EXECUTIVE SESSION

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THURSDAY, JUNE 14, 1979

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United States Senate,

Committee on Finance,

Washington, D. C.

The committee met, pursuant to recess, 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, Ribicoff, Nelson, Gravel, Boren, Bradley, Dole, Danforth, Chafee, Heinz, Wallop and Durenberger.

The Chairman: This meeting will come to order.

I want to ask about one item. If somebody on the staff, if you would turn that chart around and see if we will have the figures on the back side there that we had there, the one that has the budget figures on it.

Do we have someone here from CBO, Congressional Budget Office? I want you to help us with just one item.

You see, the thing that we are concerned about, we are concerned about that figure, the $1.8 billion figure on health. That looks to us that it is not realistic, and I think CBO says it is not realistic.

I am advised by my staff, at least the Finance Committe

staff, not mine, by the committee staff, that the reason that it is so far out of line is because of inflation.

Now, inflation is exceeding the President's guidelines, but by the same token, if inflation is exceeding the President's guidelines, we ought to be getting more income on the income end becasue of the guidelines. And so, in terms of how the budget works out, if we are in worse shape over here, we would be in better shape on the income end, and I would like to ask, as a member of the Finance Committee, directing it towards the Budget people, would that not be an appropriate adjustment to make, that you are going to get some money on that end because of some more tax collections, and here is an item where you are going to have to go over because the same thing that is causing the additional tax collection is also causing more expenses.

Mr. Ginzburg: Sir, I think the numbers on the board are all based on the CBO economic assumptions that were used for the First Budget Resolution. They already have taken into account what the tax collections would be under those assumptions.

Now, as we all know, in July, revised economic assumptions will be coming out and that might change both the projected health spending as well as certainly an increase in expected tax collection, so it could change the picture.

The Chairman: You see, what I am concerned about is

this.

Insofar as our estimates are made wrong by more inflation than the President has anticipated, then that runs up our costs on one end, but also it increases the revenue on the other end.

Mr. Ginsburg: That is right.

The Chairman: That being the case, it seems to me that we are entitled to claim our share of that additional revenue to meet that additional cost.

Mr. Ginsburg: Certainly. Keep in mind that that health figure that you see up there is based on the same economic assumptions as the revenue projections there. In other words, what you are considering has already been brought into the picture, at least as far as the view of the economy that came out in January.

The Chairman. My understanding of it is that we were handed that figure, we went along with that assumption. That was the assumption that the President made. That was the assumption that we went along with. Now you come in with figures that make that assumption wrong. That $1.8 billion is made wrong, by your new figures, by what has happened since the President sent this thing down.

And it is inflation doing it and if that is the case, it seems to us that we are entitled to claim some of the additional claim from inflation to offset that.

Mr. Ginsburg: Senator, the $1.8 billion savings that the Senate Budget Committee is expecting from this committee in the health area is based on the added projection of an $800 million savings from the President's cost containment bill, that the rest of the savings were from different ideas of lowering hospital costs that the Committee staff had prepared.

The major difference now, our $600 million estimate of savings, I think it is simply a more careful -- with the $800 million from the Senate Budget Committee staff. It was before we had a capability to do a careful estimate of the administration's proposal.

When we came down to $600 million, it was simply the result of more accurate estimates, rather than changes in the economy.

The Chairman: All right.

I just want to make it clear that, as far as this Senator is concerned, I am willing to cast some painful votes around here in order to try to get this thing in line, and ask the Senate to pass some painful votes to do our duty as far as the budget part of the operation is concerned. But when we run into a situation where it cannot be done, the answer is if it cannot be done, it cannot be done.

That being the case, what you would do about it, I guess what we have got to do about it is think in terms of claiming some of the additional revenue that would come in because of

the inflation.

Some of our program goes up with inflation. Some of it does not.

Thank you very much, Mr. Ginsburg.

Senator Dole: That is the First Budget Resolution, too. I talked to Senator Bellmon, to this yesterday. He really has us in a situation here. He said this is only a guideline. There are going to be other budget opportunities.

Mr. Ginsburg: The $600 million already takes into account the inflation that was projected in January.

SenatorDole: If it were not for.inflation, you would not save that much in the administration bill; you would not save anything.

The Chairman: The way it is going, we are not going to save anything either, but we will try.

All right. We appreciate your advice, Mr. Ginsburg. Let us see what we can do here.

Page 14. Is that where we are?

Mr. Stern: Mr. Chairman, I might say on Senator Wallop's motion of having a study with relation to reimbursement of hospital-associated physicians, at the moment, the vote is ten in favor and nine opposed and the only vote that has not been cast is Senator Byrd of Virginia.

Senator Talmadge: Mr. Chairman, at the appropriate time ---I do not think we ought to do it in Senator Wallop's

absence. As I understand it, the rural hospitals, I think the better approach rather than study would be to exempt rural hospitals period. I am perfectly agreeable to that.

Senator Dole: I have a substitute, too, at the appropriate time.

Mr. Constantine. I think that the first thing that we can get out of the way that does save some money is Senator Boren's amendment which appears on page 24 of the blue book.

Senator Boren: Yesterday we had just completed action on it. The only remaining thing, Senator Bentsen had askesd that I modify it by removing the last four lines which referred to a cap on the reimbursement rate under Section 18.

We determined that the Secretary already has that authority under Subsection 30 of 19.02(8) so that it would be unnecessary for it to be in.

So I think we have reached agreement to modify my amendment to remove the last three lines plus the word or two that refers to that cap. That made it acceptable to Senator Bentsen.

Then Senator Dole and I had a discussion. We are in agreement that the report would reflect that there is nothing under my amendment that would prohibit a state from paying incentive rates to those institutions which were especially efficient.

And I believe with that comment, with that modification,

I believe there is now agreement on it.

The Chairman: Is there any objection?

Without objection, agreed to.

Mr. Constantine: Section 19 is a provision identical with that approved by the committee in the last Congress and the Senate dealing with percentage arrangements other than those applicable to hospital-based physicians. It is designed to avoid contracting out for a variety of service, pharmacy, everything else, where people receive their reimbursement on the basis of a percentage.

This is other than the pathologist, for example.

The point is that those costs and charges arising out of rates greater than the cost of doing business and there is an incentive to overservice and oversell and the hospital rates, of course, have been rising at rates greater than general price levels, so that there is a windfall factor here.

There was a modification made to this that Senator Bentsen requested and that is retained in here this time. Otherwise the provision is identical with that previously approved.

The Chairman: Is there any objection?

Without objection, agreed.

What is the next one?

Mr. Constantine: The next provision, Section 25 on page 26, deals with the rate of return on net equity for for-profit

hospitals. This, too, is identical with the provisin that was in H.R. 5285 approved by the Committee and approved by the Senate. I believe it was the Chairman's provision to increase the rate of return, or provide an increased rate of return, relative to efficiency. That is, the more efficient hospitals determined under Section 2 of the bill that the committee has approved, would receive a greater rate of return on net equity as opposed to those which are less efficient.

The Chairman: The ida is to try to make it sufficiently attractive to attract capital and competition in private enterprise. That is what we are talking about.

Senator Dole: I think the administration opposes it.

Mr. Champion: That is correct. It is $20 million. We find there is enough capital flowing at this time. We do not see a need for that.

The Chairman: It seems to me that you ought to try to attract -- you to be willing to pay the same return on capital that the market generally provides for other investments, if you want to get private enterprise money into it, and competition.

Those in favor, say aye.

(A chorus of ayes)

The Chairman: Those opposed, no?

(A chorus of nays)

The Chairman: The ayes appear to have it.

Mr. Constantine: Section 30, a provision that seeks to rationalize to solve some of the problems in calculating how much we will allow for purchase of durable medical equipment, wheelchairs, hospital beds, and so on. And there have been quite a few inequities in the way the government pays. People are being overpaid, and others are being underpaid.

Unfortunately, the staff, in analyzing this provision further, believes that this provision itself, while in the right direction, is not quite the answer and we would suggest that a study of appropriate means of payment for durable medical equipment with demonstration authority be undertaken by HEW over a two-year period, with a report back to the appropriate committee.

Senator Dole: Or GAO?

Mr. Constantine: Or GAO, whichever the committee prefers. GAO does very good work.

Mr. Champion: The problem there is they cannot carry on demonstrations.

Mr. Constantine: That is true.

Mr. Champion: We have begun work in that area.

The Chairman: Does HEW support this?

Mr. Champion: Yes, we would. As HEW has something to do, demonstration work, we agree with the staff basically.

Senator Dole: We will get GAO to study the HEW study.

The Chairman: All in favor, say aye.

(A chorus of aye)

The Chairman: Those opposed, no?

(No response)

The Chairman: The ayes have it.

Mr. Constantine: Section 3 reiterates, puts into statutory form, what is regulatory policy with respect to encouraging philanthropic support for health care. The Association of Hospital Fundraising Council and others live in an uncertain world and they have asked that it be put into law.

Ths provision has appeared in a number of bills. It is in the Long-Ribicoff proposal. It is in the Talmadge-Dole bill.

As far as we know, the Department has no objection to it.

Mr. Champion. That is correct.

Senator Dole: As I understand it, the Department was preparing a report for Senator Heinz on the current status.

Mr. Champion: I am not aware of that.

Senator Dole: That is the notation I have. Senator Heinz is not here. Maybe we could get some status report on that.

Mr. Champion: This, by statute, simply carries out present policy and gives them some statutory base.

The Chairman: All in favor, say aye.

(A chorus of ayes)

The Chairman: Opposed, no?

(No response)

The Chairman: The ayes have it.

Mr. Constantine: Section 34 was Senator Nelson's provision, I believe. This was the same provision that was agreed to to provide for study of availability the need for skilled nursing facilities services under Medicare-Medicaid. The original provision was to require facilities to participate in both programs.

Because of the shortage of beds for Medicare patients, there were concerns in a number of areas that the problem is real in a number of states and the problem was whether that might force out some of the facilities that now take Medicaid patients. That is, if they had to participate in both programs, because of administrative and reimbursement complexities.

I believe Senator Nelson said that this was acceptable last year and it is identical with the provision that was adopted.

The Chairman: All in favor, say aye.

(A chorus of ayes)

The Chairman: Opposed, no?

(No response)

The Chairman: The ayes have it.

Mr. Constantine. This is the provision which the

Committee approved previously to expand coverage of certain dental services. I believe that the dentists, Mr. Chairman, had a recommendation amendment to expand that somewhat further.

Mr. Hoyer: That is correct.

The denstists ---this provision would remove certain inequities that now occur because we will pay physicians to do certain oral procedures that cannot be paid under Medicare if the dentist does them. They are both qualified. It would remove that inequity.

There is a further inequity, not described in the blue book, but that has been suggested and that is patients who are admitted to hospitals for dental procedures have a medical necessity on the same basis as if it were a medical patient and staff has no objection to either of these.

Senator Dole: Severe conditions?

Mr. Hoyer: Yes, sir.

I believe the cost of the second provision the first year would run something like $10 million.

Senator Dole: The administration supports this?

Mr. Champion: No, Senator. We support the original proposal, the first proposal, which is that the dentists ought to be paid for performing these procedures, but the work being done in hospitals is far more expensive. It seldom requires hospitalization.

When it becomes eligible, it gets used frequently and the expense is much higher and that is the bulk of this bill. That is the additional $10 million.

The Chairman: You are talking about a situation here where the dentist should put the person in the hospital. We are talking about the type of situation where the dentist should put the prson in the hospital in order to do the operation, and if he does that, he does not get paid for it. That is what it amounts to.

So here is the administration's contention that it will cost money to pay the dentist to perform the operation in the hospital when it should be performed in the hospital.

Senator Dole: He gets paid, but the poor patient's hospitalization does not cover it.

Mr. Champion: Mr. Chairman, you are quite right about the problem. Actually, much of this should be done by day surgery, which is much less expensive. It is very seldom that the medical condition is such that it is really required for full hospitalization.

The problem is that once this is open, a lot of hospitalization is used unnecessarily. If his is adopted, what we should probably do is go with the Professional Standards Review organization to make sure that we hold down utilization which has not been held down.

The Chairman: I am willing to do that. Goodness knows I

have gotten hell from Dr. Dorsey from being for the PSRO and that is all right. That is fine with me.

And it is all right with me to amend it to say that.

Mr. Champion: That would be very helpful.

Senator Talmadge: If the Chairman would yield, Mr. Chairman, would not the next section take care of the project that you have mentione, reimbursement for outpatient hospital care?

In other words, what we want to do, rather than throw these patients in the hospital, we want to encourage the doctors to treat him in his office. Would that take care of the problem that you have outlined?

Senator Dole: Except for severe cases. Then you have to be in the hospital.

Mr. Constantine: Mr. Chairman, we do have some good news. It is hard to come by. We have a letter from CBO saying they overestimatd the cost of the original dental provisions so that the cost estimte in here is approximately the cost of not only the dental benefit in here but the hospitalization as well, where we had $12 million.

CBO said they had made an error, and they estimated the cost would be only $5 million for the first 1981 and '82 and $6 million for fiscal years '83 and '84.

Mr. Champion: We will realize those estimates to the

extent we do a good job on utilization.

The Chairman: If there is no objection, we will couple that with the PSRO provision to say that they will have to carefully monitor the extent that they do put these people in the hospital.

Senator Danforth?

Senator Danforth: I would just like to ask some questions at this point.

It is my understanding that this section increases benefits. Is that correct?

Mr. Constantine: That is correct.

Senator Danforth: How much is this increase in benefits?

Mr. Constantine: The estimated cost, I think, is $12 million. $12 million to $15 million.

I am sorry. CBO now tells us that they overstated the original portion. It is fair to say that this will be probably $15 million instead of $12 million, including the expanded benefit for hospitalization, for dental surgery.

Senator Danforth: Just going through what we have done so far and what we are going to do, Section 20, we agreed in Section 20, I think, to expand the benefits. Is that not right?

Mr. Constantine: The ambulance service provision?

Section 20 is the ambulance service to a more distant hospital. Yes, sir.

Senator Danforth: How much was that increase?

Mr. Constantine: I believe the estimate was $1.1 million.

Senator Danforth: These are small items, of course, but they are increases, right?

Mr. Constantine: Yes.

Senator Danforth: Item 29, we agreed to increase benefits, did we not?

Mr. Constantine: Yes, sir.

Senator Danforth: How much was that?

Mr. Constantine: Well, the original estimate that we had from CBO was on the order of $3 million to $7 million. That was the original estimate.

CBO has now just increased that with their new estimate this week to where we got to $66 million the first year and rising to $216 million by the fifth year.

Senator Danforth: Up to a $216 million increase in benefits, correct?

Mr. Constantine: That was to delete the three-day prior hospitalization requirement for Medicare, for eligibility for home health benefits under Part A. And lifting the 100 visit limitation on home health visits under Part A and 100 days in Part B.

Senator Danforth: Now, then, Section 36, we have not gotten to that, right. Have we?

Mr. Constantine: Yes. That is the provision for post-catarract fitting of lenses by optometrists.

Senator Danforth: Is that an increase in benefits?

Mr. Constantine: Yes, sir, with a cost of $1.1 million.

Senator Danforth: Is it not fair to say that all of the so-called cost savings that we have agreed to or that we have discussed have been essentially accounting matters, reimbursement formulas?

Mr. Constantine: As opposed to benefits?

Senator Danforth: As opposed to benefits.

Mr. Constantine: Yes, sir.

Senator Danforth: We have not agreed to cut any benefits, have we?

Mr. Constantine: Not yet.

Senator Danforth: Mr. Chairman, let me just state my concern about this whole exercise. We call this hospital cost containment and I think what we are doing is we increase benefits. We make absolutely no reduction in benefits. That is, of course, unpopular to do.

Then we order hospitals to cut costs, and that is what we call cost containments.

Now, I read in the papers that there are all kinds of proposals being made for various kinds of health insurance apparently picking up steam, costs ranging anywhere from $20 billion to $40 billion a year, and increased benefits of one

kind or another, and I have to say that I am guilty of this exercise along with everybody else, but I am a little bit concerned that what we do around this place is increase everybody's benefits and never reduce anything, and then just order somebody else to cut costs, and that is what we call cost containment. That is how we manage inflation. We increase what we spend, increase what we tell other people what to spend in health proposals and put an artificial lid on what they are going to be reimbursed.

That is what we call cost containment.

I really am concerned that this is not the way to go about running the country. This is what was known in Senator Humphrey's time as the Politics of Joy where we tell everybody that we are going to increase their benefits and we send out our press releases on what we have done for them and then order somebody else to cut costs.

I just thought that I would at least express that concern about this whole exercise.

The Chairman: Let us just skip over this and go back to the things that you think will save some money.

Senator Dole: We have some cost savings.

Senator Talmadge: Senator Wallop is here, Mr. Chairman. I will make that proposal on pathologists.

Senator Wallop, I believe your proposal was agreed to and the Senators were polled on it by a vote of ten to nine. That

would require a study of this pathologist situation.

I understand what you wanted to do was to protect the , ral hospitals. I think the best alternative would be just to exempt the hospitals, rural hospitals. That would save the government $35 million by doing that.

Senator Wallop: We would save the government $35 million?

Senator Talmadge: Yes. Is that correct, Mr. Constantine?

Mr. Constantine: Approximately that.

Under Section 6, as modified, an approach would be simply to exempt from the prohibitions non-metropolitan hospitals in non-metropolitan areas.

Senator Wallop: What would you use?

Mr. Constantine: Standard Metropolitan Statistical Areas. I do not believe there are any in Wyoming.

Senator Wallop: The only problem I have with it, I am perfectly willing to listen and discuss the prospects, but the only problem I have is if you exempt rural hospitals then you are right back into the percentage contract thing, one of the things identified as being the problem in the first place.

It seems to me you eliminated primarily what you identified in HEW and Mr. Champion identified as the root cause of the problem, percentage contracts. We eliminated that, and that much is taken care of.

The study for specific types of new forms of reimbursement is something that was recommended by their own contracted study, the Arthur Anderson study.

I guess I do not know where the $35 million is going to come from.

Mr. Constantine: Senator Wallop, an approach might be to exempt the rural areas completely from the limitations while the Wallop study is being conducted.

The $35 million, while you prohibit the percentage arrangements, that is not quite enough. Basically, the prohibition goes to the hospitals' being able to pay the percentages but does not go to the other side where the pathologists may then bill directly and pay some proportion or percentage to the hospital.

It takes two. You have to get both elements there. You have to get the percentages flowing in two directions. The prohibition on the percentages is from the hospital paying a percentage to the pathologist, but not from the pathologist giving a percentage to the hospital.

Senator Wallop: Unless he is a hospital-based physician. They are the two areas that you have identified as problems.

Mr. Constantine: That means that he essentially practices from the hospital, or the services are for the hospitalized patient, but he is not necessarily reimbursed by the hospital. He could be billing directly, or something of

that sort.

The second part is the direct billing for services rendered by others for clinical laboratory work, and that is the second part of the problem. The $35 million would come -- the total estimate is $48 million the first year, increasing the savings to the Medicare-Medicaid programs, the federal share of savings, but it would primarily, if you limited it to urban hospitals only, that would bring the savings down to something like $35 million and would solve the problems in the rural areas because there would be no problem.

As a matter of fact, the effect might be to attract pathologists to rural areas because there would not be any restrictions as to whether they were on percentage arrangements or whatever, pending the study.

Senator Wallop: Mr. Chairman?

Senator Dole: If you will yield, I do not know whether you have had a chance to study an amendment that I was prepared to offer yesterday which would -- are you familiar with that amendment?

Mr. Constantine: Yes, sir.

Senator Dole: How much would that save?

Mr. Constantine: We do not believe it would save anything, Senator, unless you added a couple of words to it. That is, what Senator Dole's amendment does is to establish professional components.

Senator Dole: Time and effort.

Mr. Constantine: If you have the professional components related to reasonable time and effort, that would save money.

Senator Dole: I think we could probably reach some agreement with Seantor Talmadge's proposal, and perhaps the one I suggested, that we should let the staff look at it and see if we cannot all agree with this.

Is that all right with you?

Senator Talmadge: Yes.

Mr. Constantine: Yes, sir.

The Chairman: Do you want to leave it that way?

Senator Talmadge: Whatever Bob wants to do. I do not want to rush it.

I would hope to take care of the problem that Senator Wallop had. I can understand that is a problem in getting pathologists in rural areas to exempt the rural areas, period. I think we have other health education that defines what a rural area is. Is that right?

Mr. Constantine: Yes, sir.

Senator Talmadge: To follow that so it would all be uniform, I do not know how Senator Dole's proposition would fit in with this. What we do in the bill that Senator Dole and I offered which we are working on now is paying a reasonable fee for a reasonable service. And that would eliminate a percentage of the gross which many of them get in

some areas of the country.

That may be all right for rural areas but in some of the cities they get enormous fees that are not reasonably related to a fee for service.

Senator Dole: Mine would be across-the-board, relating to time and effort.

While we are considering these other cost-saving amendments, I could give this to Jay and he could take a look at it.

Senator Talmadge: What do you think of it, Mr. Champion?

Mr. Champion: I agree with your position, Senator. As a matter of fact, there were all kinds of arrangements.

I once had a hospital in which the pathologist simply paid a percentage to the hospital for the use of the facilities.

When I saw the size of the check for the first time, I realized what a terrible arrangement that was. And I think the staff is making, and your bill is making, an appropriate approach.

Senator Talmadge: What about the Dole proposition?

Senator Dole: You are talking about the original language?

Senator Talmadge: The original language in the bill?

Mr. Champion: I would like to look at it, but it sounds to me it is after the same problem. How you measure that time

and effort is your only question.

Senator Talmadge: Why do we not direct the staff, in conjunction with Mr. Champion and Senator Dole and Senator Wallop and myself to look at it further, Mr. Chairman, and act on it before the mark-up?

The Chairman: Without objection, so agreed.

Mr. Constantine: Mr. Chairman, we are now up to the additional staff alternative.

I should preface that by saying staff does not necessarily endorse all these alternatives for savings, but the committee directed us at an earlier session to come up with suggested possible ways of saving money in the Medicare-Medicaid program, and this is everything we could think of that might be politically feasible.

Senator Chafee: Could I bring up one brief point that deals with language now?

The Chairman: What we are trying to do right now, instead of talking about things that would cost something, we are talking about things like saving money. We will entertain a few bills that have something that will save money.

Senator Chafee: I will leave the judgment whether it will save or not. I believe it will, namely, we allow reimbursement for CAT scanners in out-patient facilities. We have sometimes situations where we do not allow for the ambulance transportation from an in-patient to an out-patient

facility where the CAT scanner might be, and it makes sense to me to encourage the use of such expensive facilities, even though they are out on an out-patient facility someplace.

My question is can we have report language that will allow reimbursement for ambulance transportation to an out-patient facilitiy if the out-patient facility has complied with a certificate of need from the state?

Mr. Constantine: Yes, sir, with one further caveat. It does make sense, and where it is determined to be medically appropriate, where you have a patient that could go in a cab appropriately, I do not think you would want to pay for an ambulance, but where the degree of illness is such that an ambulance would be appropriate, that does make sense.

Senator Chafee: That is a money saver, unless that qualifies it. Is that a money saver.

Mr. Constantine: It probably does not cost anything or save anything. If it is medically appropriate, because it may save money if the alternative is for the hospital to apply for a CAT scanner where it does not have one, or for a group of hospitals to have one scanner.

The Chairman: All in favor, say aye?

(A chorus of ayes)

The Chairman: Opposed, no?

(No response)

The Chairman: The ayes have it.

All right. Let's talk about some items that will save money.

Mr. Constantine: Mr. Chairman, in the out-patient hospital care area, Medicare, particularly in some of the urban centers such as New York, Chicago and so on, is being significantly overcharged for out-patient services. In many cases, the low-income population looks to out-patient for ordinary care, not emergency care.

90 percent of the patients in many of the hospitals that go to the out-patient department do not need emergency care. They are just getting routine care.

The hospitals, understandably in those areas, will often try to shift as much of the cost as they can to the out-patient department, with the result that, in New York City, for example, we are often paying $100 or more for a routine out-patient department visit.

When we went up there for the committee a couple of years ago, we had instances where patients would be scheduled at 3:00 and be seen at 4:30. They would do everything but the x-ray, ask the patient to come back the next day, and Medicare would be charged, or Medicaid, for two visits.

The state of New York, to deal with that in Medicaid, has just put a flat $55 limit on it.

Staff, going to work on this, simply said, to flag the problem, that for a routine out-patient department visit, we

would still pay on a reasonable cost basis, not to exceed twice the amount that we would pay for the same visit in the doctors' office.

We were not trying to be clever. We were just trying to come up with some reasonable maximum test.

GAO has identified similar problems in a fair number of the free-standing neighborhood health centers, where GAO believes their costs are excessive in relation to the service.

We recomomended, or suggested, a possible similar limit.

Now, in discussing it further with the Department, and with Senator Baucus and some others, we agreed that probably these limits are somewhat arbitrary that the staff was suggesting. We were trying to flag a very real problem, and I believe that Senator Baucus was going to recommend that the Hospital Costs Commission established under Section 2 be directed to give top priority, and authorized to recommend an appropriate limit on what reasonable costs for out-patient services are.

At some point, it is excessive. When you get to $120, $130 for a routine visit to a hospital out-patient department, both in Medicare-Medicaid. The ratio of out-patient visits are soaring, far greater than our in-patient days. It is an area where significant savings are possible.

Some of the states are acting unilaterally to take care of their own interests and we believe that Medicare should

protect itself also there, but we would recommend, in lieu of what we have here, that Senator Baucus's approach, which he has discussed with us, to give priority --

Senator Talmadge: If you would yield at this point, is this a provision that would permit minor surgery and things of that nature in the doctor's offices rather than send them to the hospital?

Mr. Constantine: No, sir. That provision in your amendment was previously approved.

Senator Talmadge: It is already approved?

Mr. Constantine: Yes, sir.

The Chairman: You are talking here about an amendment to set an arbitrary limit so that when a doctor goes out and provides a service on an out-patient basis in the patient's home that he cannot charge more thn twice as much as he would charge to begin with in the doctor's office, right?

Mr. Constantine: Almost.

What we are really saying, Senator, if the same services were provided in the doctor's office, you go to the doctor's office, he would charge you $50 for the visit and some lab work and so on the prevailing charges in that area. Then for the same services in the hospital out-patient department, Medicare would not recognize it as reasonable costs, those in excess of $100.

The Chairman: If I might give my off-hand impression, it

seems to me that that is exactly the way you do not want to save money. Let me tell you why I think that.

In a doctor's office, he can line the people up, just line them up. He can have two or three different rooms there to see people in.

Here in the clinic in the Capitol, they can put one man in one room and somebody else in another room and somebody else in another room, and he takes the thermometer from one person's mouth and goes over here and looks down somebody else's throat and asks somebody else to take his shirt off, or his pants, as the case may be. He is looking these people over and just gives them a prescription. Boom. It is all over.

If the amount of time it takes with each one of those people might be five minutes a piece -- he has got to get in his automobile and go from place to place, it might take just the average doctor . ten times that much time just trailing back and forth in the automobile.

Senator Bentsen: You are not talking about home visits.

Mr. Constantine: No, sir. Out-patient facilities, yes, sir.

Senator Bentsen: Cut-patient facilities, not home visits.

Mr. Constantine: The hospital's out-patient department; the clinic in the hospital as opposed to what it would cost us

in the physician's office.

Senator Danforth: Cannot HEW do this by regulation now?

Mr. Champion: Yes, although there is a question bout a statutory base to do that. I think it would be helpful for us to have some language, perhaps not as inflexible as this, but that givs us a statutory base to restrict these payments. That would be helpful.

We agree with the staff basically on the problem here. We are concerned about the inflexibility of this in that it might be -- some cases, patients might be hospitalized who did not need to be in order to get certain costs covered. I think with some flexibility, that we would like some statutory base to control these costs.

The Chairman: Can we draft it that way so it has some flexibility?

Mr. Constantine: We will flex it in a way so that the committee can take credit for the savings that CBO has listed here.

Senator Dole: How much savings is there?

Mr. Constantine: $50 million.

The Chairman: You will write some regulations. You will try to relate what they can charge for one service and what they charge for the other, the same medical procedure.

Mr. Champion: That is right.

Senator Danforth: By savings, you are simply meaning the

amount we reimburse for service performed. Is that not what you are talking about? That is what we have grown to call savings around here.

Mr. Constantine: Reimbursement limitation.

Senator Danforth: The service is going to be performed, right?

Mr. Constantine: It may be performed on a more efficient basis, on a more productive basis, at less cost.

Senator Danforth: We are saying to the medical profession, save money.

Mr. Constantine: I think under this provision, basically what it is saying to the hospital out-patient departments, do not overload the costs on there. It is not really the medical profession.

Mr. Champion: Another way of saying it is to try to remove some of the incentives to excess expenditures for certain procedures. That is what a lot of this is trying to get at.

There is a built-in incentive here to put extra costs in this out-patient department operation. That is what is being aimed at, removing that incentive.

Senator Baucus: Mr. Chairman, also we do not have any experience. We need a little more flexibility.

The mandatory limit, twice, is a little bit artificial, and hopefully we could define it in a little bit more flexible

way.

The Chairman: Draft it, and give it some flexibility.

All in favor, say aye.

(A chorus of aye)

The Chairman: No?

(No response)

The Chairman: The ayes have it.

Senator Heinz: I have an amendment that might save some money.

The Chairman: Just a moment. Let's look at this next amendment.

We have a big one here. Let's look at $223 million. What is that one?

Mr. Constantine: The Department put in something, a nursing differential in reimbursement some years ago, which, at that time we believed was inappropriate and then the Department sought to remove it, but it was stopped by the courts from taking it out. Basically, to nursing costs in hospitals, and Medicare adds 8.5 percent and the theory is that older patients require more nursing care and that -- which they may or may not.

The study on which that ws based was highly flawed. It was a study of 50 hospitals. The hospitals were selected on the basis of their closeness to the home and on the basis of a cross-section that showed somewhere between

zero, and even less, nursing care for older people, to more than 85 percent.

There is just no rhyme or reason to the establishment of the number. As a matter of fact, even a hospital that does provide more nursing care may not necessarily incur an increased cost because it has minimum staffing requirements. You have the staff available, as well.

What we are suggesting here is that the nursing differential be removed until such time as the Secretary and -- I am sorry. Until such time as the Comptroller General, who is working on this right now, comes up with appropriate recommendations for nursing differentials by type, size. In other words, so that you do not necessarily do it across-the-board. Certain types of hospitals may legitimately have a nursing differential pay-out there. Others may not, do not, pay it indiscriminately.

They will go in, to the extent that the Comptroller-General recommends, as concurred in by the Secetary of HEW.

Taking that out, as you can see in the first year would save $223 million.

Senator Packwood: Question. You have also in here malpractice?

Mr. Constantine: No, sir. We just mention that as another differential. That was a staff recommendation which

the committee directed us to transmit to the Department last year without endorsing it, necessarily. The Department and the Administration thought that it kind of made sense. It is in the President's budget. They have a savings of $300 million for the malpractice differential which, unfortunately, the Committee did not take credit for, but the Budget does.

Senator Packwood: The $223 million saved in the nursing differential is not the money that the hospitals are going to save. They will simply load it someplace else.

Mr. Constantine: They may or may not. It really depends. You may be absolutely right. They may pass it on, or they may moderate their operations.

Senator Dole: Assuming they are not overstaffed, indeed, they only he enough nurses to take care of everybody. If we have been paying $223 million more in Medicare-Medicaid funds for those nurses than Medicare-Medicaid patients got, so we cut it off. They do not have an excess of nurses. They still have the cost for nurses. They have to pick it up somepace else.

Mr. Constantine: Yes, sir.

The point, Senator, I believe, without evidence of the nursing differential the cost of those nurses should be appropriately picked up by someone else.

Senator Packwood: That is fine. As Senator Danforth says, we are talking about hospital containment. This is not

going to contain any of the hospital costs. It is going to contain our reimbursement; it is not going to contain their costs.

Mr. Constantine: That is correct.

Senator Packwood: What we are coming down to eventually, because we are not going to let the hospitals go bankrupt, or let people go without health care, we will increase appropriations and subsidize them through the back door for the costs that they have been reimbursed for in the past for Medicare-Medicaid.

Mr. Constantine: You are right. I am not disagreeing with you.

What I am saying is that the nursing differentials could be put back in as soon as GAO completes its studies to determine who gets it, rather than indiscriminately giving everyone 8.5 percent. Some of them may get 20 percent.

Senator Danforth: What you are doing is just sticking another finger in another hole.

Mr. Constantine: Hopefully at this point, yes, sir.

Senator Danforth: That is all we are doing.

Mr. Constantine: Yes, sir.

Senator Danforth: Can you tell me -- I am sorry; I am not as smart as some of these people -- tell me how is it possible to reduce the cost of health care in this way?

Mr. Constantine: I am not sure you reduce the cost of

health care, but you reduce it to the extent that the nursing differential is inappropriately being paid by the Federal government to hospitals which are not deserving of the differential, where a differential is not established. You are not reducing the aggregate costs, but you are reducing excessive payments made by Medicare-Medicaid.

Senator Danforth: I want to find out how the public is going to be better off. How are we reducing the cost of health care by any of these things that we are doing?

Mr. Constantine: So far you are simply not reducing the aggregate cost. If this is a cost that should appropriately be borne by Blue Cross or a private insurer, you are putting it in the right place, rather than having Medicare pick it up. In the aggregate, you are absolutely right.

Senator Danforth: They can shift it one way or the other, can they not? There are endless ramifications of how costs can be shifted, is that not right?

Mr. Constantine: That is right.

Senator Danforth: We are saying here is one little way it can be shifted. We are going to put our finger in this hole. Is that not right?

Mr. Constantine: Yes. If you are looking at it from the standpoint of Medicare as a payer and as a trust fund, what we are saying is these are costs we should be shifting.

Senator Danforth: I want to find out this. I am told

that the Medicare trust fund is scheduled to go belly-up in 1992. Is that not right?

Mr. Constantine: Yes, sir, unless there is additional financing there.

Senator Danforth: Unless there is additional financing.

Now, we are fiddling around with little ways of shifting costs. Is that not right?

Mr. Constantine: Or to more precisely determine what Medicare costs are.

Mr. Champion: Senator, if I may speak to this issue, some of these are large cost containments. Others are prudent buyer concepts.

What we are talking about here is the responsibilty of the government not to pay more than it gets in these areas. That was true in the malpractice recommendation; it is true in the nursing recommendation.

It was never contemplated that Medicare would be actuarily based. It never has been, and it cannot, by the nature of things. The time when Medicare wa theoretically going belly-up has changed every time there has been a change in Social Security financing.

That is not a major element operating here.

The problem really is simply, as I think the staff said, to look at these as trust funds and be sure that we are prudent buyers.

What that frequently does is make sure that the hospital is managed better, because if everybody acts as a prudent buyer, they cannot shift costs.

Blue Cross has its own prudent management devices which sometimes have shifted costs into the trust funds. We are trying to simply hold up our end as being prudent buyers.

The Chairman: Let us vote on it. This is one of the big savings items.

All in favor, say aye.

(A chorus of ayes)

The Chairman: Opposed?

(A chorus of nays)

The Chairman: The ayes appear to have it. The ayes have it.

What is the next thing?

Mr. Constantine: The next one is a problem that the PSROs have in urban areas. They have identified it as a significant problem.

We have many, many thousands of Medicare and Medicaid patients being kept in acute hospital beds that need long-term care that do not need acute hospital care. That is where we are paying for them, at $200 a day in New York City, $200 to $250 a day.

They are kept in those facilities even though there are beds that could be converted to long-term care usage in the

hospitals because of a shortage, often, of long-term care beds.

In New York State, the 17 PSROs, the Health Systems Agency in Atlanta, Philadelphia and New Jersey PSROs have identified this as a very severe and costly problem. In New York, they estimate that the difference it costs annually between the patients who should be in long-term beds and are in acute beds at over $200 million, $260 million more in Medicare and Medicaid payments in New York alone.

Now, working with the PSROs and with the administration, what we would recommend -- they are enthusiastic about it; the state people are, as well -- is a program whereby six months from enactment with respect to a patient in a hospital who nees long-term care but does not need hospital care, that Medicare would not pay for more than a 24-hour administrative stay while you are trying to arrange transfer of that patient.

Subsequent to that, we would not pay the hospital at the hospital rate. We would carve out the hospital days and pay them at the average Medicare nursing home, skilled nursing facility rate, unless it wsa an area where the appropriate agency said that there was a shortage of hospital beds, no surplus of hospital beds.

The purpose of this would be that if there was a surplus of hospital beds in New York City and Atlanta, Philadelphia, Chicago and Los Angeles and so on, that that should be

converted into long-term care, instead of continuing them.

We have had reports from New York City that ambulances are being sent out to round up alcoholics and addicts on sweeps to fill up the beds. Cab drivers were being paid bounties to bring them in to fill the beds.

We have it in quite a bit of detail by the agencies involved.

Senator Ribicoff: How do you police that to make sure that does not happen?

Mr. Constantine: For example, in New York County, Senator Ribicoff, the PSRO identified that many diagnoses were head injuries and seizures for these patients. The discharge diagnosis is where you identify the individual as an alcoholic or an addict.

What the PSRO in New York County found was that the principal diagnosis of federal patients in Manhattan was alcoholism and addiction, for Medicare and Medicaid. They are working there. They are telling the hospitals that we will not pay absent indications for more than a 24 hour to 48 hour stay in a hospital bed. You must move those patients. They have been keeping them there for eight to ten days. You must move them to a detox center.

Senator Ribicoff: Mr. Champion, what Mr. Constantine is describing now would be a conspiracy to defraud the government.

Mr. Champion: Yes, it is an intent. There is a question -- there are judgments that are very difficult for others than doctors on the scene to make.

We have it as a pattern here, however.

Senator Ribicoff: He is talking about sending ambulances to make a sweep of certain areas and pick up these people and bringing them to a hospital and charge them. That seems to be an unconscionable situation.

Mr. Constantine: We would be very glad to turn that over to the Inspector General.

The Chairman: That is about the same kind of thing that New York did to us when we put the SSI program is. They were going to have us take care of these mothers on the AFDC and we were going to have to look at them on the SSI, so they just hauled them all in and declared them all to be disabled and put them over on us.

So when the SSI program went in, we just found that we got about twice as much business out of New York State as we thought we were going to get.

Senator Bentsen: Mr. Chairman, when I used to head an insurance company we had cases where a fellow would go to a private clinic, put his children into the clinic on a football week so he did not have to hire any babysitters. We still had trouble trying to prove, even when we had a pattern that everytime there was a football game his kids were put in the

clinic, and we still had to pay the clinic.

Senator Wallop: Mr. Chairman, I hope that the committee is listening to this dialogue with some attention. If this is what we have got with this little program, I would question where we are going to be with the National Health Insurance program.

Every decision we are making in here is not related in any way to the expertise of any member of this committee, or any member of the staff in particular. I am not questioning the qualifications, but about medical care, it is being driven by dollars, being driven by budget considerations and not by any expertise on what the actual medical needs of Americans are.

The Chairman: I beg your pardon, Senator. I have known from the day that I came here that from the day we put the Medicare in ---I have known from my own doctor, my own family doctor who is the head of the Louisiana Medical Society, that the average patient stay in one of these state hospitals was twice as long, roughly twice as long, as it was in a private hospital.

Why? Because in one case, the patient is paying for it. He is anxious to get out of there and get home and cut down on the expenses. If the government is paying for it, he is in no hurry to go home at all.

In one case, it is, "Doctor, can I go home today?" In

the other case, it is, "Doctor, must I go home today?" The kind of thing you are talking about here is the kind of thing where you can save a lot of money. You are talking about paying the cost, say, of an alcoholic staying in a hospital bed for eight days.

The question is whether he should be there at all. At least when you move him to a less expensive bed, you save a lot of money, do you not?

Mr. Constantine: Yes, sir.

Senator Wallop, to reassure you, we discussed this extensively with the practicing physicians and the PSROs working in this and the people running the program and the state officials who are involve in New York, for example, and what we are suggesting here is a program, a grant and loan program as well -- if you like, we will describe that -- to help hospitals convert to long-term where there is a surplus of beds.

Senator Wallop: Do not get me wrong. I undersatnd that there is a problem. I understand that people are doing this kind of thing. That is part of my problem with this whole concept.

When the government gets involved -- even Senator Bentsen, as head of an insurance company, has said that they have had trouble -- but I will guarantee that you probably minded your store a good deal more tightly than the minding

that has been decribed in your description of ambulance sweeps and one thing and another.

The nursing differential -- all of these decisions are primarily being driven by a necessary need of this committee to reduce the amount of money we spend on it.

I am not sure -- one of the reasons why there were a few peeps of nays out here on the nursing differential, I am not sure what that does to a community. Any community in Wyoming where there is an acute shortage of nursing home facility or anything else for the elderly, we find cases where these people have been abused by regulation. They have been denied care that they would otherwise maybe have been able to get.

I agree with the Chairman entirely that the stay in a public hospital at public expense is going to be longer than a stay in a private hospital at private expense. We are making a decision based on dollars, but not an ability to identify any one thing.

Mr. Constantine: Senator Wallop, the D.C. PSRO has been one of the most active. Here in the District, they have identified many hundreds of patients in the D.C. hospitals who do not belong there. They found one who had been there for three years and did not belong there and they told Senator Bentsen 25 years because nobody could find a place.

They were so desperate, they went to the District government and the doctors offered to man supervision at D.C.

Village for care. The D.C. government did not respond to it. They told me -- the doctors, now -- that on any given time at D. C. General, for example, something like 100 to 500 patients do not belong there.

They have been totally frustrated by their inability to bring about the movement of people to an appropriate setting. There are a lot of responsible practicing physicians who are just frustrated.

The Chairman: Let us talk about what this problem is, now. Let us try to get at the problem.

You are talking about the situation just to take the addicts and the alcoholics. You are talking about the addicts and the alcoholics lying up there in hospital beds at $100 a day, maybe $200 a day, with the government paying $200 a day for addicts and alcoholics to lay up there, and you say in this area, in this metropolitan areas, you have a surplus of beds.

Take one of those hospitals, then, where you do not have to have all the operating rooms. All you are doing is warehousing a bunch of alcoholics and addicts. So you just use that one for those people and you save yourself maybe $100 a day by putting them over there rather than putting them in the hospital where you have the operating rooms, and all of that.

Mr. Constantine: Yes.

The New York doctors, for example, they are not arguing. They said the patients might be 24 or 48 hours of acute care. They should then be transferred to a detoxification unit, which in New York is about $90 a day, $75 to $90 a day, instead of a $250 acute care bed for eight and ten days.

That is one illustration.

They said on average the Medicare beneficiaries who turned over $3,000 were there an average of 36 days.

Senator Packwood: Is this not because Medicare started out with a bias towards hospitalization from its initial days and only gradually did we start to back away from it? I was fascinated when we had our hearings on home health and discovered, including the cost of the practitioner and the nurse that goes out, home health care, on the average, costs per year are those of hospitalization for a month.

This is a step in the right direction. I do not think this is an illusionary cost-savings device. Home health is another great cost-savings device of people you might otherwise hospitalize.

The bias is built into Medicare for hospitalization.

Mr. Constantine: The San Francisco PSRO came to see us. In New York and other cities it is uneconomic to run 100, 150 bed nursing homes because of the cost of land, wage rates and so on.

The only place you an get long-term care is if you can

transfer people $25 to $35 miles from the city. If you can find a nursing home for them, or convert surplus hospitals.

New York is talking about converting about four hospitals to long-term care.

What the staff is suggesting ---this is one that we are recommending -- is that the committee establish a demonstration program to facilitate this, not to exceed $50 million, to grants and loans for the conversion of surplus hospital beds to long-term care.

The way we would suggest it is that priority be given to public hospitals and to total conversion, the full conversion of a facility to long-term usage, and we just worked this up, that the grant portion be determined on the basis of the average utilization of the facility by Medicare and Medicaid in the prior two years.

If they need $1 million, to make the conversion, if they accounted for 50 percent of the usage, a grant of $500,000 from the trust fund at 1 percent of the current rate of return on Social Security investments with priority to public hospitals.

Most of our cities have this very real problem of not having long-term care beds, but a surplus of hospital beds.

Senator Bentsen: I think that is a progressive idea. This problem of a bias towards hospitalization for Medicare and Medicaid was also true of the private sector with

insurance companies and they are moving dramatically in the other direction.

I think this would be a substantial savings.

The Chairman. $89 million in savings.

Mr. Constantine: We think it will be substantially greater.

Senator Talmadge: What this provision is designed to do is to get hospitals in an area where they have surplus beds and very high costs of admissions to hospitals and stays in hospitals to convert beds where they are desperately needed for low-cost, with skilled nursing homes.

It makes sense economically to the government, the taxpayers, and it makes sense to the hospitals.

Senator Bradley: Mr. Chairman, what is the difference between this and Section 3 of 505 where you are substituting for under-utilized services?

Mr. Constantine: Section 3 is a program, a long-term program, where hospitals voluntarily apply, regardless of whether they are in a rural area, or an urban area, for assistance in closing down for conversion.

It is a much more moderate thing and this provision here is much more directed at the urban.

The Newark PSRO came in on this one.

The other deals with rural areas where a county built a hospital under Section 3, had built a hospital and is $3

million in debt, built with county funds. A new hospital has been built ten miles away. They really want to close down the present hospital that they have, but they do not know how to service the debt.

The purpose of Section 3 is it is less expensive to the government and other payers to help that hospital voluntarily to close down.

We will assist them in helping them pay off that debt and serving that than to keep it in operation. But they apply for that.

This provision deals with the determination that a person is no longer in need of acute care and that there is no shortage of hospital beds, that there is a surplus. This provision would only operate, Senator -- the one we are talking about here -- in an area where there is a surplus of hospital beds. It would not operate in an area where there is a shortage or no surplus.

They are related, but different, provisions.

Senator Heinz: Mr. Chairman, I do not have a problem with the provision per se, but I am concerned about one element of it which is the second test for an exception that there would be a shortage of long-term care beds.

I have seen various statistics, and some of them show that there is a shortage just about everywhere of long-term care beds.

I think that it certainly makes sense to have the requirement that there is no excess of hospital beds as the exception applies, because then there is no opportunity to achieve conversion.

I am concerned where you get into a situation where there is both a shortage of hospital beds and a shortage of long-term care beds, and by continuing ad infinitum to pay this, there never would seem to be any incentive for someone to go and build a skilled nursing, or acute care, facility.

Mr. Constantine: Senator, it is an additional problem which this really does not deal with. You are absolutely right. That is a different problem.

We are dealing solely with the areas where there is a shortage of skilled beds, but a surplus of hospital beds.*

Senator Heinz: Where there is not a shortage of skilled beds.

Mr. Constantine: I suspect that we can find them for you.

Senator Heinz: It is rather important. You say we are going to save between $89 million and $104 million. I suspect if you cannot find ares where there are not shortages of long-term care beds, you are not going to save any money, because that is the way the provision reads.

Mr. Constantine: Senator, Bob Hoyer just reminded me it is really the excess of hospital beds that we convert to the

more appropriate usage using these people for long-term care, rather than paying for the acute care rate.

Also, we anticipate the effect of home health programs will further work to relieve the empty long-term care beds that are not filled.

Senator Heinz: I understand that is not what the provision says.

Mr. Constantine: It does not go that far.

Senator Heinz: The provision says that it would not apply in those geographic areas where the appropriate state and local planning agencies certify that there is no excess of hospital beds; and number two, that there is a shorage of long-term care beds. They are linked; they are conjunctive.

Therefore, whether they have a million extra hospital beds or not, if there is a shortage of skilled nursing care beds, this would not, as the provision is written, apply.

Mr. Constantine: That is right.

What you are suggesting, Senator, is that we delete the second part.

Senator Heinz: I am suggesting there are no real savings here.

I do not want drug addicts thrown out into the gutter. That is what deleting the second part would do.

Mr. Constantine: I think where you have a shortage of long-term care beds, that is precisely the point. In a

surplus of hospital beds, the hospitals are keeping the patients in at acute hospital rates at, say, $250.

The thrust of this provision would be that the older hospitals, or other hospitals, would convert a wing of the hospital to long-term care or a hospital in total would be converted so you would reduce the surplus and use the shortage of the long-term.

Senator Heinz: That is fine. We are all for that. That is Motherhood. We have been saying we have been for that since 1972.

It does not solve the cost-saving problem here.

I just think if a geographical area is going to be exempt because there is a shortage of long-term care beds you are not going to come in with that $100 million savings. That is very simple.

Or maybe I am not making any sense.

The Chairman: Does HEW think that these savings are realistic?

Mr. Champion: Yes, Mr. Chairman, we do, because we think that there are places where there are excess beds but further that the real incentive system here is to convert acute care into nursing home.

We have proposed in this budget -- not this proposal, but a $30 million grant and loan proposal to convert excess acute bed and to be able to do this thing, in our analysis of the

kinds of areas that meet the tests that are offered here are the savings are between $50 million and $100 million.

The Chairman: Do you favor this?

Mr. Champion: Yes, we do.

The Chairman: Senator Dole?

Senator Dole: I would be willing to vote on it. I would like to ask a question. I think it is a good provision.

We are not going to force conversion. We are not going to overdo the other. We have overbult now, and we are going to convert everything.

Does there has to be some certificate of need, or do the planning agencies do that?

Mr. Constantine: They are all we have got, Senator. You are forcing conversion to an extent with this, because where there is a surplus of beds and a lot of patients who do not belong in the hospitals, the hospitals are going to have to get together and decide who is going to become long-term care.

We are not going to force a hospital to do it. They are going to have to decide themselves.

Senator Dole: We are going to require it before we start a mass conversion somewhere, that there is some need for it?

Mr. Constantine: Yes, sir.

Senator Dole: We are not going to force any patient to move at risk to the patient?

Mr. Constantine: No. Only where the patient does not

need that level of care.

Senator Dole: That is going to be determined by HEW?

Mr. Constantine: By the physicians.

The other point I would make, there is another provision in here that says if a hospital decides to convert 100 beds to long-term care that it does not have to go through the certificate of need process within two years if it decides to go back.

Senator Dole: That is not covered in your $50 million. You are talking about public hospitals, or total facilities, rather than wings?

Mr. Constantine: No, we say priority, Senator. You give priority in the money to public hospitals first, municipal hospitals and county hospitals, and total conversion of facilities rather than partial. If there is anything left over, you go to the nonprofits.

Senator Dole: Even a partial would want to be part of the mix to see if it is going to work. Maybe you would have some other savings we have not looked at.

I think the provision is all right as long as we insure that there is going to be some need for the conversion. We have already spent a lot of money needlessly building a lot of hospital beds. We cannot use that as part of the problem -- not we are going to spend a lot more money to convert them, and if we do not need them, we will be right back.

Mr. Constasntine: Only if it is determined by the physicians and by the agency.

Senator Heinz: Mr. Chairman?

Senator Durenberger: Mr. Chairman?

The Chairman: Senator Durenberger.

Senator Durenberger: In determining the savings or determining the cost here, that grant and loan program, maybe you can get some definition of the cost.

Mr. Constantine: We were recommending, Senator -- you mean on an individual facility basis, or on aggregate?

Senator Durenberger: Both.

Mr. Constantine: In the aggregate, we would recommend not more than $50 million over a one- or two-year period and require the Department to report back as to the results of that and then you can decide whether you want to expand the amount further, depending on the results.

The way we visualize this, Senator, you have a 400-bed hospital that wanted to go long-term, an older hospital. You needed $2 million to do it

They have debt service. They have some physical facility conversion cost, and then where they go from acute to long-term usage.

Mr. Champion: Mr. Chairman, may I add one thing?

We are in agreement. We do have, in the planning act, $30 million -- as passed by the Senate -- demonstration to do

this same kind of thing. We would like to work with the staff to make sure that those two programs work together.

Those are public health service funds. Here we are talking about trust funds.

We need to work out the details.

Senator Danforth: May I ask a question here? As I understand it, having aid for hospital construction and for beds we do not need, now we want to pay to convert that into other kinds of beds, right?

Mr. Champion: Which we do need.

Senator Danforth: Yes.

I guess that makes sense.

Now, let me ask you one problem. If we can work this out, it might be a cost savings.

I am familiar with a couple of hospitals in my state which were once hospitals and have become nursing homes. The nursing home regulations, as I understand them, are pretty much set by HEW. My understanding is the hospitals, after their conversion they could meet the federal standards for hospitals, but they could not meet the federal standards for nursing homes by way of width of doors and maybe fire things and so forth and so on.

So they cannot meet the licensing requirement.

It would seem to me that a hospital that can meet the standards for being a hospital, a fortiori should meet the

standards of being a licensed nursing home without major construction costs going into that.

In connection with this, undoing the wrong that we have done by spending more money to convert them, can we at least save part of that by making sure that the regulations for construction of a nursing home are no more onerous than the regulations for constructing a hospital?

Mr. Champion: That has been a problem, but I think we recently had regulations where we have developed equivalencies in terms of protections, instead of rigid, single standards that have to be applied to each case, which we estimate, by the way, in construction it is going to save the industry about a half-billion dollars over the next few years.

Instead of having these rigid, separate ones for each thing, we have an equivalency standard that we have tested, and it is now out before the public as a proposed regulation, and we think that will deal with the problem.

I will look also at the problem you just raised where it sounds to me that it is an equivalency situation.

Mr. Constantine: Senator, we agree with Senator Danforth and we would like the committee's permission, if it does approve this provision, to deal with that regulatory problem and add language minimizing the Department's authority to act and refine and make more complicated the necessary regulation with respect to hospitals that meet standards and a

hospital that also has a long-term time.

We agree with you, Senator, that undue complexity has entered into it. It is an area that we think would be helpful to deal with statutorily, rather than by regulation.

Senator Bentsen: Let me make one point here. I think that John Heinz's point is that it has some bad sentence structure.

Jay, I think you really ought to correct the last sentence in the next to the last paragraph that he has referred to. When you talk about the state agency certifying that there is no general excess of hospital beds, it then says, "There is a shortage of long-term care beds" I think that is kind of contradictory in the sentence structure and ought to be clarified.

Mr. Constantine: Yes, sir.

The Chairman: Let's vote.

All in favor, say aye.

(A chorus of ayes)

The Chairman: Opposed, no?

(A chorus of nays)

The Chairman: The ayes have it.

Mr. Constantine: The next provision deals with compressing the time that states have to use federal money under Medicaid to -- they have a twelve-day float, now.

What we recommended to the committee is suggesting they

might go to a checks paid policy so that the federal money is transferred at the time the payment is made. The Department proposed this, to do it in the budget in ten states. You have a one-time savings of $240 million in Medicaid shown in the administration budget.

The staff is simply suggesting that, for the committee's consideration, if it is good for ten states, it is good for fifty states. By extending it, you would have a one-shot reduction of $158 million.

Senator Danforth: Does this count in our $1.8 billion that we are saving?

Mr. Constantine: Yes, sir, if you do it.

Senator Danforth: That is wonderful. That is great.

Mr. Constantine: This would bring down the $1.8 billion.

Senator Danforth: Part of the $1.8 billion, just a little accounting trick and bookkeeping stuff. Get the checks faster and we are saving on medical costs.

Mr. Constantine: It is not that. The states are using federal money; that is the point.

Senator Danforth: We said yesterday that we were saving $1.8 billion, did we not?

Mr. Constantine: No, sir. The Budget Committee said that the Committee had to come up --

Senator Danforth: We had to come up with $1.8 billion and we are counting this towards the $1.8 billion.

Mr. Constantine: If you approve it, yes, sir.

Senator Danforth: Do you think we can say to the American people, without being guilty of fraud, that this is saving them anything?

Mr. Constantine: If you are asking me that question, if you are talking to a federal taxpayer, I suspect it is true.

Senator Heinz: Mr. Chairman, we would love to figure out how it would be just federal taxpayers. I do not know of anybody that has been able to do that.

The Chairman: It runs all through these programs between the federal-state. They want to get as much money from their federal government as they can. Once in a while we try to protect our interests.

Senator Packwood: The only point, Mr. Chairman we are going to shift $158 million to the states, and that is fine. Let's not hold it out as a cost savings to the taxpayers.

Mr. Constantine: It is the interest.

Senator Packwood: That they will not get, and they use that $158 million for gene.al fund purposes, or whatever purposes. Now they are not going to have it. They will have to get it from someplace else.

Senator Dole: Does HEW have a modification?

Mr. Champion: We agree with this. We did, indeed, propose it in ten states where we knew the administrative structure would permit us to do it right awa. Some of these

other states, it will take them some time to adjust their legal and administrative structures to do it.

We just need enough leeway language so that we can permit that.

Senator Dole: Is that in there?

Mr. Constantine: No, sir.

Senator Heinz: What are the ten states?

The Chairman: It seems to me, if you get the whole job done in a year ---you are talking about the savings. If you get the whole job done in fiscal 1980, the savings would be the same, would it not?

Mr. Constantine: Yes.

Senator Heinz: I just wanted to know which states are going to have to pay $158 million more.

The Chairman: It would be the whole 50 of them if you get the job done in a year.

Mr. Champion: That is right.

The Chairman: It seems to me we can achieve the exact same savings if we get this done before the year is out.

Senator Bentsen: Why do we not vote before we find out?

The Chairman: Is that all right, to give you the flexibility to get it done over the period of the fiscal year?

Mr. Champion: Yes.

There may be a case -- I cannot guarantee it, but we can certainly -- 50 states is the right approach. There is no

difference among the states. It just may be that there is some statutory thing that they have to change that the legislature has to get at.

If you would only exempt that one kind of thing, we can do all the rest.

Senator Matsunaga: If we withhold payment of money to states, does that mean that we will be earning the interest, or we will not be paying the interest? It actually would be a savings to the federal government?

Mr. Champion: It is an actual reduction in how much money we pay out in the fiscal year. It is one-time savings that holds through the whole period of time.

The Chairman: All in favor, say aye?

(A chorus of ayes)

The Chairman: Opposed, no?

(A chorus of nays)

The Chairman: The ayes appear to have it. The ayes have it.

All right.

Mr. Constantine: Mr. Chairman, the next one is a number of states have sought to use cost saving contracts under Medicaid through biding and contracting rate arrangements, and they are somewhat impaired from doing this by the Freedom of Choice provision and the Medicaid statute has been interpreted as applying to things other than what we believe was

originally intended, that is to permit a Medicaid recipient to choose the doctor he wanted or a particular pharmacy.

It was a 1967 amendment, to avoid sweeheart arrangements with particular pharmacies, or someone else.

Now the governors and the states would like authority to negotiate or to work out whatever mass purchasing arrangements, whatever they feel is an appropriate economic way of purchasing eyeglasses, hearing aids, wheelchairs and so on, with assurance that appropriate availability would be provided, that services would be provided.

This provision would give the state authority, at their discretion, to participate in competitive bidding.

Senator Dole: We are talking about $1.5 billion. As long as we make certain that it is for Medicaid patients. That is what you are saying, availability?

Mr. Constantine: That is availability. They must provide, at reasonable availability, that these arrangements could not prohibit reasonable accessibility.

The Chairman: All in favor, say aye.

(A chorus of ayes)

The Chairman: Opposed, no.

(No response)

The Chairman: The ayes have it.

Mr. Constantine: The next is a big one, consistent with what Blue Cross and a fair number of medical societies are

doing, and the AMA has adopted as a policy, and that is that we are recommending the PSROs review the need for pre-operative stays, elective pre-operative stays.

What they are doing in New York and elsewhere now is to say for elective pre-operative stays that they do not routinely approve more than a one-day admission, but at such other time that it is approved individually. You do not routinely and automatically keep people in there for longer than one day without specific approval. They do it on-site, and so on.

It has had very significant moderating effects in New York and in the other areas where they are using it.

Additionally, with respect to routine services on admission, complete work-up for a patient, that ordinarily they would not be provided without the doctor's orders.

Patients go in -- other than obviously an emergency case -- patients go in and are given complete work-ups. People going in for vasectomies are given chest x-rays and what have you, routinely. A complete work up, at great expense.

Blue Cross and Blue Shield have identified that as a problem and have modified their policies. The medical societies are doing it. The AMA has that as a policy and this would direct that the PSROs undertake similar policies with respect to Medicare and Medicaid patients.

Senator Dole: Are they able to do this?

Mr. Constantine: With appropriate funding.

Senator Dole: Does HEW support it?

Mr. Champion: That is our problem. We have been reducing the amount of funding of PSRO's.

We gave given them increasing functions. We will need more money to carry out these functions.

The Chairman: How muchg money will you need?

Mr. Champion: We will make an estimate.

Senator Dole: Will you still have a savings?

Mr. Champion: No question. The Michigan Blue Cross-Blue Shield length of hospital stay went down dramatically.

Senator Dole: Can you work that into this?

Mr. Constantine: Yes, sir. We can work funding in. Some are already funded to do it.

We just have June 1st, AMA News, "Joint Commission on Accreditation of Hospitals Also Opposes Routine Tests."

The PSROs in New York now, by agreement with the state, will not as an example, included here, approve a week-end admission for elective admission unless they are satisfied the hospital is equipped and staffed to provide services over the week-end.

The Chairman: That is where they really take you to the cleaners. They check in a bunchof people Friday night, give them a pass to go out on the town, and then they come back and check in again, leave, check in again Sunday, perform an

operation Monday morning.

Meanwhile, we have paid for about a three-day week-end, at the taxpayers' expense. So the taxpayers pay $500 to keep a person from spending the night at home waiting for to be operated on.

I think that is when you save something.

All in favor, say aye.

(A chorus of ayes)

The Chairman: Opposed, no?

(No response)

Senator Dole: This is wit ha provision that we will provide for funding?

Mr. Constantine: Yes.

The Chairman: We will provide for funding.

Mr. Champion: My understanding is even the budget we submitted this year has been reduced 10 percent for PSROs. We do have a great funding problem.

The Chairman: I would like to know what the net savings will be.

Mr. Champion: We will provide that.

The Chairman: Let us know as soon as you can.

What is the next thing?

Mr. Constantine: The next one is one that is controversial. We put it in to be consistent with the amendment on nursing homes.

At present, states are required to pay hospitals on a reasonable cost basis under Medicaid. This simply would delete the requirement that states pay hospitals on a reasonable cost basis as determined in regulations of the Department, give the states the discretion to determine how much they want to pay hospitals under Medicaid.

The staff has no position on this. It is just a potential money-saver. As we said on nursing homes, it depends on whether you believe that the states will act reasonably, reimburse hospitals appropriately, if their hands were not tied and if they sought to unduly restrict hospitals, whether the public and citizens of the state could generate sufficient pressure.

Senator Dole: HEW does not support this.

Mr. Champion: We are opposed to it because we believe that it would tend to further split the levels of care under Medicare and Medicaid, that Medicaid is already a depressed program. In those states where this was done, it would have an adverse effect on the Medicaid program when really we are trying to get a better standard of care throughout that program.

The Chairman: You do not feel strongly about it one way or the other?

Mr. Constantine: No, sir.

The Chairman: Let us pass it over, if there is no

objection.

All right.

Mr. Constantine: The next, number 8, has already been dealt with by Senator Boren.

The Chairman: Did we agree to that?

Mr. Constantine: Yes, sir.

Senator Heinz: Mr. Chairman, you started into that before I got here. I am sorry about that, but one concern on that, what assurance will we have that quality of care will not suffer as a result of this?

Mr. Constantine: There was some modification in the mandatory language giving the Secretary authority and in the report under existing law, he has the authority to be sure that the states payments, and so on, are consistent to provide an adequate level of care.

Mr. Champion: Senator, we asked for some rebutt language to assure us that we did have that ability to assure the quality care and that ws the understanding from the committee.

Senator Heinz: The policy that would be expressed in the report language would be, "Efficient and economical operation will not be achieved at the expense of quality of care of the patients."

Mr. Champion: The Secetary has authority.

Senator Chafee: Mr. Chairman, what is the difference between 7 and 8, the philosophy?

Why is 8 okay and 7 bad?

In my state, we do negotiate with the hospitals and we think we can get a better deal than they are required to pay under Medicaid. You are opposed to that, yet you accept 8, which as I see it is basically the same, is it not, except it is for nursing homes?

Mr. Champion: Our experience in the two situations that we have more of a problem -- we have a problem with the hospitals in the level of care that we do not have in the nursing home. That is the reason for the difference in the approach.

Senator Chafee: I am surprised at that. I would think that there would be a more standard procedure in hospitals than there would be in nursing homes, where they had them for a long time. I think the conditions in nursing homes have been more subject to criticism in the nation than in hospitals, the quality of care.

I just do not understand your philosophy. You are opposed to 7. You are for 8. I am not opposed to 8. There may be something to 7 that we just skimmed over.

Mr. Champion: Both were proposed and we saw much less of a problem in the nursing homes than we did in the hospitals. Neither one were our proposals.

The Chairman: We voted on this one. Let's go on to the next one.

Mr. Constantine: The next one, we have been working with GAO, at Senator Talmadge's request, on hospital purchasing practices. GAO is preparing a complete report for the committee. They have done partial reports showing extremely wide variation within the same city and hospital puchasing practices for common items.

For example, in Atlanta, four bottles of 500 aspirin, a low of 38 cents to a high of $2.66 and we have other cities down the line.

The Chairman: Give those two figures again?

Mr. Constantine: Thirty-eight cents for 500 to $2.66.

In Miami, from 43 cents to $1.92.

It goes on. All we are saying is that present law assumes a prudent buyer approach and we worked on this with GAO, and we would suggest that for the most frequently purchased supplies that maximum allowable cost limits be established based upon prudent buyer.

The Department has a prudent buyer regulation. They have been talking about prudent buyer. They published a proposed regulation in 1977, but have never made a report on it.

The variations, as we say, in the purchasing practices are very significant. The first report was on Seattle. As a consequence, the Washington Hospital Association now has established a monthly purchasing report disseminating information, getting information from all the hospitals as

to what are you paying for this, and all the hospitals know what the others are paying so that they can note when one is out of line.

The Chairman: We had a fellow down there in New Orleans who was highly regarded by the American Medical Association who seemed to have the taxpayers interests at heart. He was a very charming witness and a very popular little fellow, obviously holding his point of view, he will never be rich.

He has saved the taxpayers millions of dollars by just insisting on this type of thing you are talking about here.

Mr. Constantine: To give you an example, on irrigating solution, 100 liters of water -- this is water. In Miami, they are paying as much as, I guess, $4 for the unit to a low of $1.05 for the same quantity, in hospitals in the same city.

Senator Wallop: Would that not depend if he had to take the alligators out of the water?

The Chairman: If you heard that witness testify, you would be won over. I guess you have heard him testify. He will explain such things as when you buy mouthwash, none of it is going to do you any lasting good anyhow. Temporary relief. No lasting good. You have that whole big array of them.

You can buy one for $15 or buy one for 30 cents. The one for 30 cents will do just as much good as the one for $15, and the patient would not know whether he got the low-cost or the high-cost.

Mr. Champion: We agree with you about this kind of problem, and good managers can make a lot of difference here. This is a problem of regulation of enormous proportions. The kinds of reports that we would have to require, the kinds of analysis that would have to be made, unless we very carefully approach this, will be as costly as the savings because it will not be somebody just saving the money because he has the incentive and the will to do it but because the government is trying to tell him that he is not doing it right, and we have to prove that to him before.

I think this is one of those areas where we may be verging on regulatory and individual attention to everyone's case that this committee would not want to enter.

I would like to explore that to see if there is some general way of trying to do this. I think in this case, incentives are better than regulation, the kind of management incentives that we have been talking about earlier. If there is a way to do it, without, as I see here, an enormous regulatory burden, I would be glad to look at it.

The Chairman: If you will find a way to fix it up, if what the hospitals save they could keep some of it, they will save you a ton. The problem is, if they could just pass it on.

Here comes some guy selling something. He entertains the people. He gets to be friendly with the guy who runs the

hospital, the purchasing agent and so he sells them a high-cost product. Half the time, exactly the same time, it is available at lower cost.

Mr. Champion: I agree with you. That is why long-term, the way to go in hospitals are perspective limits, not in effect the kind of fixed cost system that we now have, which is the basis of all reimbursement.

Mr. Constantine: Mr. Chairman, we may avoid this. The staff would recommend not acting on it now until we get the GAO report. We are fearful, ourselves, that this would require a fair amount of auditing.

The Chairman: We will pass it over, then.

Senator Danforth: Mr. Chairman, I would like to ask the same question about all of the alleged cost savings. Here we have come up with a lot of specific numbers, $223 million, $158 million, so on and so forth.

Are these gross alleged savings or net alleged savings? Have we built into these igures the administrative costs to run around policing all these little deals?

Mr. Constantine: Some of them, Senator, we assume they are net. The estimates we have to get are CBO. CBO does those.

Some of them obviously do have administative costs. Others, for example the $158 million, means you just get the money back. There is no administrative cost on that.

This one here would have an administrative cost, Senator. The one you just went over on purchasing, it is just a sense of frustration of these tremendous differences.

Senator Danforth: On these things, on this long list of savings, has HEW looked at these, Mr. Champion, and computed out what sorts of estimates it is going to cost?

I tell you the Governmental Affairs Committee had a hearing in St. Louis on a bill that Senator Chiles and I are going to introduce relating to paperwork and we had witnesses in the health delivery area, hospital administrators, physicians and so on, and they were talking about the tremendous cost of complying with all these federal requests for information.

David Gee, the Administrator of the Jewish Hospital in St. Louis, estimated that the cost per the average patient's bill in his hospital for simply filling out forms and complying with paperwork was $200 a patient.

Now, if that is true, a substantial portion of hospital bills is this tremendous innundation of forms and paper that is placed on hospital administrators and on physicians. It seems to me, with respect to all these little gizmos -- that is what they are -- that we have been talking about over the past few days that you are building in endless opportunities for various kinds of administrative policing and under both the Nelson approach and the Talmadge approach to hospital cost

containment, when we get to the big question, if we ever get to the big question, also you are building in quantum leaps forward in the amount of paper that is going to be dumped on people.

Has that been analyzed?

Mr. Champion: Yes, Senator, it has. Let me speak to the kinds of things that have been spoken of today.

We are billpayers and most of the kind of informtion that we get, Blue Cross-Blue Shield wants, too. When you look at malpractice, or whether you look at nursing differentials and nursing, we get charged an amount for that when we determine the amount of paperwork is the same. It shifts. It does not really change our overall administrative burden.

There is some overregulation and we try to be sensitive to that, increasingly, by the kind of things we have discussed here today, but there has been great exaggeration by the hospitals about this. There is a Michigan study by Blue Cross-Blue Shield that shows the cost of the federal invention aside from its normal role as billpayer, or from those safety things like hospital charts, or things of that kind, that are part of the medical and safety aspect, are 3 to 4 percent.

New York put out a study, they counted every piece of paper in the hospital, including their own internal memoranda. The federal government is not as large a villain in this

picture as it has sometimes been portrayed. We want to avoid being that.

Most of the things disussed here today really produce little more paper. With respect to the larger question of hospital cost containment, we brought to the Congress two years ago a much simpler approach. The hospitals complained that it did not allow for all these individual differences and this year we are discussing a much more complicated piece of machinery because it responds to all the things that the hospitals said needed to be done to it in order to accommodate their concerns.

This business of detail is as much a matter of the hospitals and their concerns as it is of ours. But primarily our concern is as a billpayer and you have to have good bills and be able to account to the taxpayer for what he is paying for.

Senator Danforth: I wish I had Mr. Gee's testimony with me, but he had the figures of the manpower and the cost of paperwork before and after Medicaid and Medicare.

Mr. Champion: We would be glad to examine that specific case.

Senator Danforth: It is not a specific case. We had a number of witnesses come in and doctors and hospital administrators, and they were saying the same thing -- that they were being swamped with paper. And it looks to me that

what we are doing here is just so terribly artificial, just so terribly contrived and complex, not only these little things, but the whole approach that we are taking under either the Nelson approach or the Talmadge approach. What I am concerned about is that we are saying, you are spending over $200 a patient now on paperwork. That is not enough. We have another stack of things that we want you to fill out and we are gong to higher another batch of bureaucrats to audit you and chase around finding out who you get your aspirin tablets from and what kind of mouthwash you buy.

We are discussing today, in the Senate Finance Committee, folks, under the rubric of hospital cost containment, mouthwash acquisition by hospitals.

We are discussing irrigation solutions that are aquired by hospitals under the name of hospital cost containment, and I want to know how it is possible in that area, or any of these other areas, to really save money when in essence what you are doing with most of it is simply shifting the cost from one shoulder to another shoulder and giving people a lot of forms to try to figure out exactly where the cost is coming from.

The Chairman: If I might suggest here, according to the tabulations we have here, some of it is a one-time savings. Some of it is by reducing the lead time, so we save some money on interest. But it adds up to at least a one-time saving of

$931 million. It would be more if we would vote on some of these things rather than talk forever.

Senator Dole: We have a GAO report requested by myself, Senator Nunn and Senator Talmadge that address some of the things Senator Danforth is raising. When will it be available?

Mr. Constantine: The report Senator Talmadge asked for was a complete evaluation of all hospital regulations, federal, state, local, private, all paperwork requirements, and so on. The GAO recommendations for getting rid of the overlap, duplicating the archaic requirements.

GAO says next month they will have it back and Senator Talmadge's intention is to hold a hearing on that as soon as we get the GAO report.

Senator Danforth: Have these various bills and proposals been analyzed by GAO?

Mr. Constantine: They are pending.

Senator Danforth: They are pending.

These blue books, have they been analyzed by GAO?

Mr. Constantine: All of the staff alternatives that we have here, we sat down with the GAO people informally and evaluated with them and asked some of them for their suggestions, informally, based on their experience, not the formal suggestions of the Comptroller General. But we went over all of this here with GAO.

Senator Danforth: Did you go over the paperwork costs with GAO?

Mr. Constantine: Not specifically, Senator. I would have assumed that, had they felt that there was an enormous amount of paperwork involved, that they would have obviously volunteered that.

Senator Danforth: Looking at item 9, did they volunteer administrative costs of item 9?

Mr. Constantine: No, sir.

Senator Danforth: Did it strike you that they did not focus on the problem of administrative burden and paperwork?

Mr. Constantine: No, sir, because they had experience with this in Seattle where they had done a report. The upshot of that was dissemination of information.

What we were going to suggest on this, all we were doing here, Senator, is coming up with areas of possible savings. We are not recommending this one. We are flagging this as an area.

We are waiting for GAO's report and one where we believe that it can be worked out voluntarily with the hospital association through routine circulation by the association of information purchasing practices.

That is what the hospitals are working on. This is simply a list of everything that we could come up with.

Senator Matsunaga: Mr. Chairman?

The Chairman: Senator Matsunaga?

Senator Matsunaga: As I understand it, the Secretary is recommending that this item number 9 be handled administratively. I move that we pass over it.

Senator Talmadge: Any objection?

Without objection, so ordered.

What is the next one?

Mr. Constantine: The next one is one that the Department supports with a modification. Today, Medicare is a primary payer and there is no separation or coordination of benefits where if an older person is in an automobile accident where the driver is liable, Medicare still pays first.

The staff suggestion here is that there be a specific inclusion so that where there is a third party liable de minimis, a reasonable amount involved, reasonable expectation of collection, the government proceed to collect.

For example, if someone under 65 is hit by the car, suffering a disabling condition on Medicare, say even for a lifetime, the program assumes an enormous liability, whereas the insurer would normally be liable for someone not under Medicare, and there is an attempted recovery.

Senator Dole: HEW has a modification?

Mr. Constantine. Yes, sir.

Senator Dole: Does that still save?

Mr. Champion: As a matter of fact, Senator, we see no

reason why this policy should be limited to automobile liability. Our suggestion is at the working age where there is insurance in force, that the private should be the first payment, Medicare later, and there would be a $200 million proposal.

Senator Talmadge: You are shaking your head, Jay?

Mr. Constantine: That is not what we thought they had in mind. That is the President's proposal, but we believe it to be almost a triple tax on older people who continue to work after 65.

That is, they pay their Medicare premiums while they are under 65; they continue to pay their Medicare premiums, even though they are eligible for benefits after they are 65; and under this proposal, the administration proposal would propose that whatever insurance an employer has must pay first.

That is not what we were talking about.

We were talking about where there is a third party liability in the event of an accident. The other proposal, we believe, would significantly discourage the employment of older workers.

Senator Dole: Is that the only modification HEW has?

Mr. Constantine: We thought they had changed it to de minimus.

Mr. Champion: That is the only one.

Mr. Constantine: With the staff's suggestion you have a

$500 de minimus. They wanted discretion, as to set some reasonable amount, and malpractice.

Senator Talmadge: Who collects the subrogation rights, the patient or the government?

Senator Packwood: This would have a tendency to discriminate against older workers.

Mr. Constantine: If it were modified, what the administration is doing here is having a different proposal than was in the President's recommendation; nothing to do with subrogation, as we see it.

The President proposed if anyone were working, over 65, covered by Medicare, that is private, normal health insurance through his employer, must pay first. Then Medicaid would be residual in that case.

All we are talking about, where there is a casualty occurrence.

Senator Packwood: What you just said about the administration, tell me again?

The employer's policy is going to pay first?

Mr. Constantine: What they are proposing is if you have someone who is 66 years old and working for an employer who has Blue Cross-Blue Shield coverage for his employees, today Medicare pays first. We are the primary payer.

What the administration is suggesting is a routine. If he goes for a hernia repair or catarract, by statute the

employee's coverage must pay first.

Senator Dole: What is wrong with that?

Mr. Constantine: Today, the employer's coverage cost in premiums take into account the fact that Medicare pays, and so on. They are rated accordingly, because the experience of older people is so much higher than his regular employees, his under-65 employees.

The effect of requiring his Blue Cross coverage to pay would be to jack up the premiums and his expenses significantly, particularly among those people that have a significant proportion of older workers today.

That is where the $200 million comes in, and it would discourage -- if I were an employer with five older workers, that would add significantly to my fringe benefit costs, because it would increase the average premium.

The staff was not suggesting the administration proposal at all.

Senator Packwood: You say that would be the effect of the administration proposal.

Mr. Constantine: Yes.

Senator Packwood: Secondly, for the record, we have a cost shift here. To the extent that we save money on the hospital costs that are not excessive, we are going to shift it to Blue Cross-Blue Shield -- whoever pays the premium, Continental Casualty, or the individual.

Mr. Constantine: Under the administration proposal.

Senator Packwood: All of we are considering on cost shifts, the federal sector. Sometimes in the state sector, sometimes on individuals or businesses. In no event, with one or two exceptions, with a reduction in total cost.

Mr. Constantine: On this last one, focusing on this, Senator, the insurers prefer this, the staff suggestion. The auto insurers have that built into their premium structure.

Seantor Packwood: Which?

Mr. Constantine: The subrogation approach. They want to see that in anything the government does, because they do not want to use their premiums.

When you pay your auto insurance, the liability coverage has a premium in there, medical payments coverage.

Senator Packwood: I understand that, but I do not see where the cost savings comes to. I do not see where there is a savings in cost.

Mr. Constantine: In the aggregate nationally, no, sir. In terms of liability -- if someone is hit by a car and the driver is at fault, that is the best illustration, they become a burden. The states do that same thing today in Medicaid. They pursue third party liability as well.

Senator Talmadge: Anything else?

Senator Matsunaga: Mr. Chairman, to seek reimbursement, how many lawyers will need to be hired?

Mr. Constantine: I guess it depends. We do not know. That is a fair question, Senator.

Senator Matsunaga: You have not made an estimate?

Mr. Constantine: All we are saying here is this is a significant area of reasonable -- what we were suggesting, where there is a de minimus, we use a $500. You do not want to pursue money. That is very small. Where there is a judgment that there is a reasonable likelihood of recovery, that the government should recover.

Senator Dole: That is why you have a $500 limit de minimus?

Mr. Constantine: Yes, sir.

If it is believed to involve less than that, there is no point in pursuing it.

Senator Matsunaga: Even at $50,000 you would be making a savings.

Senator Talmadge: Are you ready for the vote?

Senator Chafee: Mr. Chairman, I do not quite see why we put a limit of $500 there. Why do we not just leave it to their discretion?

If it is not worth chasing, do not chase it, but you may have the $500 dropped in your lap.

Mr. Constantine: Yes, sir. We just did that arbitrarily. We just wanted to indicate that we thought it was advisable to have some de minimus in there.

Senator Chafee: I am suggesting you do not have that there.

Senator Talmadge: Any suggestion, Mr. Secretary?

Mr. Champion: We would appreciate that.

Senator Talmadge: Any objection?

Without objection, the $500 is stricken, and the Secretary has discretion.

Senator Chafee: I go further. Let each case be decided. Not set a limit arbitrarily from the Secretary. Just let each case be decided?

Senator Wallop: May I register a bit of fear at something like that? That has in it all the possibilities of harrassment by the Federal government which has more money to pursue than a third party would have to resist with.

I am not saying that would happen, but if you do not pay some attention to that, the government can simply keep people occupied by pursuing miniscule little things.

Mr. Champion: We have no interest in doing that. It is a cost-effective question. If it is cost-effective to go after it, we should.

Senator Wallop: I guess one of the problems I have with that is that the track record for that kind of confidence is not within HEW and certainly not within the Labor Department. They will pursue people until hell freezes over for a miniscule amount.

Mr. Champion: To the contrary, HEW's tradition has been to be somewhat underzealous about overpayments, and we have been trying to change that.

We would like to have the discretion to go after it, where it is cost-effective. Some report language to that effect, I think, would govern our conduct appropriately.

Senator Wallop: As long as it was clearly set out in the area of cost-effectiveness, I am not too worried about it. Many of the people come to me about dealings with the government, people who are dealing in things too small for them to make it worth their while to object over, yet they end up paying, whether or not their posture was correct.

Senator Talmadge: This provision is designed to save the taxpayers from having to pay a cost when the patient has paid the premiums and has coverage there that is not properly a government expense. That is all we are giving the authority to set this to do.

Senator Wallop, do you want some report language in here that we did not ask the Secretary to chase rabbits, but that we want him to pursue cases where other audits are clearly liable for the costs? I certainly would have no objection.

Senator Wallop: I would be a good deal happier.

Senator Talmadge: Get some language there and put it into the report that we do not expect the Secetary to chase rabbits.

Seantor Wallop: I do not insist on the word "rabbits".

Senator Talmadge: Any objection to that report language? Without objection, agreed to.

Mr. Constantine: Mr. Chairman, the final provision is with respect to a suggested modification and clarification of what we believe was the original intent of the committee in 1972 when it put in adjustment requirements on the HMOs for calculating the outside rate, what the HMOs rates were versus what our costs were outside.

Senator Dole: Does it save any money?

Mr. Constantine: Yes, sir, but if you do not do what I am suggesting, I can show you where it is costing you money.

Senator Dole: Does HEW support this?

Mr. Champion: No.

We are very much in opposition to it.

Mr. Constantine: In 1972, the point that we made to the committee then, was that older people -- we are talking solely about the Medicaid population now -- the large majority have one or more chronic conditions. Many of them are institutionalized.

For better or for worse, they have established a relationship with a health care system. They see Doctor X, Y and Z or go to this hospital. It is very difficult to attract them to a new organization. They do have these established relationships.

For that reason, we recommended -- and the HMO statute includes an adjustment for disability status.

The Department, in calculating the HMO rate, instead of using disability status and adjusting it on some reasonable basis in proportion for conditions such as heart conditions, arthritis, what have you, for only those people who were determined to be disabled for Social Security purposes or SSI would be adjusted for.

The effect of that is to knock out the 8.5 million older people in large part who have one or more conditions so serious as to either impair their ability to carry out one of their daily functions -- feeding themselves, dressing, bathing, shopping -- or cannot carry them out.

These are very high-cost people and our point is that in determining the PSRO's population relative to the outside world in which they are competing, you have to adjust for a disability status. The point that I would make, the only area where they have tried the statutory Medicare HMO thing was Pugeot Sound, a superb, very fine, comprehensive pre-paid group practice plan in Seattle with a sophisticated population. They went to this incentive system.

Now, there were 12,000 Medicare beneficiaries enrolled in Pugeot Sound. All had come in from employee groups. As they reached 65, they transferred over. No one from the outside population.

They had a major open enrollment period in the month of October of '76. They enrolled a grand total of somewhat less than 80 people, 80 people over 65. They then proceeded to keep that thing open for another 14 months because they were not getting enough people, at the end of which they had a total of 50,000 Medicare beneficiaries all except 350 of whom were group transfers.

So there was very little enrollment.

Of those people who enrolled, as a consequence, we paid Pugeot Sound $1.3 million more than we would have under the regular Medicare reimbursement, in order to get slightly less than 80 people.

This is in the aggregate of what was the normal open enrollment period. It is very difficult.

The HMOs might have a lot of attractiveness for people over 65. It is very tough, we believe, and they are not seeking to enroll people who have any kinds of conditions, and we would strongly recommend to the committee, unless you adjust for health status of the HMOs population as opposed to the outside world, it results in windfalls.

Senator Talmadge: Any discussion?

Mr. Champion: Mr. Chairman?

Senator Talmadge: Mr. Secretary?

Mr. Champion: We oppose this for a number of reasons.

The difficulty of determining disability health status

would be difficult, administratively burdensome. There is nothing now in HMOs that we could use to do it. The only approach we could see is the use of a physical examination for each enrollee, since the HMO has that interest. Presumably we would have to have somebody else outside to do it.

None of the studies that we have done indicate that the fundamental problem is the problem as stated here. Our problem is that we do not adequately compensate overall HMOs for caring for Medicaid populations or give them incentives.

We would be bringing to this committee a proposal to try to increase that.

Within the context of that proposal, I think that the point raised by Mr. Constantine was appropriate. To simply do this would be to further discourage what we believe to be one of the most cost-effective propositions that the health system has. It is the health maintenance organization.

Senator Talmadge: How can you avoid overcompensation, Mr. Secretary?

Mr. Champion: We are now based on a cost system. Our estimates say that HMOs actually cost us about 80 percent overall for the total population in Medicare.

Senator Nelson: 80 percent?

Mr. Champion: 80 percent of fee for service.

There are arguments about that, but the Department firmly believes there is at least that saving, and that saving is

increased with the aging of HMOs.

To come along and say, because in the past we have paid less than we were paying in the fee-for-service that we are losing money because we did not adjust for these other factors, does not seem to us appropriate.

We think HMOs are a part of the solution, not the problem.

This tends to treat our payments to HMOs as a problem.

Mr. Constantine: We would be willing to wait, Mr. Chairman, although we disagree with some of the assumptions about incentives and so on. We would be perfectly willing to have this discussed at the time the Department submits its HMO proposal.

The only thing we would suggest for people to keep in mind is that when you compare costs with the fee-for-service system, the average per capita cost by definition, 50 percent of those costs are below the average.

In other words, if your definition of efficiency is below the average, then half of those costs are below the average. We just think it is an inappropriate yardstick to use.

Senator Talmadge: If there is no objection, then that will go over.

My recollection is that the Subcommittee on Health of Govenment Operations, which my colleague, Senator Nunn, chairs, I believe, had some results of hearings on HMOs a year

or two ago. They found some that were very good and some that were very bads.

There were some horrible stories about one in California. I am sure you are familiar with that, where some of them had been penetrated by the Mafia, and some racketeers from my home state of Georgia and out in the Midwest started some. The results were absolutely deplorable.

Mr. Champion: There was no testimony. There was one case raised in one HMO of a potential Mafia. There was no demonstration or evidence of such a penetration.

Senator Dole: Where was that one?

Mr. Champion: Rock Springs, Wyoming, I believe.

Senator Wallop: We have been very skeptical about the whole prospect of HMOs in Wyoming ever since that time.

Senator Talmadge: How many issues do we have unresolved?

Mr. Constantine: I think as far as 505 is concerned --

Senator Dole: I think some of the members may have some cost-saving amendments.

Mr. Constantine: On 507, the Dole-Talmadge bill.

Senator Talmadge: Senator Long mentioned one, and one I mentioned this morning about pathologists, and what else?

Senator Dole: Bob Packwood has a home health care amendment; John Heinz has a cost-savings amendment.

Senator Talmadge: It is 12:25. How late do we want to run?

Senator Danforth: Mr. Chairman, may I make one point?

I think we have not really touched on the big questions. I hate to say it at this late date, but it is the way I feel.

There are a couple of areas where I would like to see some additional information. I wonder ilf over the week-end -- maybe that is too rush. I do not know. -- but if the staff would, first of all, look at the benefits.

We have not talked about the benefits. It may be such a sacred cow that nothing can be done here. But I wonder if there are any areas on the benefits side where we could not get some savings which would not be too onerous on the public. Nobody wants to do that. Everybody is out-doing one another, I am one of them, on what sorts of additional benefits we can provide.

I wonder if we could not have the staff take a look at the benefits, just as I have with this accounting thing, with a view towards what, if anything, could be done to realize some cost savings on that end?

Secondly, I wonder if it could be possible in connection with these minor items -- also in connection with both the Talmadge and the Nelson approach -- to get some sort of input as to the administrative cost, not only internally within HEW but within the medical community also.

What sorts of additional burdens, if any, these various small proposals, and also the major proposals would

be, because I think that is going to be, that should be, a matter of major concern to all of us before we begin to vote on whether or not to report this thing, whatever it is going to be, out of this committee.

Mr. Constantine: On the benefits side, a lot of those are really political, very tough decisions. If you asked us, we would have to deal -- if we wanted to reduce benefits, we would recommend ---I am using this hypothetically -- deletion of chiropractic coverage and coverage of abortion under Medicaid.

Those are the kinds of issues that arise when you get into benefits. But those are money savers.

Senator Talmadge: How late do you want to run today, Senators? It is about 12:17 now. Do you want to continue?

If there is no objection, we will continue.

Senator Danforth: I do not care whether we continue or not, but I am very serious about these two points. Maybe there is no such thing as cutting benefits. Maybe that is just such a political death that it is never done.

The last thing I want to do is to remove health care from people who need it. I am just wondering if we are trying to come up with $1.8 billion or if we are looking down the road to prevent Medicare from going bankrupt by the year 1992.

It seems to me that, really, there is a limited amount that can be accomplished by the sorts of things that we are

doing now.

Senator Talmadge: This bill, as I understand it, cuts no benefits whatsoever. It is not designed to. It is designed to try to save money.

Any Senator, of course, is free to offer any amendment that he desires, if he desires to do so, to cut benefits.

Mr. Champion: We would like to take up the Senator's invitation. We will provide him with the kinds of things with respect to benefits.

We have already proposed the removal of chiropracting. There would be other areas where we would think that the health effect of this is minimal and we would be glad to respond to your invitation.

Senator Danforth: Could the staff also take a look at it?

Mr. Constantine: Yes.

Senator Danforth: With respect to the administrative costs, is there any way, reasonably, that there could be some sort of an analysis as to what is involved here?

Mr. Constantine: What you are really asking for is anticipatory action under the Talmadge rule of the Senate that on all bills that would have a regulatory impact -- does that include administrative costs, and so on?

All bills that come before the Senate, there is a regulatory impact statement. I guess we could do an

administrative impact statement. I think that is what you are really talking about on a preliminary basis.

Senator Nelson: I think it is important to get whatever facts we can on this. In an interesting way, the administration plan is in effect in America. That is to say, nine states already have cost controls, and it is in place, it is working, it is dramatic.

For example, the increases of 1977 over '76, in those states that had their onn mandatory cost controls, was 12 percent. In those that did not, it was 15.8.

Now, that is a difference of 3.8 percent, which is a tremendous amount of money.

Interestingly, moving to 1978 over 1977, those mandatory states had an increase of 9.8. Those that were not mandatory had 14.1, which was a difference of 4.3 percent.

So you saw in one year that those states that had their mandatory programs had a 3.8 percent better record in '77 or '76 over those that did not have a program and a 4.3. So you see, then, it is coming apart.

If you pass the administration bill and all the states put a plan into effect, there would not be a damn bit of federal interest, because it would not be covered.

The administration has a proposal that makes it possible for no state in the union to be covered by the plan, and we are talking, by CBO figures, of $30 billion in a five-year

period.

So these are proven, in-place, operating programs which the statistics declare the savings are fantastic, and no federal interference. My state will have no problem at all.

By saying to the states, "Put your house in order," there is not a single bit of federal interference. It seems to me to be a fine states' rights position: get the damn federal government off your back. You do not have any interference at all.

To argue that we should not do something is to say that these states that are not running good programs, that are costing us an extra $5 billion to $6 billion a year, of which 45 percent is taxpayers' money, ought to be permitted to continue because there is federal interference if you stop them is nonsense. Just tell them, Goddamn it, put your house in order like the others, and you have no problem.

I do not see what this damn argument is about around here. We have a chance to save money. The states run the shows. You have hospital associations coming down here who do not want to put their house in order, saying "Don't do this to us."

They are doing it to us. It is the other way around.

If you want to save $30 billion, get the federal government out of it. Just tell them, bring your own program down to what nine states have demonstrated they are doing,

from the East Coast to the West Coast.

Colorado, New York, Wisconsin, Massachusetts. Hell. We ought to get some action here.

Mr. Constantine: The Chairman's provision on dentists, that we will go back to it after we save some money.

Senator Talmadge: Let's hear from Senator Boren first.

Senator Boren: I would like to raise a question about Section 15 that I discussed here earlier.. In Section 15, which the Committee already considered -- and if we could look at it briefly again -- under Section 15, we transfered the certified authority for long-term care facilities from the states to the federal government, which again, I think, probably would increase the administrative burden of costs on the federal government, and I am wondering if it might not be a more appropriate approach if we can still handle the problem, because I would like the federal government to be able to go to the states who are abusing their authority and not certifying institutions. They should not do that.

We should give the Secretary standby authority to intervene in those states that are not operating, rather than a blanket transfer in a state where it is working, it seems to me.

Senator Talmadge: Do you see any objection?

Mr. Constantine: No, sir. That was the intent for that certification.

Senator Talmadge: Is that agreeable, Mr. Champion?

Mr. Champion: As long as we have looked behind the authority in state certification.

Senator Talmadge: Without objection, Senator Boren's amendment will be agreed to.

Mr. Constantine.

Mr. Constantine: On page 28, the coverage under Medicare and dental services discussed earlier, the Chairman had a modification to that amendment for hospital admissions by dentists, and I think he passed it over at the time until the committee completed its work in terms of the cost savings alternatives.

That is the last benefit improvement or change that was made.

Senator Danforth: Mr. Chairman, could I just suggest -- this might just be the most wonderful thing in the world. I do not know. May I suggest if we are going to have some sort of analysis of benefits that we might put this question over.

In response to Senator Nelson, I just have to say in this whole matter of health care, to me, the notion of tremendous increases in benefits and then a very Washington-oriented, governmentally-dominated type of artificial system for controlling costs really, frankly, strikes me as the kind of free lunchmanship that we have been known for around here.

Senato Talmadge: What we have in this program now,

Senator Danforth, I think Mr. Champion and Mr. Constantine and everyone else who has done a lot of study will verify, we have no controls whatsoever on payments. We pay whatever the user says is a reasonable fee, period. In fact, if it is $500, he gets that; $250, he gets that. If it is $1,000, he gets that.

Is that not right, Mr. Secretary?

Mr. Champion: Pretty close to it.

Senator Talmadge: Is that right, Jay?

Mr. Constantine: Yes, sir.

Senator Talmadge: Reasonable costs is whatever the fellow says is a reasonable charge.

What we are doing, we are filling out a blank check, the U.S. government, and the payee fills in the amount.

What we are trying to do is to bring some more effective controls on, instead of that blank check.

Senator Nelson: I would like to say a point on that. I do not want any government interference. I am as concerned about that as anybody else.

It is absolutely correct, as Senator Wallop said, that the government has all the money. He has the taxpayers' money. I joined Domenici in a bill that will make the government pay everytime they lose one, to pay the attorney's fees.

There is a solution to the whole thing that is very simple. I do not think anybody, not many people around, would

support it except me. That is to say, you get your costs down to this level and if you do not, you are not eligible for any Medicare and Medicaid payments.

We are paying for it. You get your costs down. If you do not, you are not eligible. They would get it down damned fast.

Then you would not have to have any intererence at all. Just say you do not get any money from the taxpayer if you are going to be throwing $5 billion to $6 billion away unnecessarily, and we have other states that are proving that it can be done.

I would like to have an amendment like that. I would vote for it, just like that. Just get your costs down to this rate and do not bother. If you do not, you can run them anyway you please. No interference. You can run them at double the inflation rate, but you get no Medicare or Medicaid. You would be surprised how efficient they would get.

Senator Talmadge: Senator Wallop?

Senator Wallop: One last question. You mentioned in the $158 million one-time savings that were ten states where you got $240 million in savings already. Could I just ask why you were describing the reason Mr. Champion said why it was not? It was done in those terms? They had constitutional strutures within those states.

Mr. Champion: They were also large enough to become a meaningful exercise.

Senator Wallop: Could we be informed as to what kind of state constitutional or legislative impediments there are before we just simply lay this on them, if we are not going to be able to comply and have some other kind of burden? It just seems to me that we need to know a little bit about what kind of impediments are in there.

Mr. Constantine: The way to do that would be to say except to the extent that there is a determinant, and to say we are taking into account any constitutional or other legislative barriers.

Senator Chafee: I am not so enthusiastic about legislative barriers. There would be no reason for them to repeal legislative barriers, since they will be collecting the interest.

Mr. Cosntantine: Taking into account the dates that the legislature meets.

Senator Wallop: Not everybody will be able to hold a special session.

Senator Chafee: There should be a time limit on that. They have to fall in line with other states within a short period, two years, certainly.

Mr. Chairman, I have a very brief amendment.

Senator Talmadge: We have not acted on Section 35, have

we?

Mr. Constantine: The dentists provision.

Senator Danforth: Could we put that over, if we are going to have an analysis?

Senator Talmadge: It will be held over.

Senator Chafee?

Senator Chafee: Page 13 of the bill itself where it deals with those states which are exempt because they have mandated reimbursement systems, the states that Senator Nelson was discussing. My state is a peculiar state, Jay. I think we discussed this with you.

In fact, we do not have a legislatively mandated program, but Blue Cross covers 88 percent of our population and most Blue Cross in conjunction with the state and the hospitals out works a prospective reimbursement system every year. Secetary Califano has referred to it as a mandated program but legally it is not mandated, although everybody has to fall in line, or Blue Cross will not pay them.

Could you have some language that would make sure that we are covered?

Mr. Constantine: Yes, sir.

The key approach was that the state could do whatever it wanted, provided that, in the aggregate, it did not cost more than it would otherwise have been paid under the federal programs.

Senator Chafee: I have some language on I.

Mr. Constantine: Yours is voluntary, but sort of quasi-mandatory.

Senator Chafee: That is right. Someone can get out, if they want, except they will not be paid.

Mr. Champion: If we could use the Rhode Island system in all of the states --

Senator Talmadge: Is Senator Chafee's recommendation agreeable to you?

Mr. Champion: Yes.

Senator Chafee: The language I had on I, that the state has a system instead of a mandate. Can you see where I am there? Anyway, we will work it out.

Mr. Champion: It does have a system. It would be effective.

Senator Talmadge: Blue Cross-Blue Shield does not pay for these Medicare-Medicaid people, do they?

Mr. Constantine: It is whether the objective was to have a system that aplies to all payers in the state.

Senator Talmadge: It would apply to all payers?

Mr. Constantine: Yes.

Senator Talmadge: Any objection:

Without objection, Senator Chafee's amendment is agreed to.

Any other amendments?

Well, do you want to meet tomorrow, gentlemen?

Mr. Stern: The next meeting scheduled for the committee is next Tuesday at 10:00.

Senator Talmadge: The Chairman does not want to meet tomorrow, then?

Mr. STern: Yes, sir.

Senator Nelson: I had said yesterday when we completed the mark-up of your bill then I would have a chance to look at it and we would propose some amendments, so everybody would know what they would be. I would like to get the amendments out to you. I hope I will have them ready by Tuesday.

Senator Talmadge: I think there are at least a couple of amendments hanging. I think three: the dental amendment, the amendment relating to pathologists, and also the amendment on dentists. I believe Senator Long has an amendment, did he not?

Mr. Constantine: Senator Long's amendment related to the dentist.

Senator Talmadge: It did?

Then if there is no objection, we will recess at this time until Tuesday at 10:00 a.m.

Senator Nelson: Will we have available to us the legislative language so we will be able to draft our amendments?

Senator Talmadge: May we have order here?

Mr. Stern: The bulk of what the committee has agreed to is already contained in S. 505, basically, as introduced by Senator Talmadge.

Mr. Constantine: You would need the material agreed to this morning.

Senator Talmadge: Would that be ready by Tuesday?

Mr. Constantine: They are going to try.

Senator Talmadge: Is there anything else, gentlemen?

We stand in recess until 10:00 a.m. Tuesday.

(Whereupon, at 12:45 p.m. the Committee recessed, to reconvene on Tuesday, June 19, 1979 at 10:00 a.m.)

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