional Committee funding to study the potential benefits and costs of the Multilateral Trade Negotiations (see staff document H)

Senators Moynihan,  
Dole and Roth                      Tax treatment of employee fringe benefits (see staff document K)

A G E N D A

## SENATE FINANCE COMMITTEE

Tuesday, June 20, 1978, 10:00 A.M. and  
Thursday, June 22, 1978, 10:00 A.M.

1. Nomination of Donald C. Lubick to be Treasury Assistant Secretary for Tax Policy
2. Waiver of Budget Act point of order on H.R. 11005, the International Trade Commission authorization bill (see staff document A)
3. Budget Act allocation by the Finance Committee (see staff document B)
4. Older Americans Act provision affecting social security programs (see staff document C)
5. Approval of Hungarian Trade Agreement (H. Con. Res. 555) (see staff document D)
6. Medicare-Medicaid Administrative and Reimbursement Reform Act (S. 1470) (see staff document E)

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Additional matters which may be brought up by Senators:

Senator Haskell	Private relief bill for Jefferson County, Colorado Mental Health Center (see staff document F)
Senator Roth	S. Res. 475, expressing the sense of the Senate that the Internal Revenue Service proposal to reorganize District Offices in 12 States not be implemented (see staff document G)
Senator Ribicoff	Request for additional Committee funding to study the potential benefits and costs of the Multi-lateral Trade Negotiations (see staff document H)
Senator Moynihan	Provisions of H.R. 12426 (the New York City loan guarantee bill) within the jurisdiction of the Finance Committee (see staff document I)

## BIOGRAPHICAL SKETCH

Donald C. Lubick

## I. EMPLOYMENT HISTORY

From March, 1977, to the present I have served as Deputy Assistant Secretary for Tax Policy (Tax Legislation), Department of the Treasury.

Before that time I practiced law in Buffalo, New York (from 1950 to 1977) except for the period 1961 to 1964 when I served as Tax Legislative Counsel, U.S. Treasury Department. In my private practice I was first an associate, and later a partner in Hodgson, Russ, Andrews, Woods & Goodyear, a firm that now numbers about 50 lawyers. My practice was largely in the field of taxation, including pension planning, estate planning, and general corporate and individual tax practice, both planning transactions and contested tax cases.

From 1950 to 1961 I also taught part-time at the University of Buffalo Law School, including courses in federal income taxation and corporate taxation.

I have also contributed to tax periodicals and lectured extensively at tax institutes.

## II. CIVIC AND PROFESSIONAL ACTIVITIES

During 1958 and 1959 I was Chairman of the Tax Revision Committee of the City of Buffalo, a nonpartisan study committee appointed to review the City's tax system and to make recommendations for alternative sources of local taxation.

I am a member of the New York and Florida Bars. I have served on numerous committees (including as Chairman) of the Tax Section of the American Bar Association, the New York State Bar Association and the Erie County Bar Association. I am a member of the American Law Institute.

I was a member of the Advisory Group to the Commissioner of Internal Revenue for 1976.

In 1974 I was a member of an Advisory Committee to a Select Committee of the New York State Legislature to Study the New York Election Law and Related Statutes.

June 15, 1978

A

Waiver of Budget Act Point of Order on H.R. 11005,  
International Trade Commission Authorization Bill

(prepared by the staff of the Committee on Finance)

The Congressional Budget Act requires that Committees report authorizing legislation on or before May 15 preceeding the fiscal year for which appropriations are authorized. This requirement is imposed to encourage early action on authorizing legislation so that the various authorizations can be considered in developing the first concurrent resolution on the budget and to enable the appropriations committees to complete action on their bills prior to the September consideration of the second budget resolution.

The Committee on Finance in reporting H.R. 11005, the U.S. International Trade Commission authorization bill, did not meet this May 15 reporting deadline. The bill, H.R. 11005, was passed by the House of Representatives on May 15, 1978 and referred to the Finance Committee on May 16. The Committee filed its report on this bill on May 25, 1978. The Committee's recommendations on this bill were developed and made known well in advance of the deadline. The Committee's decisions on the bill were reported in a press release issued by the Committee and in the Daily Digest section of the Congressional Record for April 27, 1978. However, since the Committee elected to follow its usual procedure of reporting a House-passed bill and since the House bill was not received in the Senate until after the May 15 deadline, the bill is in technical non-compliance with the Budget Act and requires a waiver.

Section 402 (c) of the Budget Act provides a procedure for waiving this May 15 reporting deadline. Under this procedure, a waiver resolution would be reported by the Committee. This resolution would then be referred to the Budget Committee which would have 10 days to consider it. After the resolution is reported by the Budget Committee (or after 10 days had elapsed), the resolution could be considered by the Senate. If the resolution is approved by the Senate, a point of order would no longer lie against the consideration of H.R. 11005.

June 15, 1978

ALLOCATION OF AMOUNTS ALLOWED IN THE FISCAL YEAR 1979  
BUDGET RESOLUTION FOR FINANCE COMMITTEE PROGRAMS

(Prepared by the Staff of the Committee on Finance)

Under the Congressional Budget Act, the Congress on May 17, 1978 approved a Congressional Budget Resolution (S. Con Res. 80) setting overall spending and revenue targets for fiscal year 1979. Under the Budget Act, the total budget authority and outlays provided for in this resolution are allocated among the various Committees of the Senate and House according to tables prepared by the Conference Committee on the Budget Resolution. Each Committee is then required--after consultation with its counterpart Committee in the other House--to file a report showing how it intends to divide the amount allocated to it "among its subcommittees or among programs over which it has jurisdiction." These amounts must also be subdivided into "controllable amounts and all other amounts."

The attached table shows the assumptions as to allocation by programs within Finance Committee jurisdiction of the amounts included in the first budget resolution for fiscal year 1979. (Only programs where the level of spending is directly controlled by Finance Committee legislation are included. Thus, programs such as social security and social services are included. Programs such as counter-cyclical revenue sharing and the work incentive (WIN) program are not included since the level of spending for these programs is controlled by the appropriations process.) The greater part of the amounts shown in the budget allocation tables simply reflect the most recent estimates of anticipated spending under existing law. In certain programs, however, the allocations reflect an expectation of savings or increased expenditure under future legislation.

Other income security. -- The other income security category includes the assistance programs (AFDC, SSI) and proposed fiscal relief for welfare costs. Starting this year, it also includes the refundable portion of the earned income tax credit which was previously treated as a revenue loss rather than an expenditure. The refundable part of the credit represents about 75 percent of its total impact. The assumed allowance for \$+0.4 billion in new legislation in these programs takes into consideration some anticipated savings and also allows for some additional spending. The allowance would permit all of the changes proposed by the Committee in the bill H.R. 7200. The present law totals assume some savings resulting from changes in legislation not under Finance Committee jurisdiction as a result of better targeting of CETA jobs to welfare recipients.

Health programs. -- The present law totals for Medicare and Medicaid assume some savings from voluntary cost control and administrative improvements in quality assurance, but do not assume any savings in fiscal 1979 from legislative changes. The Medicaid allowance for new legislation would accommodate some additional spending for such changes as expanded child health services and the coverage of pregnant women.

ALLOCATION OF OUTLAYS UNDER FIRST CONCURRENT BUDGET RESOLUTION  
 AMONG FINANCE COMMITTEE PROGRAMS--ASSUMPTIONS UNDERLYING  
 CONGRESSIONAL BUDGET RESOLUTION

(billions of dollars)

Allowance for Outlays--Fiscal 1979

<u>Program category</u>	<u>Present law</u>	<u>New legis- lation</u>	<u>Total</u>
Social security	102.6	--	102.6
Unemployment compensation	11.0	--	11.0
Other income security	12.9	+0.4	13.4
Social services	2.6	+0.4	3.0
Medicare	28.6	--	28.6
Medicaid	11.5	+0.2	11.7
General revenue sharing	6.9	--	6.9
Interest on the public debt	53.2	--	53.2
Interest on tax refunds	0.3	--	0.3
Tax rebates to Puerto Rico and other programs	0.2	--	0.2
Accounting adjustment	6.8	--	6.8
Total	236.6	+1.1	237.7



June 15, 1978

Older Americans Act Provision Affecting Social Security Programs

(Prepared by the Staff of the Committee on Finance)

On May 15, the Human Resources Committee reported to the Senate a bill (S. 2850) amending and extending the Older Americans Act. Included in that bill is a provision under which all benefits funded by that program must be disregarded for purposes of all other Federal or State programs or laws. A similar, although more limited, provision is included in the House version of the bill (H.R. 12255).

Since the Older Americans Act includes public employment programs which can involve significant wage payments, this provision can have an important impact for the individuals involved under a variety of programs. Any such payments could not be counted for purposes of applying the social security retirement test or the income rules of the supplemental security income, medicaid, and social services programs. (Its application is actually broader than the Social Security Act. It would also affect veterans' pension programs, housing programs, and even State and Federal tax laws.)

This provision raises particular issues of equity. In the supplemental security income program, for example, the Congress has established detailed rules for the treatment of income with a view to treating different recipients equitably while still retaining the significant incentives for continued employment. An individual who has earnings from employment is permitted to exclude the first \$65 monthly of such income plus one-half of earnings above that level. The remainder would serve to reduce his payment. For example, an individual who works half-time at the minimum wage will earn about \$2500 in a year. This would cause a reduction of \$860 in his annual SSI entitlement. Under the Human Resources Committee bill this type of reduction would continue to apply to those engaged in private employment, but the \$860 reduction would be eliminated if the employment were subsidized under the Older Americans Act. There is no apparent rationale for this differential treatment of two similarly situated individuals. Moreover, it does not appear to be desirable to reward subsidized employment more highly than unsubsidized employment.

Another problem raised by the provision in S. 2850 is the precedent it creates for the enactment of further exemptions for other specific types of income derived from various programs. In fact, based on past actions, there is some reason for concern that such exemptions might be created by administrative action on the basis of the precedent established by this legislation.

Staff recommendation.--The Committee may wish to consider directing that an amendment to strike this provision from S. 2850 be offered in its behalf when the bill is considered by the Senate.

June 15, 1978

## H. CON. RES. 555

APPROVAL OF TRADE AGREEMENT BETWEEN THE UNITED STATES AND  
THE HUNGARIAN PEOPLE'S REPUBLIC

(Prepared by the Staff of the Committee on Finance)

The United States and the Hungarian People's Republic entered into a trade agreement on March 17, 1978. Under section 405(c) of the Trade Act of 1974, this trade agreement will become effective only if it is approved by both Houses of Congress. H. Con. Res. 555 approving the agreement was passed by the House on May 22.

Terms of the Agreement.--The principal provisions of the proposed trade agreement include the following:

- (1) The United States and Hungary will provide nondiscriminatory (Most-Favored-Nation) tariff treatment to imports from the other country;
- (2) American and Hungarian businessmen and companies will be assured of their ability to carry on normal commercial and financial activities in each country;
- (3) Property rights and copyrights will be protected in each country; and
- (4) The right of each country to restrict imports which are causing or threatening market disruption is protected.

U.S./Hungarian Trade.--Hungary is attempting to create a more flexible economy and to modernize its industry. To achieve these ends, they are importing Western equipment and allowing Western companies to establish manufacturing operations in Hungary.

Total U.S. trade with Hungary is increasing rapidly, from \$15 million in 1968 to \$127 million in 1977. U.S. exports to Hungary, primarily agricultural products, machinery, and transportation equipment, increased from \$11 million in 1968 to \$80 million in 1977. U.S. imports, primarily agricultural goods such as canned hams, increased from \$4 million to \$47 million over the same period. The 1977 surplus for the United States in its trade with Hungary was about \$33 million.

Statutory Procedure.--Under the Trade Act, the Finance Committee has 45 working days to consider the approval resolution. June 22 will be the 45th day. The Committee will be automatically discharged on June 23rd.

The Subcommittee on International Trade held hearings on S. Con. Res. 76, the companion to H. Con. Res. 555, on May 9.

The Jackson-Vanik freedom of emigration provisions of the Trade Act have been waived by the President with respect to Hungary. The freedom of emigration issue is not now technically before the Committee. The Subcommittee on Trade will hold a hearing on whether or not to extend the President's authority to waive the freedom of emigration restrictions generally, and with respect to Hungary and Romania specifically, in July.

June 15, 1978

## PRIVATE RELIEF: JEFFERSON COUNTY MENTAL HEALTH CENTER

(Prepared by the Staff of the Committee on Finance)

In 1975, the Jefferson County (Colorado) Mental Health Center in response to a survey initiated by the Internal Revenue Service was unable to find any indication that it had waived its immunity to social security taxes although it had been paying such taxes. As a result, the IRS directed the Center to refund those taxes for the prior 3 years to any employees who did not elect to have their social security coverage continued. The Center made the refund and applied to IRS to have the amount of those taxes repaid to it. At that point, the IRS discovered that a valid waiver of immunity had, in fact, been filed and that it was therefore unable to refund the taxes paid to the Center.

The Subcommittee on Taxation and Debt Management Generally held a hearing on this matter on October 14, 1977. The attorney for the Jefferson County Mental Health Center indicated that the Center seeks relief only for the employee share of the social security taxes involved and only for the period prior to the time when IRS notified the Center that its previous instructions were in error. (This notification occurred on May 14, 1975, and the amount of employee taxes which had been refunded at that point was \$74,128.)

The Administration witness at the October 14, 1977 hearing agreed that relief to the Jefferson County Mental Health Center is appropriate. However, the Administration expressed concern over the possible loss of social security coverage for the affected employees and the possibility that they may not have made an informed choice in opting for the refund.

Under Senator Haskell's proposal, the Secretary of the Treasury would be directed to refund to the Jefferson Mental Health Center the amount of \$74,128 representing the employee social security taxes which it had refunded to its employees on the basis of the IRS misinformation. The wages on which those taxes were paid would not be used for determining social security eligibility or benefit amount. However, the affected employees would be given an opportunity to elect to restore the deleted coverage upon repayment of the refunded taxes. Such repayment could be made in installments over a reasonable period of time as determined by the Secretary of the Treasury. The Department of Health, Education and Welfare would be required to make a reasonable good faith effort to contact the affected employees and to inform them of the consequences of their decision as to whether or not to repay the taxes. (The exact amount to be refunded to the Center will be subject to verification by the Secretary of Treasury of the amount that the Center repaid to its employees.)

June 15, 1978

S. RES. 475 -- TO DISAPPROVE PROPOSED  
INTERNAL REVENUE SERVICE REORGANIZATION

(prepared by the staff of the Committee on Finance)

The Internal Revenue Service has proposed a reorganization plan which would involve the "streamlining" of 12 of the smallest district offices. The proposal would eliminate certain middle management, technical and administrative support positions in the States of Delaware, Idaho, Maine, Montana, New Hampshire, New Mexico, North Dakota, Rhode Island, South Dakota, Utah, Vermont and Wyoming. Adjacent larger districts would be designated as "prime" districts to provide administrative support for the streamlined district offices (i.e., recruitment of personnel, procurement of space, etc.) In addition, the audit review function would also be performed in prime districts.

Under the IRS's plan for streamlining smaller districts, 220 positions would be eliminated. Sixty-five of these positions are supervisory and technical positions, such as division chiefs and reviewers. Twenty-six positions would be added in the prime districts so that the net effect of streamlining would be a reduction of 194 positions.

The IRS has based the need for streamlining these 12 smallest districts on the premise that they have fewer than 600 employees, which is the minimum employment level for acceptable efficiency levels based on present staffing patterns. The IRS estimates that there will be a \$4 million annual savings in salary and support costs as a result of streamlining the 12 smallest districts. This cost savings would be offset to some extent by increased travel and mail expenditures.

S. Res. 475 would express the sense of the Senate that the proposed reorganization should not be implemented.

June 15, 1978 H

ADDITIONAL COMMITTEE FUNDING TO STUDY THE POTENTIAL  
BENEFITS AND COSTS OF THE MULTILATERAL TRADE NEGOTIATIONS

(Prepared by the Staff of the Committee on Finance)

S. Res. 392, which provides funding for the Committee on Finance for the current fiscal year, includes \$40,000 for consultant services. These consultant funds have been obligated for contracts to permit the Committee to obtain independent cost estimates in the areas of social security, health insurance and welfare. The Committee has agreed to seek additional funds to contract with Chase Econometrics Associates, Inc., to improve their economic model on which revenue estimates are based.

Funding for Additional Studies

During the remainder of 1978, the United States will be completing the Multilateral Trade Negotiations (MTN). Early in 1979 the President will submit an implementing bill(s) to Congress. To date, no executive agency has undertaken an assessment of the potential costs and benefits which will accrue to the U.S. from the trade agreement.

The Committee staff has contacted the International Trade Commission, the Library of Congress, and the Congressional Budget Office about performing analyses of the MTN. But to obtain as broad a perspective as possible on the MTN, it would be useful to utilize consultants from universities and other institutions.

It would be desirable to have studies in at least these areas: An overall evaluation of the effects of the tariff reductions; the likely impact of the agreements on U.S. agriculture; the likely impact of the agreements on U.S. labor.

The study on tariffs would include an examination of the impact of tariff reductions on U.S. employment, exports, and imports. An especially important element of the study would be the measurement of the average tariff cuts. Typically, the depth of cuts on tariff schedule rates are averaged. For a variety of reasons, these averages can be misleading. For example, a 50 percent reduction on a 100 percent duty rate can have a totally different effect on trade compared to a similar level of reduction on a 5 percent duty rate. Only by studying the tariff reductions systematically at a detailed level can the overall impact be properly gauged.

The agricultural study would focus on the effects of the nontariff segments of the negotiations. Access to foreign markets and the effects of foreign subsidies are two particularly important areas. The effects of the reductions of some of the nontariff barriers facing American agricultural exports will not be easily quantified. It is anticipated that qualitative assessments would have to be made about the net benefits to the U.S. of the agreements on nontariff matters.

The overall employment effect of tariff and nontariff agreements would be an especially important study. The study would identify those industries where employment might increase and those where employment might contract. Additionally, the study would examine the impact on U.S. real wages and distribution of skills.

In addition to the studies outlined above, several consultants would be retained on a per diem basis to provide the staff with ongoing consultation.

The staff estimates that an additional authorization of \$200,000 should be requested to fund the studies and outside consultants on the MTN.

PROVISIONS OF H.R. 12426 (THE NEW YORK CITY LOAN GUARANTEE BILL) WITHIN THE JURISDICTION OF THE COMMITTEE ON FINANCE

(Prepared by the Staff of the Committee on Finance)

In 1976, Congress passed two pieces of legislation to help New York City resolve its financial crisis. The New York City Seasonal Financing Act (Public Law 94-143), which expires this month, provided for federal loans for fiscal years ending in 1977 and 1978. Public Law 94-236 permitted the New York City pension funds to buy and hold New York City and Municipal Acceptance Corporation (MAC) obligations without endangering the pension funds' tax-exempt and tax-qualified status. The purchase of these obligations was made pursuant to a November 26, 1975, agreement among the City pension funds, eleven New York commercial banks, and four New York City sinking funds. The Act precludes any extension of the agreement beyond December 31, 1978. At present, the House Ways and Means Committee is considering H.R. 12051, a bill which will permit the same type of agreement as the November 26, 1975, agreement reached under P.L. 94-236.

On May 10, the House Committee on Banking, Finance and Urban Affairs reported Title I of H.R. 12426, the New York City Financial Assistance Act of 1978. This bill provides for a 4-year program of federal guarantees of New York City obligations (or obligations issued on behalf of New York City); the guarantees may be for periods up to 15 years from date of issue, may not exceed \$2 billion in principal and accrued interest, and are available only if certain specific conditions are met. On May 22, the House ways and Means Committee reported Title II of H.R. 12426, providing that interest on such guaranteed obligations will be taxable if interest accrues while the guarantee is in effect and prohibiting the Federal Financing Bank from acquiring such guaranteed obligations. This bill was passed by the House on June 6.

In the Senate, the bill was referred to the Committee on Banking, Housing and Urban Affairs on the understanding that the Committee on Finance would review the tax provisions of the bill and communicate its views to the Committee on Banking, Housing and Urban Affairs.

June 20, 1978

LEGISLATION EXTENDING THE EXPIRING LAW WHICH PERMITS THE NEW  
YORK CITY EMPLOYEE PENSION FUNDS TO PURCHASE AND HOLD  
NEW YORK CITY AND MUNICIPAL ACCEPTANCE CORPORATION (MAC) OBLIGATIONS

(Prepared by the Staff of the Committee on Finance)

In 1976, Congress enacted two pieces of legislation to assist New York City in resolving its financial problems. One of these, Public Law 94-236, permitted the New York City employee pension funds to purchase and hold up to \$2.5 billion of New York City and Municipal Acceptance Corporation (MAC) obligations, without regard to the self-dealing prohibitions and exclusive benefit rules imposed by the Internal Revenue Code. This preserved the tax-exempt and tax-qualified status of these pension funds.

Pursuant to the provisions of Public Law 94-236, an agreement was reached on November 26, 1975 among the City pension funds, four New York City sinking funds and 11 commercial banks. Purchase of the New York City and MAC indebtedness by the pension funds was made pursuant to the agreement. Any amendments to the agreement were required to be approved by the Secretary of the Treasury. Also, Public Law 94-236 precluded any amendments to the agreement extending it beyond December 31, 1978. In September 1977, the United States Treasury Department approved an amendment to the agreement whereby they surrendered the short-term New York City obligations which they held in exchange for longer-term MAC obligations. This exchange of obligations occurred in the fall of 1977.

In order for the pension funds to continue their investment in New York City and MAC obligations beyond December 31, 1978, the terms of Public Law 94-236 must be extended. However, the pension funds can continue to hold the obligations which they have already purchased by that date without endangering their tax-exempt and tax-qualified status.

On June 15, 1978, the Senate Committee on Banking, Housing and Urban Affairs approved, with limitations, H.R. 12426, the "New York City Financial Assistance Act of 1978." The bill provides for a program of Federal guarantees of New York City and MAC obligations, with the limitation that United States-guaranteed obligations can only be acquired by the pension funds.

Senator Moynihan's proposal would extend, with limitations, the provisions of Public Law 94-236. The bill continues the exemption for the City pension funds from the self-dealing with exclusive benefit rules imposed by the Internal Revenue Code. In addition, it provides a similar exemption for New York State pension funds. However, the bill limits the amount of investment which may be made in New York City and MAC obligations: the total purchases of City obligations (which have a maturity of more than one year) which the plans can make in any fiscal year cannot exceed \$750 million, no more than 35% of the total assets in the City pension funds may be invested in these obligations, and any one City pension fund cannot invest more than 50% of its assets in these obligations. In addition, the bill requires that New York City achieve a "balanced budget" by the end of Fiscal Year 1982, and obtain and submit audited financial statements each year. Finally, the bill imposes discretion in the Secretary of the Treasury to enforce the terms of Public Law 94-236.

June 20, 1978

TAX TREATMENT OF COMMUTING EXPENSES AND EMPLOYEE FRINGE BENEFITS  
(Prepared by the Staff of the Committee on Finance)

The Tax Treatment Extension Act of 1978 (H.R. 9251), which has passed the Senate and has been sent back to the House, precludes IRS changes in the taxation of certain commuting expenses prior to May 1, 1978 and in the taxation of employee fringe benefits prior to July 1, 1978.

S. 3145, introduced by Senator Moynihan, prohibits IRS changes in the tax rules in these two areas before 1980.

S. 3147, introduced by Senator Dole, deals only with the taxation of fringe benefits. It precludes IRS final regulations until July 1, 1979.

S. 3194, introduced by Senator Roth, also deals only with fringe benefits and would preclude IRS regulations on fringe benefits before 1980.

The House Ways and Means Committee has reported a bill (H.R. 12841) which generally precludes regulations on commuting expenses or fringe benefits before 1980. Thus, on these two subjects, S. 3145 and H.R. 12841 are substantially the same. In addition, H.R. 12841 contains a provision excluding from gross income the subsistence allowances of State law enforcement officers after 1969 and before 1978.