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MEDICARE AFTER 15 YEARS: HAS IT
BECOME A BROKEN PROMISE TO THE
ELDERLY?

REPORT

(With Supplemental Views)

BY THE

SELECT COMMITTEE ON AGING
U.S. HOUSE OF REPRESENTATIVES
NINETY-SIXTH CONGRESS
SECOND SESSION

Comm. Pub. No. 96-245



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PREFACE

This report is an analysis of the successes and shortcomings of the medicare program. It is a mosaic made up of excerpts from thousands of letters from senior citizens to committee members. It is a summary of hundreds of reports on this subject and it contains findings obtained from thousands of questionnaires sent to senior citizens and providers.

What emerges is a picture of a highly successful Government program which is currently undergoing severe stress. It becomes clear that medicare is at a crossroad. Satisfaction with the program has been high in the past but dissatisfaction is rising with each passing day.

This report notes that whether medicare continues as one of the most efficient and well received of Federal programs or whether it becomes truly another broken promise made to the elderly, depends on the Congress. Certainly, the improvements in home health, mental health and prepayment for medicare coverage in health maintenance organizations and other provisions which recently passed the House are a good start. However, the committee has concluded that these efforts fall short of what is needed. The committee recommends that the Congress immediately enact sweeping improvements to encourage physicians to accept assignment and to cover eyeglasses, hearing aids, dental care, and prescription drugs through a new self-financing part C of medicare.

The committee believes that the Congress must act at once, and that such improvements cannot wait for the enactment of a broader national health insurance plan. Because these recommendations are based on insightful analysis of the evidence, this report is an excellent contribution toward the goal of improving the quality of life for older Americans.

I wish to commend the committee staff who produced this document. This report was written by Senior Counsel Val J. Halamandaris with research assistance provided by Professional Staff Member Kathy Gardner, Investigative Researcher Nancy Smythe, and Intern Mike Kaelin. The report was edited and produced by Nancy Smythe with editorial assistance from David Holton, chief investigator, Lou Bracknell, staff director of the Subcommittee on Health and Long-Term Care, and Yosef Riemer, deputy chief of staff, as well as Committee Interns Brian Adams and Elizabeth Flynn.

It is my fervent hope that this report will result in the immediate enactment of legislation to implement the committee's recommendations.

CLAUDE PEPPER, *Chairman.*

INTRODUCTION

The purpose of this study is to investigate the effects of various factors on the growth and development of the human body. The study is based on a comprehensive review of the literature and a series of experiments conducted over a period of several years. The results of the study are presented in the following sections.

The first section discusses the importance of nutrition in the growth and development of the human body. It is shown that a diet rich in essential nutrients is necessary for the proper development of the body. The second section discusses the effects of physical activity on the growth and development of the human body. It is shown that regular physical activity is essential for the development of a strong and healthy body. The third section discusses the effects of environmental factors on the growth and development of the human body. It is shown that environmental factors such as temperature, humidity, and air pollution can have a significant impact on the growth and development of the human body.

The fourth section discusses the effects of genetic factors on the growth and development of the human body. It is shown that genetic factors play a significant role in the growth and development of the human body. The fifth section discusses the effects of hormonal factors on the growth and development of the human body. It is shown that hormonal factors play a significant role in the growth and development of the human body.

The sixth section discusses the effects of psychological factors on the growth and development of the human body. It is shown that psychological factors such as stress and anxiety can have a significant impact on the growth and development of the human body. The seventh section discusses the effects of social factors on the growth and development of the human body. It is shown that social factors such as family and community can have a significant impact on the growth and development of the human body.

The eighth section discusses the effects of medical factors on the growth and development of the human body. It is shown that medical factors such as disease and injury can have a significant impact on the growth and development of the human body. The ninth section discusses the effects of lifestyle factors on the growth and development of the human body. It is shown that lifestyle factors such as smoking and drinking can have a significant impact on the growth and development of the human body.

The tenth section discusses the effects of age factors on the growth and development of the human body. It is shown that age factors play a significant role in the growth and development of the human body. The eleventh section discusses the effects of sex factors on the growth and development of the human body. It is shown that sex factors play a significant role in the growth and development of the human body.

The twelfth section discusses the effects of race factors on the growth and development of the human body. It is shown that race factors play a significant role in the growth and development of the human body. The thirteenth section discusses the effects of ethnicity factors on the growth and development of the human body. It is shown that ethnicity factors play a significant role in the growth and development of the human body.

The fourteenth section discusses the effects of religion factors on the growth and development of the human body. It is shown that religion factors play a significant role in the growth and development of the human body. The fifteenth section discusses the effects of culture factors on the growth and development of the human body. It is shown that culture factors play a significant role in the growth and development of the human body.

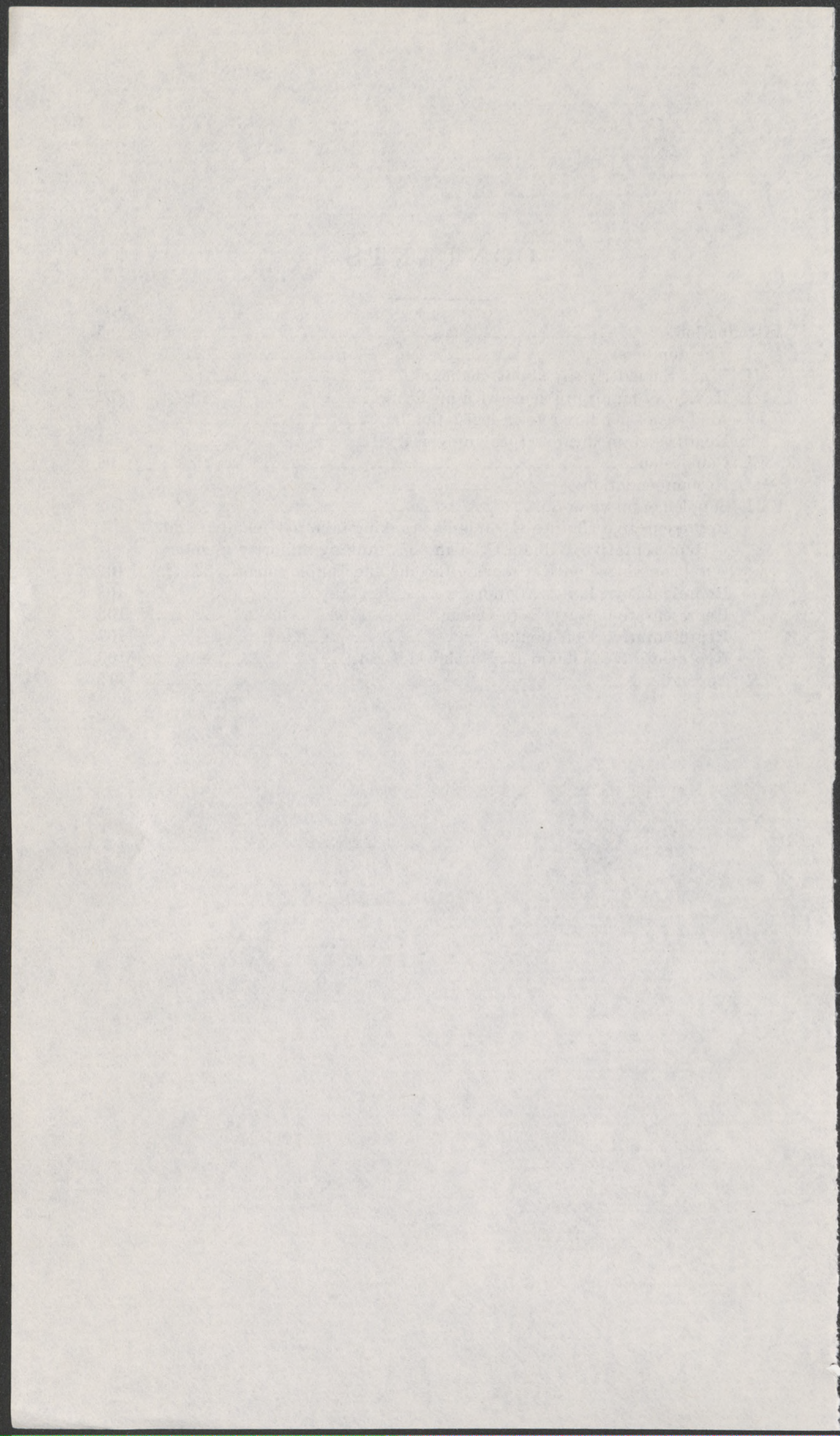
The sixteenth section discusses the effects of language factors on the growth and development of the human body. It is shown that language factors play a significant role in the growth and development of the human body. The seventeenth section discusses the effects of history factors on the growth and development of the human body. It is shown that history factors play a significant role in the growth and development of the human body.

The eighteenth section discusses the effects of geography factors on the growth and development of the human body. It is shown that geography factors play a significant role in the growth and development of the human body. The nineteenth section discusses the effects of climate factors on the growth and development of the human body. It is shown that climate factors play a significant role in the growth and development of the human body.

The twentieth section discusses the effects of time factors on the growth and development of the human body. It is shown that time factors play a significant role in the growth and development of the human body.

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INTRODUCTION

Shortly after his inauguration, President John F. Kennedy called upon Congress to join with him in a partnership to explore the special health problems of older Americans and to redress these problems with the enactment of a national health insurance program. The Congress responded. The House Ways and Means Committee and the Senate Finance Committee began conducting hearings. The Senate passed a resolution in 1961 creating the Senate Special Committee on Aging to explore these problems in-depth.

What Congress learned through lengthy hearings was that more than one-fourth of the nation's elderly had incomes placing them at or below the established poverty line. Many seniors had only their social security checks to live on. On the average, seniors could expect to have less than half of the income that they received when they were working. Those who wanted to continue working soon learned that they would sacrifice one dollar of their social security checks for every two dollars they earned above an arbitrary \$1,660 limit. Moreover, while the incomes of the elderly were comparatively small and contracting, their health care costs and their utilization of health services were increasing at a rapid pace. While younger adults spent perhaps 10 percent of their incomes for medical care, it was not uncommon to find senior citizens who spent 30 percent of their incomes in pursuit of needed health care. National statistics indicated not only that on average senior citizens spent three times as much for their health care but that their incidence of utilization and relative recovery times from surgery were three times as great.

Congress also learned that 30 percent of the elderly were living in substandard housing without adequate heat, plumbing or electricity and that there was a distinct lack of social services, both of which undoubtedly had an impact on health care. Thousands of elderly persons continued to live in rural areas where few medical practitioners were available. It was overwhelmingly clear that older Americans were not being provided with the health care they needed or that they were continually faced with a desperate choice of spending their limited incomes on food or health care. Finally, it was clear to Congress that the "welfare medicine" offered to the aged, poor and needy by the States or municipalities was uneven in quality and generally far short of what was necessary.

In cooperation with President Lyndon B. Johnson, the Congress took note of these inequities and in July of 1965, created a new Title XVIII of the Social Security Act, Health Insurance for the Aged and Disabled. Congress declared in the preamble to this historic piece of legislation that access to good health care was the right of all Americans, and that there should be no discrimination with respect to access, to the finest health care America has to offer based on a person's ability to pay for such care.

From the beginning there was a misunderstanding about the extent of Medicare's coverage. Partly the result of wishful thinking and partly the result of the distribution of misleading publications which trumpeted Medicare's virtues, senior citizens were left with the impression that Medicare offered them comprehensive coverage. This was not the case. It was never intended to do so. Still senior citizens were left with the impression that Medicare would pay for 80 percent of their health care costs. In the years following enactment, millions of senior citizens have had their illusions rudely shattered having been left with sizeable bills which Medicare refused to pay.

In the 15 years since Medicare was enacted, the United States has seen a dramatic increase in the cost of health care. For whatever reasons, the cost of health care has continued to increase three times as fast as the cost of living. These increasing costs have been passed along to the consumer of services and to the taxpayers.

In terms of Medicare, the escalating costs have meant that the senior citizens of America have had to pay more out of their own pockets to participate in the Medicare program. Moreover, they have been left with an increasingly larger share of the bill which Medicare has refused to pay. It has become increasingly difficult for them to find a doctor who will accept what Medicare offers as full payment. Most doctors now refuse to take assignment—the technical term for billing Medicare directly and accepting whatever Medicare pays. Most doctors bill and collect from senior citizens, leaving the elderly to fill out the paperwork and seek repayment from Medicare. The paperwork generally confounds the elderly—so much so that for-profit firms are springing up all across the country offering the service of helping the elderly fill out their Medicare forms. Collection from Medicare is a slow process and inevitably older Americans are left with a large portion of their doctor bill for which Medicare will not reimburse them.

The situation has reached the crisis stage as more and more senior citizens have come to understand that there are great gaps in Medicare's coverage. Some of these gaps were present in the original legislation: Congress did not provide coverage for eyeglasses, dental care, or out-of-hospital prescription drugs. Other gaps are the result of restrictive Federal regulations which have shortened Medicare's range of coverage. For example, Federal regulations have sharply limited Medicare's coverage for nursing home care. The result is that Medicare is paying for a decreasing portion of the average senior citizen's health bill. In 1969, Medicare covered almost 50 percent of the average senior citizen's health care bill. Today, excluding the premiums the seniors pay to participate in the part of Medicare that pays for physician's fees, Medicare pays for about 40 percent of the average senior's health care bills.

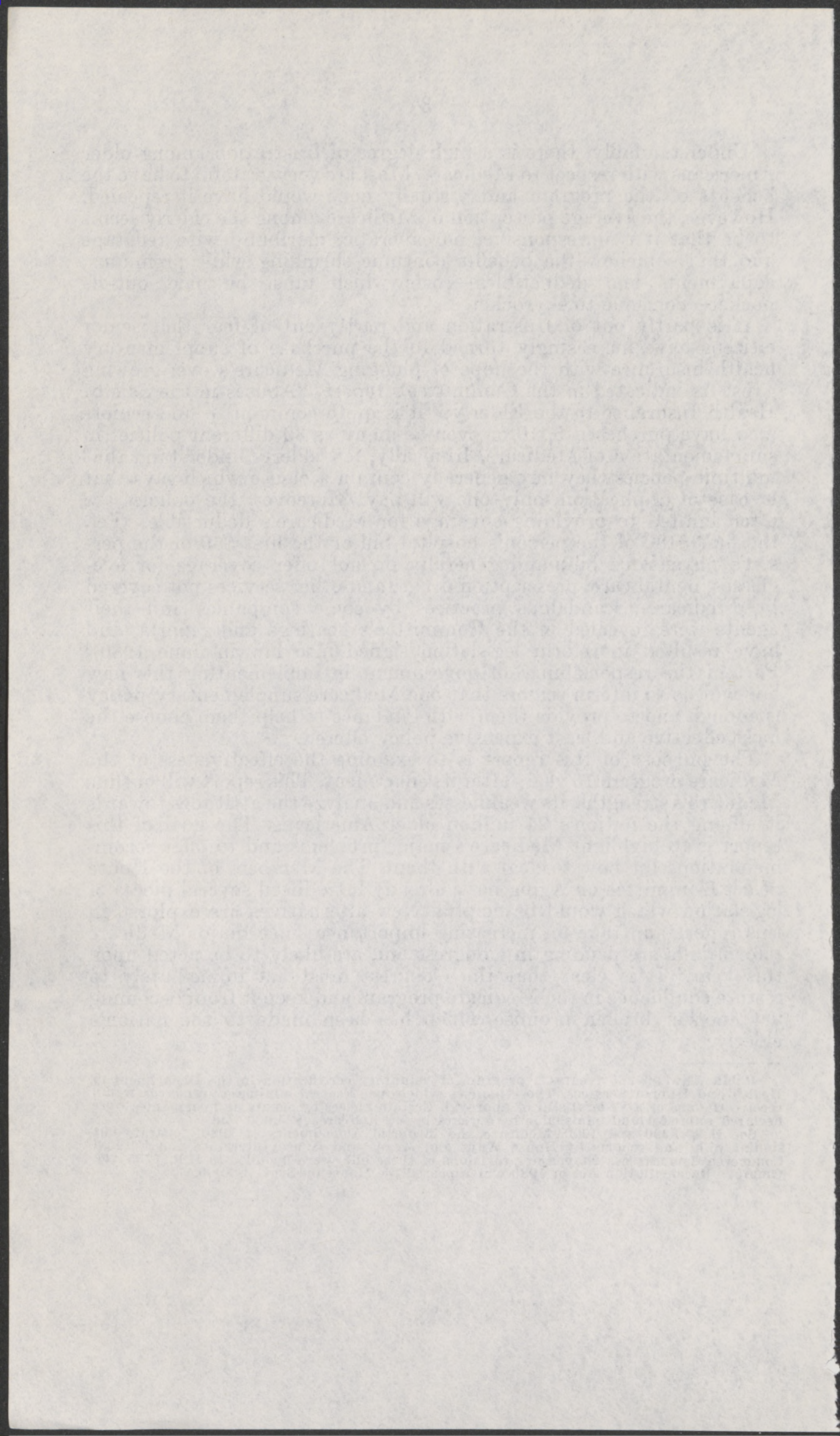
Understandably, there is a high degree of frustration among older Americans with respect to Medicare. Most are very grateful to have the benefits of the program and virtually none would have it repealed. However, the average perception of Medicare among the elderly seems to be that it is unresponsive, bureaucratic, moribund with red tape and that somehow the benefits continue shrinking while premiums, copayments and deductibles—costs which must be paid out-of-pocket—continue to skyrocket.

It is partly out of frustration and partly out of fear that senior citizens have increasingly turned to the purchase of supplementary health insurance with the hope of plugging Medicare's ever-growing gaps. As indicated in the Committee's report, "Abuses in the Sale of Health Insurance to the Elderly," it is quite common to find seniors who have purchased 5, 10 or even as many as 30 different policies in supplementation of Medicare. Ironically, few elderly understand that multiple policies they buy generally contain a clause which says that in case of duplication, only one will pay. Moreover, the policies are often limited to providing coverage for Medicare's deductibles (i.e., the first \$180 of the person's hospital bill or the first \$60 of the person's physician's bill) and generally do not offer coverage for eye-glasses, dental care, prescription drugs, and other services not covered by Medicare. Scandalous practices by some companies and their agents were revealed in the Committee's hearings and reports, and have resulted in reform legislation signed into law in June 1980.¹ Part of the responsibility of government in implementing this new law will be to inform seniors that one Medicare supplementary policy is enough and to provide them with guidance to help them choose the most effective and least expensive policy offered.

The purpose of this report is to examine the effectiveness of the Medicare program 15 years after its enactment. This report will outline Medicare's strengths, its weaknesses and analyze the attitudes towards it among the nation's 24 million older Americans. The goal of this report is to highlight Medicare's major problems and to offer recommendations for how to deal with them. The Members of the House Select Committee on Aging have already introduced several pieces of legislation which would be helpful. New alternatives are explored in this report and take on increasing importance since major Medicare reform bills are pending in Congress and are likely to be acted upon this year.² It is clear that the Congress must act immediately to restore confidence in the Medicare program and keep it from becoming yet another broken promise which has been made to the nation's elderly.

¹ Public Law 96-265 creates a program of voluntary certification in the Department of Health and Human Services. Those policies which met Federal minimum standards would receive the use of a Federal seal of approval. Certain abuses by agents and companies were declared unlawful and punishable by 5 years in jail and/or a \$25,000 fine.

² See H.R. 3990 and 4000, Medicare and Medicaid Amendments of 1980, separate but similar bills and reports by House Ways and Means and House Interstate and Foreign Commerce Committees. The major provisions of these bills were included in H.R. 7765, the Omnibus Reconciliation Act of 1980 which passed the House on Sept. 3, 1980.



I. THE NUMBERS

In 1950, Americans spent \$12 billion for health care; by 1977, expenditures had increased 1,250 percent to \$162.6 billion. Expenditures for health care are slated to double between 1977 and 1983 when Americans will be paying a staggering \$320 billion for health care. It is estimated that in 1980, Americans will spend about \$245 billion in pursuit of health care.

It should be no surprise to most Americans that health is the second largest and fastest-growing industry in the United States, currently accounting for about 9.5 percent of the gross national product.

Table I shows projected health expenditures for 1980. Some \$97.3 billion or 40 percent of the total, will be paid toward hospital care. The importance of this statistic is indicated by the fact that those over age 65 are more likely to be hospitalized at two and a half times the per capita frequency rate for persons under age 65, and their average length of stay is twice as long as other segments of the population.

The next largest category is physician's services, which will total about \$45 billion, or almost 20 percent of the total. Dental services account for another 6.9 percent of the total, costing about \$17.9 billion in 1980. Drugs and sundries account for \$18.1 billion, eyeglasses and appliances for \$4.7 billion, other health and professional services account for about \$11 billion and nursing home care will cost the nation \$21.6 billion this year, or about 9 percent of all health expenditures. Expenses for administration will total \$11.6 billion, government public health activities account for \$7 billion, construction of health institutions will cost \$15.8 billion and about \$5.2 billion will be spent for research this year.

TABLE I.—AGGREGATE AMOUNT AND PERCENTAGE DISTRIBUTION OF NATIONAL HEALTH EXPENDITURES BY TYPE OF EXPENDITURE, PROJECTED FOR CALENDAR YEAR 1980

Type of expenditure	Amounts paid in 1980 (billions)	Percent
Total.....	\$244.6	100.0
Health services and supplies.....	234.1	95.7
Personal health care expense.....	215.5	88.1
Hospital care.....	97.3	39.8
Physicians' services.....	45.0	18.4
Dentists' services.....	17.9	7.3
Other professional services.....	5.7	2.3
Drugs and drug sundries.....	18.1	7.4
Eyeglasses and appliances.....	4.7	1.9
Nursing home care.....	21.6	8.8
Other health services.....	5.2	2.1
Expenses for prepayment and administration.....	11.6	4.8
Government public health activities.....	7.0	2.9
Research and medical-facilities construction.....	15.8	6.5
Research.....	5.2	2.1

Source: Health Care Financing Review/Winter 1980.

This same picture of ever-escalating health care costs can be seen even more graphically by reference to per capita figures. In 1965, the year Medicare was enacted, each American citizen spent an average \$217.41 for health care. This year they will spend \$1,078.00—an increase of 395.84 percent! Senior citizens spent about \$445 per capita at the end of 1965 and are expected to spend about \$2500 each this year, an increase of 525 percent. Actual expenditures for 1978 show that \$2,028 was spent per capita for health care of those age 65 and over as compared to \$863.01 spent per capita for younger persons.

ABOUT MEDICARE

This year there are an estimated 24.6 million older Americans and an additional 3 million disabled enrolled in Medicare. Most people do not realize that Medicare is really two programs. First there is Part A, sometimes called the "basic protection plan" or the "hospital insurance" portion of Medicare. Almost all of America's over 65 population is automatically eligible for Part A which is funded through a payroll tax and a separate trust fund. The small number of older Americans who are not eligible for Medicare are generally individuals who have worked in the military or government, who have a separate retirement system and thus have not contributed to the hospital insurance or social security trust funds during their working lives. These people may buy into Medicare by paying the full actuarial cost, now set at \$78 a month. As the name suggests, Part A pays for hospital and related costs. Some 20 percent of the Part A enrollees use the services of Medicare Part A in any given year.

Coverage under Part A is based on the concept of a "benefit period" or spell of illness, a period which begins when an individual enters the hospital and ends when that individual has been out of the hospital or a skilled nursing facility for 60 consecutive days. In each benefit period, individuals are entitled to 90 days of hospital care and, following a hospital stay, to 100 days in a skilled nursing facility and 100 home health visits. If hospital benefits are exhausted in a spell of illness, Medicare allows the individual to draw on an additional 60 reserve days.

Although Part A is principally financed through a special hospital insurance payroll tax levied on employees, employers, and the self-employed and requires no premium payment, beneficiaries are liable for sharing in the cost of the health services they receive by meeting certain "deductibles" and "coinsurance" payments:

From the 1st day through the 60th day in each benefit period, hospital insurance pays for all covered services except the first \$180.00. This is called the hospital insurance "deductible."

From the 61st day through the 90th day in a benefit period, hospital insurance pays for all covered services except for \$45.00 a day. This is called the hospital insurance "coinsurance."

An additional lifetime reserve of 60 days may be drawn upon when an individual exceeds 90 days in a benefit period. Each additional reserve day is subject to a \$90.00 a day copayment.

Following a hospital stay, eligible individuals are entitled to 100 days in a skilled nursing facility. Hospital insurance pays for the first

20 days. After 20 days, hospital insurance pays for all covered services for the 21st through 100th day, except for \$22.50 a day.¹

Individuals are also liable for a deductible of the cost or the replacement of the first three pints of blood.

Part B is a voluntary program of supplementary medical insurance. Those individuals who are eligible for Medicare Part A may elect to have Medicare pay for some of their physician's services. To do so, they must sign up for Medicare Part B and agree to pay a monthly premium now set at \$9.60 a month or \$115.20 a year. Premiums, however, make up only about 30 percent of the income in the Medicare Part B trust fund. The remaining 70 percent is made up of general revenues from the U.S. Treasury. Some 95 percent of all older Americans understandably elect to participate in Part B.

Those seniors who sign up for Part B must pay the first \$60 of their doctor's bill every year—this amount is otherwise known as the Part B deductible. Thereafter, by law, Medicare will pay 80 percent of what the program determines are "reasonable charges."

The term "reasonable charge" has become increasingly controversial; to understand what it means, the reader must first understand two other terms. Payments to physicians and other providers under Part B are based on two other factors—the "customary charge" and the "prevailing charge."

The "customary charge" is the physician's median charge in the previous year. Example: Your doctor may have been charging patients from \$1 to \$30 for an office visit, his median or customary charge will be determined to be something like \$15. One obvious point is that the use of this factor creates a disincentive for doctors to lower rates. In cutting fees, the physician lowers his median charge and hence reduces what Medicare is likely to pay him the next year.

The "prevailing charge" is the 75th percentile of what all physicians charge in a specified area. Example: Medicare officials look at the charges for office visits of several doctors in your area and find they are in the \$1-\$30 range. The 75th percentile would be \$22.50, hence this amount becomes the prevailing rate.

Thus, "reasonable charge" is defined as the lowest of the following: (a) What your doctor has charged you; (b) his customary charge; and (c) the prevailing charge in the area.

"Accepting assignment" occurs when a doctor agrees to bill the Government directly for services he provides to you and to accept as full payment whatever Medicare determines to be a reasonable charge using the above formula. Understandably, the number of physicians who will accept assignment is dwindling. Less than half of the physicians participating in Medicare will do so. Most physicians prefer that the senior citizen pay them their fee, say \$25 for an office visit. The senior must then fill out the Medicare forms and seek repayment from Medicare. The fact that Medicare determines that the reasonable charge in this case was \$12 and pays 80 percent thereof

¹ As will be noted later, the reference to the individual being entitled to 100 days care in a skilled nursing facility is more of an illusion than a fact. Only about 25,000 individuals out of the more than 1.4 million aged in nursing homes on any given day have their care paid for by Medicare. Medicare pays for less than 3 percent of the nation's total nursing home bill. In short, there are few people who will actually qualify for Medicare's assistance in connection with a stay in a nursing home; only a handful will actually receive 100 days coverage.

or \$9.60, means that the senior citizen must pay the remaining \$15.40 out of his own pocket.

The determination of whether charges are reasonable and proper in both Part A and B of Medicare are made by various insurance companies under contract with the Department of Health and Human Services. These companies claim to have the computers and the expertise to make sure that payments to providers are prompt and accurate. Insurance companies which play this role of administering the Medicare program are known as fiscal intermediaries or carriers. A great deal of controversy has arisen over the past 15 years about the role of these insurance companies. Obviously, some do a better job than others. The most common complaint by providers is that the determinations as to payment by the intermediary are often arbitrary; that they are made by clerks who are often in the position of second-guessing trained medical practitioners and that there are great disparities in what is compensable under Medicare from intermediary to intermediary in various geographic regions.

The following tables prepared by Jennifer O'Sullivan of the Library of Congress are included at this point in order to graphically demonstrate which services are covered by Medicare and the copayments and deductibles which seniors must pay out of their own pockets. For example, Table II shows that with respect to inpatient hospital services, the beneficiary must pay the first \$180 of his or her bill. Beginning on the 61st day, the person must pay \$45 a day toward the hospital bill until the 90th day when Medicare's coverage ends. However, each individual has 60 lifetime reserve days that they may call upon to continue receiving Medicare benefits if there is an extended hospital stay. In using these reserve days, the person must pay \$90 a day toward the hospital bill.

TABLE II.—*Medicare part A benefits and amounts which must be paid by the beneficiary*

Medicare benefits—Part A: Hospital insurance benefits

Coverage per "benefit period":

A. Inpatient hospital services:	Beneficiary payments:
First 60 days.....	\$180 deductible.
61st—90th day.....	\$45 per day.
60 lifetime reserve days.....	\$90 per day.
B. Skilled nursing facility services (To qualify a beneficiary must: (1) need skilled nursing and/or skilled rehabilitation services on a daily basis, (2) have been in a hospital for 3 consecutive days, and (3) be admitted to a medicare-approved facility within 14 days following hospital discharge):	
First 20 days.....	None.
21st—100th day.....	\$22.50 per day.
C. Home health care (provided in 12-month period following a 3-day hospital stay or discharge from a skilled nursing facility):	
100 visits.....	None.
D. Blood.....	First 3 pints.

Table III sets forth the benefits provided under Part B of Medicare and the amounts that the beneficiary can expect to pay beginning with the annual \$60 deductible.

TABLE III.—*Medicare part B benefits and amounts which must be paid by the beneficiary*

<i>Coverage</i>	<i>Beneficiary payments</i>
A. Doctors services:	
Services provided by:	The beneficiary pays:
Doctors of medicine and osteopathy.	1. \$60 annual deductible.
Dentists performing dental surgery or setting certain fractures.	2. Coinsurance of 20 percent of "reasonable charges".
Podiatrics (excluding routine foot care).	3. Any amounts in excess of charges determined "reasonable."
Chiropractors for treatment involving manual manipulation of the spine to correct a subluxation.	Exceptions:
B. Other medical and health services:	1. Inpatient radiology or pathology: no deductible or coinsurance.
Diagnostic X-ray and laboratory tests.	2. Home health services: no coinsurance.
Outpatient hospital services.	3. Blood: no coverage for first 3 pints.
X-ray and other radiation therapy.	Annual program payment limitations:
Services and supplies furnished in connection with physician's services.	1. Outpatient psychiatric physician services: \$250 (beneficiary pays 50 percent coinsurance on first \$500 of reasonable charges and all expenses in excess of that amount).
Surgical dressing, splints, and casts.	2. Licensed physical therapist's services: \$80 (beneficiary pays 20 percent coinsurance on first \$100 and all amounts in excess of that amount).
Durable medical equipment (whether rented or bought).	
Artificial devices that replace all or part of an internal body organ.	
Ambulance services.	
Braces and artificial legs, arms, and eyes.	
Physical and speech therapy furnished by institutions, clinics and public agencies.	
Physical therapy provided by an independent therapist.	
Rural health clinic services.	
C. Home health services: 100 visits per year.	

MEDICARE'S PAYMENTS

How much does Medicare pay towards the health care of the aged? The latest complete figures are for fiscal 1978. They indicate that \$50 billion was spent for health care for the aged of which \$18 billion represents private funds with the remainder being government money. Medicare paid the lion's share of these expenditures—some \$22 billion worth. Much of this money, some \$15.8 billion, was paid to hospitals by Medicare and about \$5 billion was paid to physicians. Medicare made no payment to dentists or for drugs and sundries which are not covered by the program. Medicare paid about \$380 million for nursing home coverage and about this same amount for home health coverage.

The remainder of the \$22 billion was made up of payments for medical appliances and to a miscellaneous category called other professional services. In terms of percentages, Medicare paid about 75 percent of the average senior's hospital bill, 55 percent of their physician's bills, none of their drugs and dental care, less than 3 percent of their nursing home care and very little in the way of eye care—except for eye surgery performed by a physician.

The crucial question for many senior citizens is: Does Medicare pay more or less of the average senior citizens health care bill than it did when it was enacted and put into effect 15 years ago? The answer is clearly less—a great deal less. One way to show this is to take the average per capita payment for health care of the elderly in 1966 and in 1978, and ascertain what portion was paid for by Medicare. In 1966, the first year following enactment, annual per capita health costs were \$445 for the elderly. Medicare paid \$204 or slightly less than 50 percent of the total. In 1978, average per capita health expenses for the elderly amounted to \$2,028 while Medicare, when Part B premiums are included, is credited with paying \$893 per capita or about 44 percent of the total. (It is important to note that in this example, the amount of Medicare's contribution has not been adjusted downward to reflect the cost of Medicare premiums, deductibles and copayments which are paid out-of-pocket by seniors. With these items subtracted, Medicare's true contribution drops down below 40 percent).

Since it is clear that Medicare is paying less, the collateral question is: Are senior citizens paying more? In 1966, the average senior paid slightly more than 50 percent of his own health care costs—\$241 out of a per capita total of \$445 per older American. In 1978, seniors paid about \$862 or 43 percent of their health care costs themselves. (Once again, this figure must be adjusted to take into consideration premiums, deductibles and copayments which will have the effect of taking out-of-pocket contributions close to the 50 percent mark where it stood 15 years ago). The gap, that is the difference between what Medicare pays and what seniors pay from their own pockets is being paid, in many instances, by Medicaid, the welfare health care program available to the aged, blind, and disabled. It should be clear that unlike Medicare, which is a program of universal entitlement funded almost entirely with Federal money (except for private contributions in premiums, copayments, etc.), Medicaid is a Federal-State grant-in-aid program which is available to the needy listed above, provided they have the common denominator of poverty. The States have the responsibility of setting income limits in Medicaid but individuals with \$3,000 in income or more are generally ineligible.

In summary, it appears that Medicare is paying something less than 40 percent of the health care costs of the elderly which is a significant drop from when the program began. The elderly apparently are continuing to pay almost 50 percent of their health care bills as they did in 1966. The obvious conclusion is that the cutbacks in Medicare have shifted the burden of health care for the aged increasingly to the welfare program, Medicaid. This can be clearly documented with reference to nursing home care. In 1969, nursing home expenditures constituted fully 5 percent of Medicare outlays and Medicare paid for 19.5 million covered days. By 1978, the number of covered days had been reduced 56 percent to 8.6 million covered days and nursing home outlays accounted for a little more than 2

percent of the total. In fact, only 25,000 patients of the 1.4 million in America's nursing homes on any given day have their care paid for by Medicare. At the same time, the nursing home portion of the Medicaid program has expanded dramatically, accounting for over 40 percent of the entire Medicaid outlays in fiscal 1978.

Obviously, one advantage of shifting utilization from a program of universal entitlement like Medicare to a grant-in-aid program like Medicaid which is triggered by a means test, will be cost savings. Moreover, since Medicaid is a Federal-State program, a shift in that direction will serve to place increased burden upon the States. This shift can have severe consequences. Staying with the nursing home example, it appears that one consequence is that patients are going without the care they need. Another consequence seems to be that in attempting to save money at the lesser level of care, this myopic policy has caused unnecessary overutilization of more expensive hospital beds. Finally, there is severe psychological damage done to the elderly and their confidence in government. This damage grows out of their perception of Medicare which, like social security, is seen as a program of entitlement—a program to which they contributed when young in order to be “entitled” to benefits in the form of a repayment of what they paid in when needed in their senior years.

Because of this concept, there is wide respect, acceptance and even reverence for Medicare. Medicaid, on the other hand, is seen as a hand-out, a welfare program, a gift of government largess to those down, out and destitute. To older Americans who lived through the Great Depression, most of whom are imbued with the work ethic, the notion of going on welfare is abhorrent. There are many who will go without the health care they need rather than accept Medicaid. Medicaid is viewed with contempt by many seniors who fear going broke, going on welfare, and becoming a burden to their families, perhaps as much as death itself. The manner in which many States require the elderly to divest themselves—“spend down”—their incomes and relinquish their assets and belongings in order to qualify for government aid has done little to enhance the program's image with the elderly. Little wonder that so much of Medicaid's money is paid to nursing homes which, in and of themselves, and like acceptance of Medicaid, are viewed as a last resort—a resignation to the inevitable.

INCREASING COPAYMENTS: DECREASING ASSIGNMENTS

When Medicare went into effect in 1966, seniors were required to pay the first \$40 of their hospital bill. Today, this hospital deductible has increased 350 percent to \$180. The hospital coinsurance has also increased 350 percent from \$10 to \$45 daily—these amounts must be paid by the beneficiary beginning with the 61st day of hospitalization. The coinsurance of the lifetime reserve days has increased 350 percent from \$20 to \$90 a day. The coinsurance which must be paid from the 21st to the 100th day in a skilled nursing facility has also risen 350 percent from \$5 to \$22.50 a day. The monthly premium to participate in Medicare Part B has increased from \$3 a month in July 1966 to \$9.60 a month today—an increase of 220 percent. The Part B deductible, which can only be changed by Congress, was increased once in 1973, from \$50 which was the level set when the program began, to \$60 today.

Just as confounding to the elderly as the ever-increasing premiums, deductibles and coinsurance amounts, is the reduction in the number of physicians who take assignment and the feeling that Medicare is paying less than it should of their physician's bills. It is worth restating that if a doctor "accepts assignment" he commits himself to accept whatever payment Medicare considers reasonable. When he "refuses assignment" and sends the bill to a patient, he sets whatever fee he chooses—usually higher than what Medicare will pay and it is up to the patient to get reimbursed by Medicare. However high the doctor's bill, Medicare returns to the patient only 80 percent of the "reasonable" charge. Many doctors believe that the fees reimbursed by Medicare do not adequately cover the cost to provide medical services, therefore, fewer physicians are agreeing to accept assignment. Today, doctors accept assignment for only 1 out of every 2 elderly patients; 2 out of 3 elderly patients were accepted for assignment in 1966.

Many senior citizens are outraged when they read in the literature that Medicare will pay for 80 percent of their physician's bill after they have satisfied the \$60 deductible and yet they know from personal experience that Medicare is paying closer to 50 percent of their doctor's bills. They react by writing thousands of letters to Congress asking how the Congress could permit this contraction of statutory benefits to take place. One explanation for what has happened is the increasing refusal of physicians to accept assignment. This is perhaps the hottest issue with respect to Medicare today. Senior citizens and providers alike have implored the Congress to undertake corrective action.

INCREASING COSTS OF SERVICES "NOT COVERED BY MEDICARE"

In addition to their frustration with Medicare caused by increasing costs and decreasing coverage for covered services, seniors have been hard-pressed in these difficult economic times to keep up with the costs associated with an array of vital health services which, as noted above, are explicitly excluded from coverage in the current Medicare law. Among these include:

Drugs which can be self-administered.—Drugs and drug sundries account for 6.5 percent of the health care expenditures of people 65 and over. Americans over 65 comprise only 11 percent of the population, but account for about 25 percent of the total drug expenditures annually. The total bill for drugs and drug sundries for elderly in 1978 amounted to \$3.2 billion. Medicare paid little. Medicaid and other sources paid 14.5 percent, but the bulk, almost 85.5 percent, came out of the pockets of those least able to pay, the elderly themselves;

Dental care (except jaw surgery).—Dental problems, such as tooth decay and periodontal disease are so widespread among the elderly that half of all persons over 65 have no natural teeth; 6.2 percent of those elderly people who are without natural teeth also have no dentures. Medicare covers only selected forms of dental surgery, but not routine dental care or dentures. As of 1976, Medicaid programs in

36 States covered dental care or dentures, but that number has continued to decline as many States strive to cut back their expenditures. (Dental services account for 2.8 percent of the health expenditures of people 65 and over);

Eyeglasses or eye examinations.—More than 60 million elderly require and own eyeglasses. However, over 5 million elderly Americans are wearing glasses which need to be corrected. Medicare does not cover the cost of eyeglasses or related examinations. Medicaid is only slightly more helpful, paying for eyeglasses for those elderly who are eligible in only half the States. (Eyeglasses and appliances account for 1 percent of the elderly's health care expenses);

Hearing care or examinations.—More than one half of all persons over 65 suffer from impaired hearing. For 8 percent of the elderly, the problem is so severe that they are unable to hear words spoken in a normal voice. Medicare does not pay for hearing aids at all. In 1976, Medicaid paid for hearing aids for the elderly in only 11 States.

Custodial nursing home care.—Nursing home revenues will total \$21 billion in 1980 which works out to about \$900 per capita for the aged. Expenditures for nursing home care therefore constitute the single largest expenditure for the elderly or fully 35 percent of the \$60 billion spent for health care of the aged this year. There are approximately 1.4 million elderly in nursing homes on any given day. Private patients pay an average of \$14,000 a year for care. Medicare pays less than 3 percent of the bill.

Home health care.—Home health services are covered by Medicare where individuals are confined to their homes and require "intermittent" skilled care. In 1976, the Congressional Budget Office estimated that only about 2 percent of the Medicare budget went for home health care services. Committee hearings revealed that as many as 1 out of every 4 older Americans are needlessly institutionalized simply because home health alternatives are not available;

Routine physical examinations.—Medicare does not provide coverage for physical checkups in order that developing disabilities might be detected early; Medicare also does not pay for *immunizations; most foot care; homemaker services or meals at home; and treatment outside the United States.*

This abbreviated list of noncovered services is testimony to the narrow view Medicare has regarding the care an elderly patient needs. Unfortunately, Medicare, the program which was intended to give older people a hedge against the overwhelming cost of health care, denies reimbursement for many of the health care services the elderly need the most.

This quick statistical overview of Medicare has already done much to confirm the view that many older Americans have of this important program. Seniors are grateful for the assistance they receive but they are uneasy. They sense that something is very wrong with the program. They see it as a continuous ride on a merry-go-round which never stops—instead it gradually picks up speed every year. It is costing them more and more to participate and it seems that Medicare is paying less and less of the bill. Coming chapters are devoted to further exposition of weaknesses with the program and how these ills might be remedied.

II. WHAT THE ELDERLY SAY ABOUT MEDICARE

In order to learn firsthand about Medicare, Chairman Claude Pepper recently asked all Congressional offices to share with the Committee all the correspondence they received pertaining to the subject for a period of one month. At the same time, there have been numerous hearings by the Committee and its Subcommittees which have given senior citizens and national organizations a forum to present their views about Medicare. One such hearing, conducted by Congressman Don Bonker under the auspices of the Subcommittee on Health and Long-Term Care, took place in San Diego, California on October 24, 1979 in conjunction with the California Legislature Assembly Committee on Aging and the Western Conference of the American Association of Retired Persons/National Retired Teachers Association. During this time, the Committee also received thousands of letters relating to Medicare directly from older Americans throughout the United States. This section of this report includes short comments from several hundred older Americans. They are included under categories with the thought that it would be useful to the Congress, which is considering reform, to hear the voice of the people.

A. GENERAL COMMENTS ABOUT MEDICARE

As noted earlier, most senior citizens are grateful for Medicare. They feel that it is an important program which benefits them in old age because they contributed to it in their younger years. At the same time, there is a general uneasiness and the feeling that somehow Medicare is close to becoming another broken promise made to the elderly. The following comments reflect the prevailing attitude:

My late husband and I worked 7 days a week, 12 to 14 hours every day operating a small grocery store in order to save enough to live on in our old age and now I can see it draining away on unpaid doctor bills. I thought Medicare paid 80 percent of the doctor bills but at the rate they have been paying mine they are paying whatever they feel like . . .

A.H., *Leisure City, Fla.*

It is my understanding that the Medicare program was established by Congress to relieve the burden of high medical expenses during people's retirement years. This has not happened . . .

C.A.K., *Topeka, Kans.*

My first experience with Medicare has been costly and a terrible disappointment . . .

G.E.G., Sr., *Baltimore, Md.*

The Medicare program as it is today is worthless to the aged and the handicapped . . . I am sure if you would send out one of your surveys to the people in your area you would find far more people who are dissatisfied with Medicare's payment program and coverage than those that are satisfied. I urge you to do something about the sad coverage that is being afforded by Medicare . . .

V.R., *Medford, Oreg.*

From my experience and my observation, it appears that Medicare has failed to provide what it was designed to provide . . .

L.C., *Houston, Tex.*

Our first experience with Medicare has been an eye opener and has almost driven me up a tree. I think there should be improvements made in all areas and senior citizens provided with a more efficient health care system . . .

W.F.F., *Indianapolis, Ind.*

Medicare was intended to be wonderful and a help to the elderly, but sad to say, it is being extremely abused . . .

E.H., *Bremen, Kans.*

First, let me say that we appreciate very much what benefits we have under Medicare. But, our first experience with medicare has been less than satisfying and not the coverage we had expected . . .

W.F.F., *Indianapolis, Ind.*

I had great coverage until I became 65 and now it is terrible because the companies of any consequence all use Medicare guidelines and so do not pay out a part of the bills, saying they are "unreasonable" . . .

D.K.S., *Indianapolis, Ind.*

Why does Medicare fool the people into buying their insurance by telling them that they pay 80 percent of their bill when it is not true . . .

E.D.R., *Ogden, Kans.*

Medicare coverage of doctor's bills has not been paying 80 percent of the doctor's bills, as advertised. Please find enclosed Item 1, in which Medicare paid 80 percent of only \$45.30, where the doctor's bill was \$78.00 (Medicare paid not 80 percent, but only 46 percent of the doctor's bill!!!!) The difference between 80 percent and 46 percent could wipe me out . . . The situation STINKS. You could and should do something effective about it!

H.M.M., Sr., DDS (Retired),
St. Paul, Minn.

My wife and I are 68 years of age. We are on Medicare, on a fixed income. Our Medicare certainly doesn't provide

nearly enough protection on our small income. Some time back I had to have some minor surgery on my eye. The doctor did the surgery in his office. It didn't take him 30 minutes and his bill was \$200. Medicare paid \$80, our plan paid \$35, and I still had to pay \$85. If this would have been a major bill I could not have been able to afford it. This is one example. As we grow older and become weaker you can see our problems are going to increase. Can you tell me how to handle something of this nature on a small fixed income? We are also on a considerable amount of prescription medication and these bills are very difficult to meet on our income. We had heard at one time that Medicare would take care of this, but don't hear anything about it any more . . .

G.H., *Goff, Kans.*

I was not eligible for Medicare until legislation made it possible to buy in because the school system was not in Social Security. When eligible I paid \$36.00 a month but now the premium is \$77.70 a month and undoubtedly this will be increased next July 1980. Medical bills exceed what Medicare will approve so this adds to the cost. If I should require expensive, intensive care, surgery, or long term hospitalization I'd be bankrupted and a pauper. If I were a pauper I'd be cared for at taxpayer expense. To avoid this should I commit suicide?

H.E.S., *San Diego, Calif.*

I constantly hear reports that Medicare is broke and that all of the funds (that we have paid into the coffers in the past) have been used up.

F. S., *El Cajon, Calif.*

The inequities of the Medicare/Medicaid program currently places a tremendous financial burden on the older Americans. It must be realized that the retired citizenry are no longer earning top wages. A large percentage live on fixed incomes and with soaring doctor and hospital costs, it takes but one illness to wipe out a lifetime of savings—and there is no way to replenish that loss.

I.S., *Irvine, Calif.*

Many of the medical profession are using unfair billing practices which exacerbate what is already a stressful situation by demanding full payment of their bill before furnishing the client with the necessary papers to bill Medicare.

M.H., *Chula Vista, Calif.*

I am upset that Medicare premiums continue to increase and yet Medicare does not pay 80 percent of the cost as I had assumed . . . In as much as the cost of both Medicare coverage and Blue Cross coverage has risen appreciably in the past several years and also, doctor's charges and lab charges have risen, Medicare has not kept pace with their allowance to the covered individuals. Do you know of any

qualified internist that would only charge \$13.50 for a physical examination? Or do you know of any qualified and recognized laboratory that would charge less than \$5 for blood work? It seems to me that whoever is responsible for establishing the allowable fees has not kept pace with the country's economic situation. It seems to me that the powers that be should take a good hard look at this situation and revise their attitude toward those people that are up in years and come under Medicare coverage . . .

M.G., *Southfield, Mo.*

Since my husband has just reached 65 and unfortunately became ill, he of course had to use Medicare. We were aghast that the payment is only about 38 percent instead of the 80 percent as originally intended, therefore taking a large amount of money from our savings. I believe the schedules have not been updated for some ten years or more, yet they keep raising the cost of Medicare and endeavoring to find new plans to add to it, whether it be optional or mandatory.

H.S., *Baltimore, Md.*

I'm in my 70's and in poor health and on a limited income and a widow. Tho' I manage to pay for Medicare and Blue Cross/Blue Shield, I've had difficulty with both. Not enough is paid on medical bills. Both find excuses to pay as little as possible. Ah, yes, Sir, if I sound bitter, I am. You see, the cheats, and there are thousands on welfare, can get anything they want. Why? We seniors paid heavy taxes and now we are treated like "second hand citizens."

C.C.F., *Jersey City, N.J.*

We are sick through the very fibers of our body from the promises and hopes that the political hacks send our way. Don't those idiots in Washington ever listen, do they think we all fell off the turnip truck, do they care? No they do not give a damn so long as they get elected over and over . . . and live the good life. What we want is the very same medical plan that the politicians have. We are not looking for something for nothing, we want a good plan that takes care of our needs and we want to pay for it. We do not think this want to be out of line. If it's good for a Senator then we want the plan. We talk to many people during each year and the number one complaint is the crooks in Washington, in the City, and in the State. This I think is the shame of America and it's time we turn this thinking around by doing something for all Americans through better health care. As we grow older our hopes and aspirations remain intact, the beauty of life remains the same, it's just the body appearance that changes. In many of these old bodies there is a very young person trying to get out. We want a Medical Care Plan and we want it now.

Mr. and Mrs. R.L.C., *Camarillo, Calif.*

B. SPECIFIC COMPLAINTS ABOUT MEDICARE

The Committee analyzed thousands of complaints it received which fell into several categories. The same kinds of complaints were repeated again and again. The emerging patterns confirmed the general belief on the part of the Committee that there are certain problems which are urgent and in need of immediate redress. The results will help the Committee arrange its priorities. Some solutions are apparent while others will require greater long range planning. Excerpts from correspondence received are included below under subheads which reveal the scope of these recurrent problems.

1. THE WIDENING GAPS IN MEDICARE

Senior citizens soon learn that there are numerous gaps in Medicare. Certain health care services are totally excluded from coverage; others are only partially covered. Following are some of their comments in these areas:

Lack of Coverage for Drugs

Cost of prescription drugs and of doctor recommended medication is a real drain on senior citizens and not covered by Medicare.

B.P., *San Diego, Calif.*

Not only myself, but thousands of other cancer victims find themselves in the untenable position of not receiving proper remuneration for chemotherapy treatments from Medicare.

C.S.K., *Panorama City, Calif.*

Chemotherapy for cancer treatment is covered by Medicare when it is given by the doctor by needle . . . A drug called Qamoxifen, in pill form is substituted for the above treatment. Since it is self-administered, it is not covered by Medicare. I am interested and would like to know whether anything can be done to help other retired people experiencing similar problem. Also, people needing this expensive drug have to pay \$100.00 a month to gain relief.

G.I., *Kauai, Hawaii.*

Cost of prescription drugs and of doctor recommended medication is a real drain on senior citizens and not covered by Medicare. If we were under Medi-Cal—some would be covered. What can be done?

R.F.M., *San Diego, Calif.*

The aged spent \$72 per person in 1974 for prescription drugs which was nearly two-and-a-half times the \$30 average per capita expenditure for all age groups. Since many elderly are fortunate enough to get by with no or few prescriptions this average per capita picture does not really show the true situation. Our associations did a more meaningful survey of drug users among our members and we found that expenditures between \$200 and \$1,000 a year were not uncommon among the respondents. Amazingly,

this represented from 10 percent up to as much as 45 percent of their incomes.

John B. Martin, *Consultant, NRTA/AARP.*

We deal with many elderly patients and one thing I am interested to know is why Medicare does not pay for medicine. It hurts me deeply to tell an 80 year old patient that he or she must come up with \$20 for a prescription. I need not tell you about the difficulty of this predicament for a person on a fixed income.

D.J.D., *Fort Lee, N.J.*

Lack of Coverage for Eyeglasses, Dentures and Hearing Aids

As noted above, Medicare does not provide coverage for eyeglasses or eye care, except for eye surgery. There is no coverage for dental care or dentures, again, except for certain surgical procedures. Hearing aids are specifically excluded from coverage. Senior citizens have reported severe problems caused by the lack of Medicare coverage in these areas:

I think Medicare has done a wonderful job as the law is written. I hope some day the program will become a preventive program rather than an after the fact program. As I looked around the room every three out of four people were wearing glasses. Yet unless one has an operation these glasses cannot be replaced if broken, or needed initially. While a student in the fifth grade a teacher told me to chew my food well. Now many of us has lost their teeth and cannot have them replaced by medical, without an operation. There are so many other things common to the elderly not covered by Medicare. Let us work and make this a preventive program and not wait until illness hits us.

H.B.C., *Berkley, Calif.*

I am mad and I think it is time the American taxpayer stands up and says this is it. My mother has one eye, which has a cataract on it. She lives on social security and has a small Navy pension. After struggling along for several years, I finally took her down to see about some assistance . . . but there is no help for glasses or dental work. (Medicare) is a terrible misuse of taxpayers money . . . and something should be done, either that, or just forget the whole program . . .

B.H., *Wichita, Kans.*

Financial assistance to senior citizens (is needed) for dental care and hearing aids.

D.M., *Whittier, Calif.*

I would want to be certain that a program of health care did not exclude some aspects of health care. For example, as a practicing dentist, I could not do crowns which could have prevented my patient from becoming a dental cripple, but had to do extractions and dentures because the California program (welfare) would pay for dentures, but not for crowns. I would also want to see classes, seminars, or

some program, that would educate the lay people about simple health care. It would also be helpful if the solutions achieved could reduce and simplify the paper work involved.

L.A., DDS, *Shafter, Calif.*

Also Medicare must provide eye care, dental care, as well as preventive medicine such as flu shots, etc.

S.G.F., *La Mesa, Calif.*

The elderly have accepted a lower level of dental care, and a majority of time never receiving or seeking the care at all. As it is with most elderly persons, their dental care has been neglected. If a person is 65 years of age or older, the chances of them not having visited a dentist within 5 years is rather high. Approximately one-half of the persons who are 65 and older, not including the edentulous, home bound and long-term care residents, had not seen a dentist or received dental care in over 5 years. If these other groups are included, the percentage of elderly requiring dental care would be at least 60 percent or more of all elderly persons in the United States. This 60 percent comes to a staggering 13.74 million elderly Americans who have not seen a dentist in at least 5 years.

Brian Adams,

Staff, California Assembly Committee on Aging.

(There is a need to) include dental, optical, hearing aid, and prescription coverage in National Health Insurance package.

P.E.R., *San Diego, Calif.*

(There is a need to have Medicare pay) for prescription drugs; increase amount of payment of physicians service; include payment for dentures.

Anonymous, *Lewiston, Idaho.*

Since the program does not pay for dental care, out-of-hospital prescribed drugs, or eyeglasses, Medicare's share in the financing of total health care for the aged has not kept pace with the advance of its share of financing hospital and medical services.

Anonymous.

Much of the health care problem that you see in terms of nutrition for the elderly is that many of these individuals do not have teeth. If we had begun to pay for dentures earlier instead of just pilot programs, which we did push for in Colorado, I think we would have made sure the people had adequate nutrition in the process and perhaps avoided their movement into the hospital situation or into a nursing home. So I see it as a two-front attack: One is to reimburse for the training of physicians in the out-patient setting; secondly, we must begin to make the case in that process for making available dentures and hearing aids, et cetera, so that people do not become disabled.

Dr. Henry Foley, *HEW.*

Proper vision care is one of the overlooked needs of the elderly, as vision problems are among the most prevalent of all health problems in our country. The percentage of our citizens requiring vision care to maintain good vision performance increases to approximately 96 percent at age 70. The profession of optometry is immediately capable of meeting the vision needs of our elderly population throughout the country and we urge the Committee to recognize the lack of covered optometric services as one of the major gaps in the Medicare system.

American Optometric Association.

Both my husband and I find a great lack in Medicare A. & B. (because) so many insurance companies do not cover the most important things for aging people—eyes, teeth and prescriptions.

R.H., *Boynton Beach, Fla.*

Senior citizens who must live on fixed incomes often incur medical bills. Also, many of them require hearing aids, eyeglasses and daily medication, which is not covered by Medicare or supplemental Blue Cross and Blue Shield.

I.C.B., *Baltimore, Md.*

A great many of us have a hearing loss. In my case, it is a very severe hearing loss. My immediate problem is the rising cost of batteries. I had been paying \$4.00 for a package of six Ever Ready S 76 E. This month the price rose to \$10 and I was informed that they may go up as high as \$20 per package. The life of a battery is about 4 days so you can see what this means to me.

B.K., *Miami, Fla.*

I will now live on \$430.00 a month, my pay. No chance to get ahead. Besides our teeth and eyes (glasses) are the most important problems with our age—this Medicare can't pay. Government! Eh!

A.V.D., *South Daytona, Fla.*

Lack of Coverage for Preventive Medicine

Another serious criticism of Medicare is that it does not pay for an annual physical examination or for other preventive medicine. The argument in favor of this coverage is that the investment of a small amount of money in time may save lives or prevent the need for greater expenditures in terms of hospitalization and surgery at some later point.

I would like to add my voice to the growing number of older citizens in the N.E. district of Kansas, as well as the entire country, on the matter of Medicare coverage. Doctors and all health authorities urge preventive medical care. Most doctors insist on it—yet, Medicare refuses to pay for it. We find our savings eaten away by this raging inflation and costly health care. My drug bill is unbelievable. Isn't there something that can be done?

C.L.A., *Marysville, Kans.*

Provide policies for senior citizens and those on Medicare to participate in preventive medicine. Thereby making it possible for people to have advice on how to prevent disease from occurring. Cautious methods should be developed so that this privilege is not abused. Physical examinations should be available to persons to assist in preventive medicine and care.

D.M., *Whittier, Calif.*

To keep in the best physical and emotional health we seniors need to be active physically, mentally intellectually, socially and spiritually, inspirationally for as long as possible. In order to achieve and maintain this state of activity we require a comprehensive national health insurance program which permits us entry into the health care system on a regular and preventative basis rather than on a crisis situation, and at a cost which those of us on a fixed income can afford. At present our health care costs are reducing us to below the poverty level at an alarming rate. The cost then falls on public medical assistance and attendant public welfare programs all of which are an excessive drain on the tax dollar.

J.N.B., *Oceanside, Calif.*

I think the real problem of cost in medical service in general and in the Medicare program in particular is that if you do not address the right problem at the right time, you are doomed to address it again and again.

S.S., M.D., *Milwaukee, Wis.*

Now I find that Medicare will not accept charges for "preventive medicine." Idiotic? I would say so. The chances of my getting pneumonia every year without the vaccine is better than 50 percent or a cost to Medicare of \$500 (\$100 a year), the vaccine lasts five years. With the vaccine chance of pneumonia is reduced to 5 percent or a savings to Medicare over five years of \$500—or \$485 if they accepted the \$15 vaccine charge!

G.E.C., *Pompano Beach, Fla.*

The present position of Medicare means that a recipient must be clinically ill in order to benefit from the program. This position is in complete opposition to that of this agency, which believes that preventive care will lead to better health at less overall cost to the patient and to the community.

R.T.J., *Charlotte, N.C.*

Problems With Nursing Home Coverage

Senior citizens have reported numerous problems with Medicare's nursing home coverage. To begin with, Medicare covers only about 1.5 percent of the nation's total nursing home expenditures. Nursing home expenditures account for less than 3 percent of Medicare's total, down significantly from 1969 when they accounted for over 5 percent of the total. Moreover, Medicare's covered patient days have been more than cut in half since 1968. Understandably, there is a shortage of facilities that will accept nursing home patients under Medicare—at

least in some areas of the United States. Hearing by the Committee in the States of Washington and Connecticut confirm that as a result of this policy to limit Medicare's nursing home expenditures, large numbers of elderly patients are being retained longer than necessary in hospitals.

Congressman Don Bonker, who chaired the Washington State hearing, commented on this point:

We have a full scale national crisis on our hands. The Committee has polled hospitals in Washington, California, Ohio, New York, Florida and the District of Columbia. The hospitals speak with the voice of near unanimity telling us that they routinely keep patients days, weeks or even months longer than necessary because of the lack of Medicare or Medicaid nursing home beds. In my State, over 90 percent of the hospitals polled said they had large numbers of senior citizens who could and should be moved to nursing homes but were not because of the shortage of Medicare certified nursing home beds.

In 1969, nursing homes received fully 5 percent of all Medicare monies while they receive only 2.6 percent of all Medicare monies today. This reduction is even more dramatic when measured in terms of Medicare covered days. In 1968, for example, Medicare paid for 19.5 million benefit days in nursing homes which has been cut 56 percent, so that only 8.6 million days were covered by Medicare at the end of 1978. Measured in yet another way there were about 200,000 patients who had their nursing home care covered by Medicare on an average day in 1968 while only 25,000 of the nation's 1.4 million nursing home residents now have their care paid by Medicare.

In our poll of nursing home professionals, we learned that they are increasingly discouraged and dropping out of the Medicare program because of red tape, excessive paperwork and delays in payment associated with the program. We learned there is 7 times as much paperwork for a nursing home to care for a Medicare patient as there is for a Medicaid patient. Having tightened up the program as much as they can by regulation, HEW has now asked Congress to restrict the Medicare nursing home benefit still further.

The Committee has heard testimony related to a host of other nursing home-related issues which range from alleged fraud and patient abuse to the fact that seniors contend it is unfair to require 3 days' prior hospitalization before any coverage is provided for nursing home care. These issues are detailed in the correspondence below.

While Medicare has been adequate in defraying a major portion of the costs associated with acute medical care, there are serious omissions which have a detrimental effect on older persons. The lack of coverage for long-term care and the absence of catastrophic protection have a devastating financial impact on those who have inadequate resources. Medicare beneficiaries are also affected in an adverse way by the failure of the program to provide a more complete benefit

package which includes such items as: maintenance and preventive services; home health care; and out-of-institution drugs.

John B. Martin, NRTA/AARP.

Although we provided more than 23,000 patient days care last year, less than 70; yes 70, of these days were covered by Medicare. Only three tenths of one percent! It is wrong to lead people to think that Medicare will cover their needed care in a nursing home. Medicare covers only that part of the care that leads to recovery usually, only a few days. Most nursing care stays amount to months costing \$35 to \$40 per day. We must not let our dependents depend on coverage that simply is not there!

R.R.C., *Saratoga, Calif.*

The vast majority of family members have to work for a living and are unable to pay the exorbitant rates charged by nursing homes and elderly victims, having worked years ago at what would be peanuts today are unable to cope with prices now. Neither are they eligible for Medicaid. This is not a matter affecting a small number of people, as anyone who lives long enough will be required to enter a nursing home. Therefore, it is a national problem affecting millions of people, directly and indirectly. It is manifestly unfair that the Congress should appropriate billions of the taxpayers dollars and hand them out free to foreign countries regardless of the reasons, when so many of our own people and their families remain in this condition permanently. The old maxim of charity beginning at home has no relevancy to the Congress. Medicare can and should pay these charges even if a small part of the cost is added to the Medicare deductions. I believe that most civilized countries pay these expenses for their senile elderly.

T.B.D., *Miami, Fla.*

I am interested in these laws because I could tell you a story of how I was induced to spend all my life savings (I am now 80 years of age and my wife is 78) in order that I get some State Aid to help her in a nursing home because she has Parkinsons disease. In Iowa if one needs State Aid the laws are such that he must spend everything he has down to \$2,250. I do not think this is a fair deal because we had about 77 shares of GM stock and a few other stocks and it was necessary to spend that in order to get State Aid. There were some other conditions that I am not mentioning at this time, but when us older people have to suffer so much why make us suffer more.

H.F.W., *Clinton, Iowa.*

At the present time, when he needs it, a qualified citizen is likely to be prevented from receiving nursing and health care prescribed under his Medicare hospital insurance because skilled nursing facilities are not being licensed to take care of the Medicare patients. There are only 16 skilled

nursing homes in the State of Washington which will admit Medicare patients. Of the 1,756 beds in skilled nursing facilities in the State of Washington, only 67 are Medicare beds. From Lewis Counties south including Woodland, there are only 32 Medicare beds as of July 1, 1979. With increasing years, these citizens will be in need of skilled care between the period of hospitalization and the time when they can return to convalescence after an illness eligible for Medicare hospital insurance for which they have paid their premiums.

According to page 19 of the Medicare Handbook "Major services covered by a skilled nursing facility, include:

1. A semiprivate room (2 to 4 beds);
2. All meals, including special diets;
3. Regular nursing services;
4. Rehabilitation services, such as physical, occupational, and special therapy;
5. Drugs furnished by the facility during the patient's stay;
6. Medical supplies, such as splints and casts; and
7. Use of appliances, such as a wheelchair.

On page 17 of the handbook, a skilled nursing facility is defined as "a specially qualified facility which has the standard equipment to provide skilled care or rehabilitation services as well as other related services." Five of the seven nursing home facilities in Longview, Washington are skilled nursing facilities and could take Medicare patients. Yet at present only 15 out of 485 beds are Medicare beds. Medicaid patients who need health services listed as being provided by skilled nursing facilities are being accommodated. But Medicare patients have only 15 beds assigned to them.

During the last year patients who have had no further need for full hospital attention have had to wait as long as three weeks in order to be accommodated under Medicare skilled nursing facilities. In some cases, patients in Centralea have had to travel 100 miles to Woodland in order to receive proper care in a Medicare facility. This distance has removed them from visits from families and friends, visits which are often necessary for mental health and continuing good spirits of patients during recovery. The inconveniences of needing to change doctors because of distance between the patients physician and the recovery center has also had its drawbacks.

To remedy the situation, I propose that all skilled nursing facilities be required to be licensed to accept both Medicare and Medicaid patients in order to receive the full benefits of federal funding.

Katherine Long, *Longview, Wash.*

I have always considered it my responsibility to take care of me and mine, and I guess I thought I was doing this when I paid into the social security fund each month for about 40 years, and to the State retirement fund for a somewhat

lesser period. But, now that nursing home care for my wife has become a reality, I am indeed heading for deep trouble. I don't think any prideful American citizen should be forced into a position of this kind and if retirement and medical programs are going to accomplish the full purpose for which they are intended, a provision should be made to cover calamities and unforeseen health care costs.

B.B., *Topeka, Kans.*

My area of concern is Mental Care for the Aging as well as nursing or long term care. Either you are very wealthy and can afford this or if you are middle income America you are wiped out—or if you have the indignity of going on Medi-Cal or Medicaid Welfare you get all care.

S.G.F., *La Mesa, Calif.*

While the suggested plans for "Alternatives in Long Term Care" are very meritorious there will still be a great number of the American public that will eventually be faced with the reality of spending the final years, months or weeks in nursing homes or convalescent hospitals. I am at present, going through the heart-breaking experience of having my father in a convalescent hospital where I was forced to place him after three and one-half years of devoted and meticulous care by me, and I have checked many of these facilities and had to settle on one that is considered by many to be a very good one. I hope I die before I have to end my life in such a place. That statement should tell one and all of the deplorable conditions that exist in most of these places.

Please, let us all work diligently to correct the conditions that exist and let us all be aware that we are all potential candidates for ending our lives in a nursing home. The correction of existing standards by the Government for such places bears close scrutiny. I feel this is a problem that rates a very high priority for all of us to become concerned with.

R.A.V., *Inglewood, Calif.*

There is a great need of some health plan or assistance that will cover the long stay (terminal) in convalescent hospitals or nursing homes, after one's condition no longer calls for skilled nursing care as required for qualification, i.e., when it becomes custodial care as a result of a stroke, etc. No supplemental insurance covers this—Medicaid or Medi-Cal covers for those on welfare but the middle-American has to come up with \$1,000 a month or more, without aid from any insurance—often one's children with growing families are burdened beyond their means. These cases cannot be handled at home but need a nursing home setting—certainly some insurance plan is needed or government or state assistance seems appropriate. I am aware of desperate situations.

J.A., *La Jolla, Calif.*

Most people are unaware of the provision of "continuous skilled nursing care" or do not understand it and so they are unprepared for the decision of non-covered care or continued stay "not medically necessary." We have had to watch the despair of many because of the frustrating guidelines for coverage under Medicare. The Department of Health, Education and Welfare has done a very poor job of educating the public, physicians, social workers, staff of Social Security offices, and others on what constitutes skilled nursing care. No one realizes that at the present time Medicare pays less than 40 percent of the cost after the 21st day. The patient now pays over 61 percent of the cost if he/she should be lucky enough to qualify for more than 20 days of covered care.

D.C.H., *Atascadero, Calif.*

It has been a repeated observation of mine that many nursing homes are guilty of over-medication of patients. Their answer is always, "The doctor ordered it." I would hope that your new standards for nursing homes could include some controls in this problem. Over-sedation seems to be the worst offender to keep the patients from making demands on the staff members. This is sad.

G.W., *Yucaipa, Calif.*

Why can't the overbuilt hospitals be turned into (Medicare) Long Term Care? How can we insist on hospitals sharing services of expensive treatment. Why must each hospital have duplicate treatments?

R.L.S., *San Diego, Calif.*

People fall through the holes of the current system of health care delivery. I think of a teacher retired for disability of multiple sclerosis in her late forties. After 10 years and her husband's death she required hospital custodial care. When Blue Cross cut off payments, other resources were exhausted, she sold her home to pay the \$3,000 per month rest home bill. It took only 2 or 3 years to deplete that resource and this has happened. This woman now has sought other help to pay for her necessary care. Not covered by Medicare, too large a monthly income from pension to qualify for Medicaid, she is unable to cover the gap between costs of her care and her monthly income. Her four children, one of whom is still in college are unable to provide her long term care, nor to assist to the extent necessary for her basic needs. She is effectively now pauperized in spite of her pension, but only state special measures can help her at this time.

Mr. and Mrs. R.L.C., *Anchorage, Alaska.*

In late 1973, subtle changes began taking place in the Title XVIII program to reduce the availability of coverage. Without written notification heart attacks and specific nurse-patient teaching programs were no longer considered a

"covered care" diagnosis. The term "skilled nursing care" became a definition contest between the professional personnel rendering the care and the intermediary. Suffice to say the Medicare program headed down-hill. The limitations and restrictions on what constituted covered or non-covered care became increasingly repressive on patients—people the program was originally supposed to benefit. The paper-work particularly for professional staff doubled and the quality of care diminished. What had once been a health care program of distinction now was a disgrace and not a word had been uttered or a statute changed.

You can just imagine the kind of defeating situation in which I am continually placed when I must tell a family member that a patient shall not receive Medicare benefits for a particular illness when it is stated right in the manual of Social Security Benefits and is touted by the intermediary that every Medicare beneficiary is entitled to 100 days of skilled nursing care. You have to know that in family's eyes I am more loathsome than an outright liar. There is no help from the intermediary. Often they simply have an inexperienced person handling information calls who reads from the same Social Security booklet and tells people they are entitled to Medicare benefits. The popular belief even today is that anyone can get coverage in a Medicare facility if they need skilled nursing care—and no one yet has defined skilled nursing care. The F.W. Home, however, has during most of 1978 and 1979 never had more than five or six patients on the program at any one time. As of this writing no one is being covered by Medicare and you must know how that has put a tremendous burden on the state Medicaid system.

There has been a concerted effort by the Bureau of Health Insurance to stifle the Medicare program in skilled care facilities. In order to meet Medicare criteria our facilities are being held to an acute care standard. Administrative costs are extremely high. Paper work is a monotonous act of reproducing in triplicate level of care statements which have little or no relevance. The "no billing" procedure would take pages to explain but certainly must be the ultimate in "make-work management." In July of last year (1978) we were paid \$40 for one day of Medicare coverage on a patient and spent over \$12 in postage mailing Blue Cross and Blue Shield billing and medical information.

D.S., Mattapan, Mass.

Need For Alternatives to Institutionalization: Expanded Home Health Care Services

There is a growing realization among older Americans that current regulations severely limit the availability of home health services to the elderly. For example, in order to receive home health care, an elderly or disabled person must have had a prior hospital stay of at least three days under Part A; the plan of care must be prescribed by a physician; the care must be "skilled"; the patient must be home-bound and the home visits are limited under Part A (hospital insurance)

to 100 per spell of illness and under Part B (supplementary medical insurance) to 100 per calendar year.

On January 4, 1978, Congressman Pepper released the results of a study by the U.S. General Accounting Office which he said, "underscores my longheld contention that the Government has adopted a costly, counterproductive institutional bias toward the nation's elderly citizens who need health care." Pepper said it was the height of folly to spend billions to keep people in institutions while we were unwilling to spend more than a few million to keep people in independence in their own homes. He quoted the GAO report: "Until older people become greatly or extremely impaired, the cost of nursing home care exceeds the cost of home care including the value of the general support services provided by family and friends."

In the October 24, 1978 joint hearing with the House Aging Committee, Henry Mello, Chairman of the Aging Committee of the California Assembly, had similar thoughts:

The other area is in the area of trying to prevent the premature institutionalization of senior citizens, and I think this is the most outrageous thing that happens today to elderly people, because if the first need for a particular type of service is not available, we take the easy way out and institutionalize many of our persons. This, of course, breaks family ties. It isolates them in a convalescent home. It takes them away from their home environment and their friends and the many values that they placed so great for many, many years.

Chairman Pepper has authored legislation to broaden the scope of home health services under the Medicare program. Following are comments received from the elderly and national organizations:

Many of the limitations and deficiencies of the Medicare program can be traced to its focus on short-term or acute illnesses. Medicare's stringent requirements governing the delivery of home health services are directly traceable to this emphasis. Under Medicare, home health services are allowable only when skilled nursing care, or physical or speech therapy are required. This stipulation explains why home health care accounts for such an extremely small (1 percent) percentage of Medicare expenditures. Our experience in helping with in-home services to meet the needs of advanced cancer patients and their families provides dramatic evidence to support the proposition that skilled nursing care need not and should not be a prerequisite for home health care.

The National Cancer Foundation, Inc.

How can we get more money for home health care versus nursing home care? It is estimated that \$300 million per year would do the job—as against ten times that amount for nursing home care—and the recipients would be much happier by being in familiar surroundings.

R.L.R., *Honolulu, Hawaii.*

Please do your utmost to encourage and make possible more home care services for the elderly to keep them out of hospitals and nursing homes as long as possible.

W.K.M., *Walla Walla, Wash.*

Many persons, by having home health care services could remain at home, rather than having to be in a hospital or nursing home. If insurance plans would include reimbursement for some nursing and housekeeping services in the home, the expense of health care would be greatly reduced, the mental health of the patient would benefit from the home atmosphere, and existing hospital and nursing care facilities would suffice for those who have to be in such institutions.

K.W., *Escondido, Calif.*

I have been hearing much about the Medicare program trying to promote more help for the elderly within their own homes rather than in "Homes for Elderly." This is certainly a step in the right direction, but there is one part of the Medicare program that I strongly feel should be deleted and that is the necessity of spending three days in a hospital before being eligible for visiting nurses care in the home. Many of us have reached our older years when unexpected illness may quickly occur. I for one have much anxiety about going to hospitals and do not think that I should be forced into a hospital for three days when all that I may need is the guidance and occasional visit of a professional nurse. The money saved by not having to spend this time in the hospital could be applied in some way toward home care.

F.G., *Casmalia, Calif.*

I feel that Medicare does not allow enough areas to be covered so that our elderly can be cared for in their homes instead of being forced to go to nursing homes. With legislation to cover more types of equipment, nursing service, etc., an elderly person could remain in his/her own home, secure in the knowledge that they are with their loved ones and they are in familiar surroundings, which tends to lesser confusion, and they are treated with the dignity that is so vital to every human being.

Another important aspect of this type of legislation is the financial aspect. With the constant rising cost of nursing home care, which averages \$1,000 a month or more, no one that worked a lifetime for wages has saved enough money to pay for this type of care for an extended length of time, in which case the cost has to be paid by Medicare or state funded Medicaid. It seems much more sensible to me to have funds available to keep our people in their own homes whenever and however possible, as long as the family can do so with the help of equipment and services.

E.G., *Walker, Minn.*

Why doesn't our educational system provide a training course for training home care persons? As a former teacher I know there are millions of students who will never fathom higher math, physics or Latin in high school but who would be eager for such graduate certification in homecare. Training in simple diet preparation, household duties, bathing,

changing beds, laundry, etc. for patients. First Aid and training in giving medication the doctor prescribes as well as other services so we can stay in our homes is priority No. 1.

B.P., *Fallbrook, Calif.*

I would like to see Health Insurance cover more fully for home care services including homemaker care services along with skilled nursing if necessary. I wish to keep people functional in their own homes as long as possible or funding available for more senior citizens living centers. Independent living quarters but help available when needed in an emergency situation or to oversee elderly's safety needs. People prosper and do their best in their own homes.

M. J., *Grass Valley, Calif.*

Home care for the aged is the most humane way to go and it would not be nearly as costly as in-hospital or nursing home costs. Thank you for your efforts.

G. W., *Yucaipa, Calif.*

Are any plans being made to include registered nurses and nurse practitioners in the expanded Home Health Care program? These people have much to contribute but I believe that, thus far, no means have been provided for paying them. Have vested interests (the AMA) in particular been able to prevent their use or can this possibly be investigated?

G. H., RN, *Imperial Beach, Calif.*

I would like to mention that Medicare (discriminates) against any kind of home health care. If we were to place my husband in a nursing home he would get half the attention he does at home and the cost would be in excess of \$1,000 per month upon which Medicare would not pay. But as long as we keep him at home, not a dime can be taken off the income except for medical expenses . . . So long as this country does not provide for home health care we think it is most unfair . . .

R. M. B., *Shelbyville, Ind.*

I would like to address myself to three areas of deficiencies in the current Medicare program, which because of these requirements, greatly impair the delivery of health care services. One: Present Medicare regulations prohibit and discourage alternatives to institutional care because of their skilled nursing requirements. Two: Present Medicare requirements which limit the number of home health care visits to 100. Three: Present Medicare requirements which mandate prior hospitalization before an individual becomes eligible for home health care services. We see these requirements as needless and costly barriers which prevent low cost quality health care delivery.

The inadequate utilization of home health care benefits is due primarily to the Medicare requirement for skilled nursing care. The Government has selected a series of medically

oriented tasks and observations and defined them as "skilled" care and limited reimbursement eligibility to these tasks, thereby eliminating many preventive and maintenance services needed to keep the elderly out of hospitals and other institutions.

An elderly widow in North Carolina who was weak and palsied needed certain eye medication administered on a daily basis, but because of her infirmities she could not administer the medication herself. Though the actual giving of the medication would take less than 1 minute, as the result of such impractical regulations, Medicare did not pay for the services because it was not termed "skilled" nursing care.

Clearly, one could see that this artificial and unnecessary requirement for reimbursement severely impairs the ability of licensed practical nurses and others to provide needed services.

S.G., *North Carolina.*

Day Care

Numerous letters have been received over the past few months suggesting that Medicare be amended to pay for day care. With more and more spouses finding employment, there is often no one to stay home with elderly relatives who need some supervision. One result is unnecessary institutionalization. Family members in these circumstances have suggested it would be of great value if their loved ones could participate in a day program where they would have the benefit of supervision, social services, recreation and therapy. After work, the working family members bring their loved ones home with them to share the evening hours together.

The Subcommittee on Health and Long-Term Care of the House Select Committee on Aging held a hearing on day care and its importance to the elderly on April 23, 1980. In a press notice announcing the hearing, Chairman Claude Pepper said:

Adult day care can be an exciting discovery for the family trying to care for an impaired elderly relative at home. Contrary to the prevailing myth, the vast majority of American families are not abandoning their elderly relatives; they want to keep them at home. In spite of this desire, it can be a tremendous burden for families to provide 24-hour care for an older person who needs professional services. The cards are stacked in favor of nursing home placement. Day care gives these families a break while allowing elderly persons to remain in the community, outside an institution. Adult day care, a concept unique to most Americans, has been successful in other industrialized countries for many years, but it is a relatively new approach in the United States. Our Subcommittee will examine this form of care for the promise it holds not only enriching the lives of the elderly but for holding down health costs and delaying or preventing institutionalization.

There have also been many positive experiences reported with day care, particularly in California where the concept has been pioneered

by the On Lok Center for the aged in San Francisco. Following are comments which have been received:

My experience as a recipient of Senior Day Care when my father died and my mother came to live with us:

1. We were successful only because of Day Care.
2. My mother was able to function at her level of capability and was able to keep her dignity.
3. Our entire family grew as a result.
4. My 3 teenagers are now aware of the needs of the elderly which enriched their lives as well as the community and society in general.

Too many people are unaware of services available and too many do not qualify for services because they are not on Medi-Cal. Medicare should cover these services. More like services should be available as well as overnight weekend care and temporary care, 1-2 weeks.

L.L., *Chula Vista, Calif.*

We have been providing Adult Day Health Care for five years. The 79-80 California Medical Review Team Report of our center concluded that without this level of care 98 percent of the clients reviewed would have been placed in Skilled or Intermediate Care Facilities. As the attached brochure indicates we provided a wide spectrum of services to the participants. All of these components from nursing care to field trips contribute to maintaining the participants at the highest possible level of functioning. In some cases, this is maintenance but we also have many stories of participants who have been rehabilitated and moved on to more independent programs and/or life styles. To us Adult Day Health Care has become the cornerstone for keeping the "frail" and "at risk" elderly in the community.

B.W.S., *San Francisco, Calif.*

After making an investigation into possible alternatives to nursing homes for the aged, I have found adult day care programs to be a most promising alternative. I recently visited the Total Life Center in Raleigh, and was greatly impressed by their program. Here, the elderly are treated more humanely, and indeed more humanely than in any other facility I have investigated.

S.A.O., *Raleigh, N.C.*

Because it filled a void in my life, I have the fondest regard for the Woods Adult Day Care Center. Three years ago, while recuperating from a stroke, the Health Department Therapist suggested that I attend an adult day care center for continued maintenance therapy, both physical and mental. Thank God, in November, 1976, I was accepted by the Woods Adult Day Care Center in Severna Park, Maryland. At that time, despondency and a feeling of uselessness prevailed in my life. Usually in the case of senior illness or handicap he/she experiences a traumatic shock when they discover their inability to function as well

as before. Prior to my stroke, I worked with retarded adults in work training at the Providence Center in Annapolis, Maryland for five gratifying years. Married, I lived with my wife in my own home.

On acceptance at the center, consideration of my physical limitations were dealt with (being paralyzed on my left side). The therapist from the Health Department followed me at the center during this transition time and provided a physical fitness program for the center staff to follow in my maintenance routine. Also, I participated in the center's activities, learning to make tapestries—using a punch needle with one hand, and later teaching others how to perform with one hand also. An aide encouraged me in creative writing and, much to my surprise, I found myself developing my latent talent of writing. These associations renewed my usefulness, sense of purpose, and hope for the future. I regained my confidence in my ability to assist and train.

It was quite a relief to get out of the house for a few hours daily to meet new friends and socialize with peers. While my attendance at the center was without fee, my home was at a great distance and I had to pay for my own transportation. Unfortunately, it was so expensive I could only afford to attend two days a week.

The counseling and training at the center taught me to live more independently, strengthening family ties, as President Carter has advocated, and to remain in my community—dispelling my fears of institutionalization. At the same time, my presence at the center allowed my family to fulfill their daily obligations, content in the knowledge that their loved one was adequately being cared for during the day.

During my three years at the center, I witnessed some dramatic changes in center participants. Those who had withdrawn into a shell became actively involved in activities and relationships, and those who had been rejected, looked forward to the center as a haven, "a Home Away From Home," all due to the atmosphere and the knowledge that someone cared.

Physical, mental and social rehabilitation, the prerequisites for a full life, in our waning years is available at the day care center through their counseling, activities and associations—again, I have a feeling of self-worth.

H.W., *Baltimore, Md.*

Lack of Comprehensive Coverage (HMOs)

Because of the growing gaps in Medicare's coverage, some senior citizens and consumer groups have fostered the idea that Prepaid Health Plans or Health Maintenance Organizations (HMOs) be encouraged to enroll Medicare beneficiaries. The thought is that for a single flat fee equal to somewhat less than the average per capita Medicare payment, HMOs could contract to provide comprehensive health services to the elderly. The Subcommittee on Health and

Long-Term Care held hearings on HMOs and the Elderly in May 1978. At the hearing, Chairman Pepper said:

HMO's have been heralded most recently and most emphatically by the Carter Administration as part of the answer to galloping inflation in health care. Through emphasis on prevention and maintenance, they discourage use of the costliest kinds of care—hospitalization and nursing homes. But we also know that HMO members have advantages that many of our elderly citizens do not share. For a flat advance payment, they are entitled to almost all health care services in one setting, without the snares and pitfalls which plague the Medicare program.

We are not suggesting that HMOs are the answer to the problem in totality, but they may well have a very important part in the solution of the problem.

Nelson Cruikshank, then Counsellor to the President for Aging testified:

The vast majority of the elderly today in our country are living on fixed incomes. They need to budget very carefully all of their expenditures. An unpredictable expensive illness can shatter the best planned budget. This can result not only in economic disaster, but bring about anxieties and fears which in turn contribute to the illness of the individual.

A health maintenance organization built around group practice and providing prepayment enables older people to budget their expenses and to be protected against the threat of a catastrophic medical bill. It is no exaggeration to say that this economic aspect of an HMOs program is a part of its preventive services.

Dr. Milton Roemer of the University of California School of Public Health said:

(I heard) this morning that one HMO . . . was accepting a flat premium from Medicare. I had the impression it was more than one, but I may be wrong.

In any event, I should think it could be done perfectly easily with existing HMOs, such as Puget Sound, or the Group Health Association in Washington, or Kaiser—simply by Government paying to the HMO a premium equivalent to the per capita expenditure for Medicare beneficiaries in the open market to the Nation generally.

Senior citizens have written to the Committee with similar thoughts:

Great health results have been obtained by the creation of Health Maintenance Organizations, and they are keeping the people out of the hospitals and long-term care homes by preventive measures and early treatment of various forms of disease.

The extreme high costs of medical services today causes the senior citizen to put off treatment as long as possible because Medicare usually pays only about 41 percent. If

the Doctor could be paid to keep us well, and stop his pay when we have to go to the hospital, I believe that the cost of Medicare would go down rapidly. Only a very small percentage would be in hospitals and nursing care homes.

A.R.K., *Corning, Calif.*

Transportation To Health Care Facilities

One of the most common problems expressed by the elderly is transportation to health care facilities. A particular problem exists in rural areas, however, the frail elderly in the central city are also in need of help. Following are comments on this point:

One of the biggest needs throughout the State is transportation for medical needs. There are insufficient funds and low priorities for paratransit medical transportation. Most especially effected is the low income, frail elderly who cannot drive and get to doctors, hospitals and to the social services agencies to take advantage of the services available to them. In every needs assessment transportation is in the top three needs expressed. However, it is a low priority in legislative funding.

C.M., *Vista, Calif.*

There is a great need for transportation to get the seniors to their medical appointments, to the hospital, for their Part B Medicare, X-rays, lab tests, and that thing, and I don't think that the local, State, and Federal government have their priorities in the right place for funding for transportation for the elderly, for paratransit and for demand response, so that the seniors can get to their medical appointments and keep healthy. I would like to see that priority changed in the local, Federal and State governments to help the elderly, the frail elderly, that does not have transportation, get to the services they need. There is no use having services if there is no access to them.

Anonymous.

Lack of Coverage for Mental Health Services

Testimony received during numerous hearings held by the Committee has revealed that mental illness is more prevalent in the elderly than in younger adults. An estimated 15 to 25 percent of older persons have significant mental health problems. Interestingly enough, even though the elderly make up 11 percent of the total population, they account for over eighteen percent of those persons in need of mental health services. In light of the extent, incidence, and prevalence of emotional and mental problems encountered in later years, it is surprising to find that Medicare places a limit of \$250 annually for the coverage of mental health services an older person might need. In addition, the elderly must pay 50 percent of the costs associated with mental health services received on an outpatient basis and can expect a lifetime limit of only 190 days for mental health services in a hospital.

It is this knowledge that Medicare will not adequately cover mental health treatment, and the fear that the cost for such care will be exorbitant that prevents many older persons from seeking counselling

to cope with the stresses associated with mandatory retirement, failing health, bereavement and other life changes. Although 65 percent of the elderly suffer a significant mood disorder, predominantly depression, only 4 percent of patients seen at public outpatient mental health clinics and two percent of those seen in private psychiatric care are elderly. The following viewpoint, offered by a Californian, expresses the concern shared by many elderly regarding the lack of coverage for mental health services:

My area of concern is mental care for the aging as well as nursing or long term care. Either you are very wealthy and can afford this or if you are middle income America you are wiped out—or if you have the indignity of going on Medi-Cal or Medicaid welfare you get all care. All doctors should be required to take assignment, and Medicare should not arbitrarily cut down doctors, ambulance and other fees. . . .

S.G.F., *La Mesa, Calif.*

The American Psychiatric Association made a similar observation:

We know that the elderly are disproportionately subject to emotional and mental problems Yet our Federal structure of medical insurance for the elderly has developed few means of dealing with this ever-increasing problem. It continues to cling regrettably and tenaciously to the view that medical care needs of the elderly are short-term, episodic in nature and singular rather than multiple in cause. The stress under Medicare is on inpatient treatment for acute rather than chronic illness. Nowhere is this more clear than in the restriction under Part A which limits lifetime availability to a psychiatric hospital to 190 days, and the restriction under Part B which limits annual outpatient coverage for mental illness to \$250 per year—including ancillary Medicare services.

The outpatient elderly mentally ill restriction violates the mandate of the Older Americans Act to insure older persons independence, integrity and vitality in society at large.

The fact that sixteen percent of all reported suicides in this country are committed by elderly persons is evidence to the magnitude of the mental health problems experienced by older persons. Problems of loneliness, isolation, and depression which accompany old age can be as deadly as physical illness. Yet mental illness is not reimbursed on the same basis with coverage for physical health care services. A Massachusetts resident told the Committee of the pressing need to allow Medicare coverage for mental health services:

The loneliness of old age causes mental health problems. Medicare and/or National Health Insurance should cover mental health services for the elderly.

As a full time public advocate for consumers of mental health services in Massachusetts, I see a pressing need of the aforementioned to relieve the financial burden placed on the client and/or family of the client.

I. U., *Boston, Mass.*

At present, it can be shown that persons over the age of 65 represent a high risk population for emotional disorders and organic brain syndromes. It has also been shown that such persons often respond favorably to therapeutic intervention, thus reducing the need for unnecessary nursing home placement. Yet, Medicare does not reimburse for the medical care associated with senile dementia, chronic brain syndrome, psychosis associated with cerebral arteriosclerosis, etc., even though many of these forms are treatable and reversible. The following view highlights the need to consider the allowance of Medicare coverage for such diseases:

The medical neglect or physiological or therapy neglect of elderly patients with Alzheimer's disease in geriatric homes—so-called nursing homes. (Referring to the less-than wealthy and above the poverty level). The neglect of the non-Medicare Alzheimer's disease patient typically starts the first day when she is "dewalked", i.e., confined to bed instead of given individual care to promote walking. In like manner, no individual therapy counters developing loss of speech. The patient has no pain, doesn't feel sick and is not being treated. She wonders why she is incarcerated. I do also. Causes of Neglect: (1) Because Medicare does not recognize Alzheimer's or Pick's diseases, popularly and indiscriminately known as senile dementia, no medical care of the patient ensues. Does not therapy consist of more than medicines, surgery and medico-technical equipment? Is this disease not as much of a health concern as pulmonary T.B., alcoholism, and disabilities? True, old fashioned doctors are not aware that it is "a progressive degeneration of the brain" as stated in Text-books of Medicine, vol. 1 and other reprints herewith.

One doctor being confronted by such a patient said, "Well, we all have to grow old someday!" Only 6 to 8 percent of elderly have the disease. Progress is equating Alzheimer's disease with senile dementia was highlighted in 1977 by an international conference at the National Institutes of Health and at Georgetown University, and research reports from universities such as Toronto, Pittsburgh, Boston, Albert Einstein College of Medicine, Miami Heart Institute, National Institute on Aging, National Hospital of Mental Diseases of London and several others. (2) Since it is not recognized as a disease by Medicare, doctors in regular practice and in non-nursing "Nursing Homes" will overlook and neglect those patients and not attempt any treatments. Standard practice. Are diseases whose causes are not known left untreated in our mores? If medical practice does not include the comfort and well being of the patient, must we turn to other health services? Costs: I have only the space to say that the patient could pay for board and room, laundry and cosmetics as at home. Medicare would pay for health care—all kinds of therapies. It may happen to your lifelong companion.

O.J.W., *San Diego, Calif.*

It is clear that the discriminatory treatment of mental health services under the provisions of Medicare should be eliminated to

reduce the financial barriers which currently prevent thousands of older Americans from obtaining the mental health care they need. The following testimony by Hilda Robbins, then president-elect candidate, National Mental Health Association before the Subcommittee on Health and Long-Term Care in October, 1977, illustrates this observation:

The discrimination of Medicare against the mentally ill does not lie in its administration or in some arbitrary regulation drawn up in the vast HEW bureaucracy. The discrimination is written right into the law to title XVIII of the Social Security Act. Title XVIII is the part of the social security program, of course, as you are thoroughly familiar, that provides hospital and medical insurance.

Well, where does this discrimination lie? Under Part A, hospital insurance, the beneficiary is covered for a certain number of days each time she enters the hospital. The beneficiary may return to the hospital as many times as is necessary for the rest of her life, as long as there is the break of 60 days between hospital stays, and still be covered by Medicare unless she is a patient in a psychiatric hospital.

If the beneficiary is a patient in a psychiatric hospital rather than a general hospital, there is a lifetime limit of 190 days of coverage under Medicare. To repeat there is no limit on the number of times the beneficiary may be treated if they have a physical illness, but there is a lifetime limit of 190 days for hospital treatment for mental illness. This is blatant discrimination against the mentally ill, and it was written into law by the U.S. Congress.

It becomes even more apparent how dreadful this is when you realize that most general hospitals or many general hospitals will not accept a psychiatric case. Moreover, if the beneficiary is a patient in a psychiatric hospital at the time that he becomes eligible for Medicare the number of days he has already spent in the hospital is deducted from his initial benefit period. No such deduction is made against the patient who happens to be in a general hospital when he reaches 65 or becomes eligible.

Now, to move on to part B, the medical insurance. This provides for those who choose to subscribe, that the Government will pay 80 percent of allowable doctor bills and related medical expenses, after a deductible of \$60 per year. Once the deductible has been met there is no limit on the amount of reimbursement in any one year except for mental illness. If the diagnosis is mental illness the absolute maximum reimbursement in any one year is \$250. This is gross discrimination as compared to the unlimited opportunity for health care by the physically ill.

Moreover, whereas medical bills, assuming they are reasonable and otherwise, of course, for all other illnesses are honored at face value, part B of title XVIII states that the allowable cost for the treatment of—I quote: “Mental, psychoneurotic and personality disorders shall be only 62 and a half percent of the actual cost.”

What this boils down to is that for all other illnesses Medicare pays 80 percent after the deductible, but for mental illness pays only 50 percent and then only up to a ceiling of \$250.

2. SOME PEOPLE ARE INELIGIBLE FOR MEDICARE

Approximately 3 percent of the older population is not eligible for Medicare. Most of these people were in the military or in other positions where they did not pay into the Social Security and Medicare trust funds during their working lives. Any medical services rendered to an otherwise eligible person while outside the country either temporarily or permanently are also not reimbursable. Following are typical comments:

Medicare for those of us who had no social security has increased in price a frightening percentage each year. As of July 1, 1978, increases will total 52.46 percent in the 3 years I have carried it. At the present rate of increase, the cost will make this insurance prohibitive in the next few years, so where do I turn then? . . .

M.K.I., *Humble, Tex.*

I do not have Social Security coverage. Therefore to have insurance I am now paying \$77.70 per month for Medicare and Medicaid plus Mat-Med. for supplemental insurance. This takes a big share of my pension.

Anon., *Escondido, Calif.*

Have you considered the plight of persons who never worked outside of teaching or other state or local government, who never received any preretirement counseling regarding registering with Social Security, and were not permitted to carry insurance from their employment into their retirement? They now find that no private insurance wants them because private insurance is written to pay only the difference between what is paid by Medicare and the actual cost of the illness. It will cost them \$90 per month to buy into Medicare, and they still have the private insurance to buy.

N.S., *Carson City, Nev.*

During my recent visit to Germany, I became critically ill and was admitted to the Army Medical Clinic at Ansbach. After a preliminary examination, they rushed me to the Army hospital in Nuremberg by ambulance. Upon my release, no insurance claim blanks (Medicare, Blue Cross, etc.) were available, so arrangements were made for me to forward the necessary papers upon my return to the States.

You may imagine my disappointment and chagrin, upon being advised by the local Social Security office that Medicare coverage of my hospital costs would not be allowed. This is certainly a denial of my privileges as a U.S. citizen and former service man, (my WW I discharge is on record). A vigorous protest is being made, not for the monetary aspect, but for the principle involved.

Medical services were administered in a U.S. Military hospital, supported in part, with my tax dollar.

It is rather odd, that a patient, under circumstances, as noted above, is being penalized by being deprived of Medicare.

Congress has voted millions of dollars for foreign aid and other questionable projects. It is my humble opinion and suggestion that they consider Charity and Welfare at home, first, last and always.

A.J.S., *Kiel, Wis.*

3. REFUSAL OF PHYSICIANS AND OTHER PROVIDERS TO ACCEPT ASSIGNMENT

Rather than bill Medicare on behalf of the elderly and accept whatever Medicare pays, the majority of practitioners now bill the elderly directly, putting the seniors to the burden of collecting from Medicare. Obviously, this means that a physician can charge \$35 for an office visit knowing that Medicare will only pay \$12. The senior citizen must make up the difference plus do the paperwork. Senior citizens feel they are being cheated by the growing failure of physicians to accept assignment and the consequences that flow from it, including the fact that intermediaries are often slow to reimburse them even for their \$12 portion of the physician's \$35 bill. Comments follow:

I had hoped that someone would address themselves to the problem of the doctors accepting Medicare and Medicaid assignments. There are very few doctors doing so. I would like to address this problem.

Mrs. G.G.L., *California.*

There's a case of a person: goes to his doctor and he tells him, "Yes, you have got to have an operation. My fee is \$5,000." Medicare says, "The customary fee for that particular operation is \$1,000."

At that point, if it means your health, you are not going to quibble. You may not even have the \$5,000, but you are going to tell him, "Go ahead. Perform your operation." What happens with the Medicare? Well, Medicare will take care of 80 percent. Eighty percent of what? Eighty percent of \$1,000. You are out \$200 that you pay yourself. On top of that, you are out \$4,000. Now, what kind of an equity—is Medicare taking care of the elderly individual?

I.S., *Irvine, Calif.*

Do you really want to know what really frightens people? It is the word "reasonable" charge in Medicare. Medicare pays approximately 80 percent of a total bill. If you have cancer and the bill is \$40,000, Medicare supposedly will pay \$32,000, using the 80 percent as the base. Then comes the question, what if Medicare does not pay 80 percent because the charges in some bills are not "reasonable" so the amount the individual pays increases over \$8,000. Then what if the supplemental policy goes the same route of paying just

“reasonable” charges. It is frightening to anybody regardless of age.

C.I., *Peoria, Ill.*

The narrow definitions of benefits available have led to paper work procedures which are tedious and burdensome. Also many of the statements are not understandable. This is a plea for more understandable and less paper work.

P.J.Z., Address Unknown.

I request the adoption of the improvement in Medicare coverage as proposed by President Carter, plus increase in the “reasonable charges” as now in use. Presently Medicare pays about \$11.20 on a \$25.00 charge for a doctors visit. I propose at least 80 percent payment of this charge.

F.R.D., *Santa Monica, Calif.*

My wife had a physical examination by our family physician recently. The doctor discovered a small cyst, size of a large pea, in the roof of her mouth. He recommended a physician in a neighboring town to remove it. This was done, one night in the hospital, very little discomfort.

I offered to pay the bill immediately, the doctor said wait and see what Medicare would pay. They said for such minor surgery the pay would be \$150. I was billed for an additional \$200 which I thought was excessive. But of course I paid.

To justify the charges the physician said, “Maybe you think the charges excessive—but if it had been malignant you wouldn’t have questioned the charges.” I replied the surgery was the same—malignant or not.

J.C.S., *Blackford, Idaho.*

If the charges billed for 1979 are typical of the customary and prevailing charges, I believe that Congress intended that Medicare repay 80 percent of these charges after the deductible is met. Is this not correct? You will note that in the attached case—Insurance Co. of Dallas allowed \$252 out of a \$480 anesthesia bill for major neuro-surgery. That’s barely 50 percent of the bill. After deducting the \$31 deductible, they repaid the retiree a mere \$176.80, less than 37 percent of what the retiree paid for the necessary services. Now, admittedly, the amount of money involved here is relatively small, especially to you and I. However, this retiree is in the process of paying some \$4,000 plus in doctor bills related to this surgery. Can she only expect to get from 37 percent to 50 percent refunded from Medicare??? Is that the intent of Congress?

B.S., *New Orleans, La.*

What can be done to equalize the difference between the amount the doctor charges and the amount Medicare determines to be fair and reasonable, for example:

Doctor charges for services.....	\$1, 000
Medicare claims to be fair and reasonable.....	700
Difference.....	300
Medicare pays 80 percent of 700.....	560
Leaves balance of.....	440

Who pays the \$440? The patient. This balance is of great concern to the older American on a fixed income.

J.R.S., *Yucaipa, Calif.*

My beef is mainly that they have set up what they call reasonable charges for medical fees, and thus they get out of paying a great portion of the bills. My bills are supported by copies I have and they are unbelievable as to what small help Medicare is.

D.K.S., *Indianapolis, Ind.*

I feel that many insurance programs take too much paper work to prove that one's claim is valid. When my husband was ill and I was trying to get skilled nursing care the insurance company that we paid for from our salary questioned my truthfulness and honesty saying, "Are you sure your husband is ill—Is it possible you want a day off at our expense?" We had paid for these policies for years and I felt home nursing care was our answer. I felt "conned" by the company. They are getting richer and richer. A friend had to prove that her mother was ill and died before she could collect from the mother's health insurance company.

F.S., *Las Vegas, Nev.*

Enclosed are two reports of "Explanation of Medicare Benefits" for services rendered to my 90 year old mother. You will note that the amount approved by Medicare is less than 50 percent of the amount charged by the doctor. I am appalled by this "rip off" of my mother by an unscrupulous and greedy doctor who refuses to accept Medicare assignments, opting rather to charge unconscionable fees.

T.E.D., *Columbus, Ohio.*

I am a senior citizen whose husband died November 1978. I have had one heck of a time with Medicare "B." I have not received all my money. I got \$478.00 so far and the doctor bills totalled \$1,778.00.

S.W., *Boynton Beach, Fla.*

4. PROBLEMS WITH INTERMEDIARIES AND CARRIERS

Senior citizens have some difficulty in understanding the role of the Medicare contractors—the insurance companies which, under contract with the Department of Health and Human Services, evaluate and pay claims submitted by providers. Intermediaries sometimes get the blame for increasing Medicare premiums when such increases are required by law. A more reasonable area of criticism relates to the decision by particular intermediaries to pay or not to pay a particular claim based on policy statements provided to them by HHS. In a recent survey of senior citizens in his district, Congressman William Lehman learned that 80 percent of those polled felt that Medicare's payments as determined by the intermediary were too small. Here are some excerpts from letters received by the Committee on Aging:

Elderly patients lose tens of thousands of dollars in interest on their rightful monies when profit-making insurance

firms take up to four months to make Medicare reimbursements. (Interest on such delayed payments could run into huge extra profits for the private firms).

Has the General Accounting Office (Congress' watchdog) or any congressional Committee ever investigated the procedure under which Medicare contracts have been awarded to private, profit-making firms, or determined the amounts of the profits amassed off illnesses of the elderly, or adjudged the competence or fairness of such firms in making reimbursements to elderly patients? If not, why not?

Elderly patients are victimized when Medicare operators base reimbursements on obsolete charts of doctors' fees which are some two years out of date, instead of allowing for reasonable increases caused by inflation. The monthly Medicare costs paid by the elderly are increased regularly.

P.F., *Murfreesboro, Tenn.*

My statement is this. Medicare allows 80 percent of reasonable charges, and we wring our hands and we stop there. Now, reasonable charges as determined by Medicare is based upon the basic year of 1971. For the calendar year of 1979, there is an allowance made of 42.6 percent. Now, you wring your hands, and you say, "This is too bad. There's not enough money." Thirty-eight cents out of every medical expense is paid by Medicare for 1978. Why does the Congress of the United States allow that?

H.K., *Redding, Calif.*

A current irony needs to be drawn to your attention. At the same time that you labor to enlarge the scope of home health and increase the number of visits for home care, fiscal intermediaries chop away and disallow services heretofore considered an integral part of home care. Under the Waiver of Liability Presumption, through disallowance and implied threat of future financial rejection, certified agencies are "being taught" to reduce both length of stay and number of services allowed. It is arbitrary and capricious to attempt to establish that the impaired elderly in an urban setting (or any other setting for that matter) can manage to remain out of a nursing home with a foreshortened stay and 8 or 9 visits a month to support them. Certainly this was not the intent of the original law or the present thrust of the Committee on Aging.

B.K.S., *Baltimore, Md.*

I am writing this letter on behalf of my mother to make you aware of what I perceive as an enormous "rip-off" of the elderly by either government action or bureaucratic bungling and to solicit your help in remedying the situation, if not for my mother, at least for the millions of others who are too confused or intimidated to question adverse actions. My references are to the practices of those insurance companies who are empowered to reimburse the elderly for their medical bills under Medicare, and more specifically, the railroad retirement board (however, the practices seem to be the same under all plans).

An elderly person undergoing major surgery must pay all their own doctor and surgery related bills (excluding hospital) as virtually no doctor accepts assignment to Medicare, and obviously for a very good reason.

Are you aware that when these people, who you and I recognize are least able to afford major medical expenditures, submit their paid bills that—Insurance Company of Dallas, TX, (and others as well, I assume) uses “so-called” customary and prevailing charges for similar services by providers in the same area during a specified base year. I find it unbelievable that you would allow these insurance companies and the Federal agency responsible for the program to so bilk the aged. Would you stand for a medical insurance program that reimbursed you based on data that is up to 2½ years old? I definitely wouldn't.

Why, in God's name, must these companies use such aged data when, as a result of every day processing they are handling current charges in the identical locales? Surely they are not so inefficient that they are unable (or perhaps, unwilling) to refer to the data that is already in their hands and is being constantly updated.

From the foregoing I can only draw these conclusions:

1. Either the insurance companies processing the claims are so inefficient that they can't do any better and if this is the case, they should be replaced.

2. The bureaucratic federal agency setting up the rules that allow these “crimes against the elderly” should have the program taken away from them and the persons responsible for establishing such criteria fired.

Or, the Congress or the Administration purposely intended to defraud the elderly to save money at the expense of the elderly.

I hope it was not the intent of Congress or the administration to willfully penalize our Nation's old folks by such inefficient practices. The program as it is being implemented is totally unfair.

B.A.S., *New Orleans, La.*

It simply appears to me that the intent and purpose of the Medicare program has been thwarted by the arbitrary refusal to pay the reasonable charges assessed by physicians in attendance. What this has meant in my mother's instance is that instead of being reimbursed 80 percent of the cost she incurred she is actually reimbursed 56 percent in the case of Dr. T's bill . . .

L.P., *Miami, Fla.*

I wonder if you are aware of and approve of the Gestapo methods by which the employees of ——— Insurance Company dispose of Medicare claims. My experience: Unfortunately, in my 89th year I had to submit to major surgery for which my surgeons carefully prepared me, operated and accomplished my safe return to active life after removal of about 24 inches of my colon, affected by cancer.

My surgeons billed me for \$1900 for the preparation, operation and post services. I submitted the bill to Medicare

through ——— Insurance Company. An employee of the Company chopped the bill down to \$946.40 (a primary cut of 50.19 percent). The only explanation given directs attention to "item 5 on back." That "item" is indicative that the charge made by my surgeons exceeds that made by them for similar services in 50 percent of their billings during the base year, or exceeds the charge made 75 percent of the time by others for similar services in the area during the year. There is no specification of which of these different events determined the action of the employee. I have vainly requested the name of the employee who made the determination.

Incredible though it may be, it seems that a claimant is required to accept, without question, the secret determination of an unidentified person. If such be approved procedure, it is more Gestapo-like than consistent with guarantees in the Constitution of the United States.

Would you favor a statutory requirement that the name of the person and facts upon which determination was reached be made available upon demand to claimants for Medicare relief?

C.R., *New Orleans, La.*

We pay our doctor's bill promptly, but when it comes for Medicare to pay us back, they don't . . .

P.A., *Miami Beach, Fla.*

The Medicare problem we are having is trying to collect reimbursements after I pay a medical bill . . .

B.A.Y., *Pasadena, Tex.*

Why does it take such a long period to be reimbursed for Medicare payments when you have paid the bill out of your own pocket. It takes from 3 months to 6 months.

D.K., *Boise, Idaho.*

5. CONCERN ABOUT FRAUD AND ABUSE

The comments of older Americans are replete with concern that the Medicare program may be the victim of wholesale fraud. A few quotes follow:

Is Anybody Listening? A scandal in which millions of elderly are being victimized by mishandling of Medicare funds is being ignored by the White House, the Congress, HEW, the news media, state officials and so-called consumer protection groups. To the elderly it is far more consequential than a dozen Watergates.

P.F., *Murfreesboro, Tenn.*

Some type of medical care is obviously needed for the elderly in our country. I believe the biggest problem of Medicare is the way that people in health related fields ripoff the Government by charging excessive amounts to do things. I believe it is important for Medicare legislation to set some type of limit on payments to the medical professions. Though

there are probably other aspects of Medicare that need to be closely looked at, I believe this area is the most important . . .

J.R., *Manhattan, Kans.*

Can we stop this waste of Medicare monies and give it instead to the great needs of the elderly? . . .

B.A.M., *Livingston, N.J.*

Another big thing I would like to see done is the elimination of all false claims made by laboratories and unscrupulous hospitals and doctors. The doctors are benefiting mostly.

I.G.S., *El Cajon, Calif.*

Our doctors have been revered by the people thru the ages. Why should they go greedy in the last 3 years? Are they afraid there will be controls, so they are going to get while the getting is good? Or are they a group who wants to show control?

D.V.R., *Laguna Hills, Calif.*

I fear the implementation of a national health care program because of the opportunities for fraud in a government subsidized program. Too many people take advantage of any service that is "free." Look into safeguards against fraud in a health care plan.

K.W., *Escondido, Calif.*

I think physicians have tended to abuse the system because the system required them to do it in order to serve their patients. If the only way you can get your patient served is to admit him to the hospital and have to justify why the admission was necessary, you are going to do it because your patient needs it.

Dr. S., *Milwaukee, Wis.*

C. THE MINNEAPOLIS EXPERIENCE: FURTHER EVIDENCE THE ELDERLY GO WITHOUT THE CARE THEY NEED

Medicare's shortcomings were starkly revealed in 1975, when Daphne Krause, President of the Minneapolis Age and Opportunity Center, Inc., testified before the Committee. The center, backed by staff and funds of Abbott-Northwestern Hospital, opened a clinic for older persons with medical problems in 1973. Elderly persons, with modest incomes, were assured that there would be no charge for anything Medicare didn't cover.

This offer of free help brought out a rush of older people who had been neglecting their health for fear of cost. Mrs. Krause said:

Within 3 months, over 8,000 older persons had registered. The pathology was unbelievable—there are books of it here to show you, if you are interested. One client walked in with a handkerchief over a cancerous hole in the cheek; another with an aneurysm as big as a grapefruit. We barely got that one down to surgery in time. Another had had a heart attack 5 days before and decided not to get help until they heard about us. One man arrived on a stretcher with

the newsletter advertizing the center pinned to his chest after having a heart attack. Apparently, he just pointed to the newsletter and said to the ambulance driver, "Take me there." There is no way, unless I sat and read to you some of those pathologies, of your realizing the terrible, horrendous conditions that exist out there in the community.

Abbott was hard pressed to find enough doctors and nurses to take care of patients. No one expected this tremendous outpouring of elderly. Nor could anyone imagine the pathology. A random sample of patients disclosed the following problems:

- A man admitted for heart surgery;
- A woman with imminent gangrene of both feet;
- A man suffering from rectal mass, anemia and rectal blood;
- A woman who needed surgery to replace her left hip (she could not walk a quarter of a block without pain);
- A man in need of stomach surgery;
- A man with congestive heart failure, edema, cataracts, marked tooth decay, and dementia;
- A woman with incontinence, urinary infection, severe arthritis;
- A man whose last contact with a physician was when he had his World War I physical; and
- A man who was blacking out because the batteries in his pacemaker needed replacement but who put off having the batteries changed because he was still paying for the installation of the pacemaker 3 years ago.

Not all the patients served by MAO are chronically poor. Patients include former schoolteachers, former lawyers, former physicians, insurance company presidents, all of whom had exhausted their resources and who had neglected seeking the care they needed because of the expense, i.e., Medicare premiums, coinsurance and deductibles. Mrs. Krause believes that fear of ruinous expenses is causing old people all over the United States to hide as much illness as she found in Minneapolis. She added, "A lot of people say—don't people abuse this, won't they leave their doctors just because this (the clinic) was free? This has not been our experience."

Services are provided by the clinic to those individuals with incomes below \$4,500 (\$5,000 for couples) and limited assets. Medicare is accepted as full and final payment for any treatment rendered by the hospital and participating physicians who thus agree to absorb all the copayments and deductibles which the senior citizens ordinary would have to pay out of their own pockets.

Mrs. Krause testified that older persons need a whole range of health services rather than just expensive hospital and institutional care when they are in dire need. Services offered by the clinic include health care in the outpatient clinic, free transportation to and from the clinic, counseling, all necessary home care, homemaker services, meals, the first 3 pints of blood, and prescription drugs. A more detailed description of the scope and range of services provided by the clinic is presented in Table IV.

TABLE IV.—*The M.A.O. network of medi-supportive services*

The following are brief descriptions of M.A.O.'s main services and partnerships. It does not show the services within services, or even all the services we provide. We hope it provides a glimpse of the scope and range of services.

Home Delivered Meals—Two meals are delivered once a day, 7 days a week, including special diets.

Home Care Services—Complete housekeeping services and personal care services, e.g. meals, laundry, cleaning, baths, hair care, etc.

Chore Services—Handyman services and heavier chore services, e.g. window and wall washing, smaller house repairs, yard clean up, etc.

Transportation—M.A.O. transports Seniors unable to use public transportation, to obtain services, or brings them services, such as meals.

Employment Services—Primarily to locate and obtain employment, full and part-time, for older workers. Also, to provide a method for Seniors to obtain younger people to help them, such as yard work, repairing and fixing their homes inside and outside when they can afford to pay for services.

Legal Services—Complete range of attorney's services, with the exception of criminal cases.

Special Health Services—Emotional, alcoholic, and drug dependency counseling and other professional services, in-patient and out-patient, on an individual basis and through various therapy groups. (Psychiatrists & psychologists provide services as needed.)

Counseling—To evaluate and assess with each senior what services they need, and help them obtain them, to provide personal and financial counseling, etc., develop and coordinate the senior's individual care plan with him, and to follow up to see that the senior's needs are being met to the senior's satisfaction.

Grief Therapy—Individual and group therapy.

Diet Counseling—A professional dietitian provides individual and group therapy, counseling and education.

Information and Referral—Provides information on all M.A.O. Services and other programs, as an integral part of all M.A.O. components, escort services to obtain services are provided as needed.

Facilitation of Health Services and Assistance Programs, etc.—Help in obtaining, and ongoing assistance with the complexities of such programs as Medical Assistance, Medicare, Housing, Social Security, Supplemental Security Income, Aid to the Blind and Disabled, Supplemental Insurances, Bills, Taxes, Food Stamps, obtaining housing repair loans, Legal and Civil Rights, etc.

The Abbott-Northwestern/Minneapolis Age and Opportunity Center, Inc. Senior Citizens Clinic—The entire range of Medical Services are provided as in any private doctors' clinic. The Clinic is free to any eligible Senior Citizen or younger handicapped person; others would pay normal charges, but still be eligible for some additional benefits.

Hospital Care—The entire range of Hospital care at Abbott and Northwestern Hospitals, and the Kenny Institute, is free to eligible M.A.O. Clinic patients.

M.A.O. Health Counselors—Provide in-patient counseling for an "unbroken" service.

Abbott-Northwestern/Minneapolis Age and Opportunity Center, Inc. Clinic Pharmacy—Low cost drugs are available through our Pharmacy in our Clinic. Our two full-time Pharmacists are part of the Medi-Supportive team, reviewing, educating, and advising on the Seniors' drug profile.

Blood Bank in Partnership with the War Memorial Blood Bank—Free blood obtained through M.A.O. for any Senior Citizen or younger handicapped person needing it—not just M.A.O. Clients.

Meals in the Community in Partnership with the Minnesota Restaurant Association—Low cost meals provided to eligible Senior Citizens and younger handicapped at participating restaurants. Membership is without charge through M.A.O.

M.A.O. Crisis Funds—Through donations, funds are available for emergencies, e.g. food, clothing, medicine, etc.

Operation Grandparents—In Partnership with Channel 11 (Stu Lindfman), who airs the information. This Program brings together younger people and Senior Citizens in a mutually rewarding friendship—in which they do things together, e.g. shopping, meals, rides, friendly visiting, etc., and also provides channels for friendships between older people.

The Junior League of Minneapolis/M.A.O. Partnership—The Junior League originally financed and sponsored M.A.O.'s Volunteer Department and now continues to provide volunteers and back-up services, e.g. obtaining blood, visiting shut-ins and hospital patients, providing administrative volunteers, etc.

Volunteer Services—M.A.O. has a full-time staff person responsible for training and assigning over 166 volunteers, who provide services throughout M.A.O. and is responsible for all M.A.O. Volunteer Programs, such as Operation Grandparents, and Meals In The Community, and for coordinating services with other volunteer groups, such as Red Cross, CEAP, etc., and for supervising AFL/CIO Senior Aides.

AFL/CIO Senior Aides—Senior Aides working at M.A.O. provide a cross section of services.

Chaplaincy Services—M.A.O. has a Partnership with the Abbott-Northwestern Hospital Ecumenical Chaplaincy Service, for Seniors needing spiritual comfort and advice, in the Hospital, at their homes or at M.A.O.'s Center.

Reassurance or Tele-Care Phone Service in Partnership with Northwestern Hospital Volunteers—Who provide a daily phone check-up for M.A.O. Clients needing it. In return, M.A.O. provides an *Emergency Home check-up* for all our Clients as needed.

Food Closet—M.A.O. has a food closet to provide emergency or supplemental food, including cash for perishable food, e.g. bread, milk, etc.

Police Referral Program—The Police refer Seniors with problems to M.A.O., and in turn provide M.A.O. with back-up support in crisis situations, e.g. if we have to break in to a Seniors' home if they are critically ill and can't open their door (incidentally—M.A.O.'s Chore Staff then have to repair the door!)

Twenty-Four Hour Emergency Service—After working hours, 24 hours a day, weekends and holidays, some M.A.O. Staff voluntarily cover our Beeper Service, providing emergency coverage for all M.A.O. Services, ready and able to help the Seniors, or obtain the help they need, e.g. hospital care, emergency personal care, etc.

Advocacy—The M.A.O. Staff takes advocacy action on behalf of their Clients as needed. The M.A.O. Board of Directors, acting on its knowledge from the community or on information received from the groups they represent, directs and assists the President in taking advocacy action on a broader basis. Common concerns of Senior Citizens thus are considered in an active and organized way.

Although Mrs. Krause's center offers more services than Medicare does, she argues that it saves money in the long run because low-cost care which permits a person to remain in the home can often avert high cost of care in a hospital or nursing home. Mrs. Krause was able to demonstrate that the proper intervention of home health services is not only more humane and desirable but also cheaper than placing patients in nursing homes. She presented numerous examples to prove her point in testimony before the House Select Committee on Aging in 1978. Two examples follow below which contrast the cost of providing in-home supportive services at MAO with the cost of nursing home placement:

Case A

Supportive services for Mrs. M.R. from 1971-73 by MAO:

Meals, including delivery charges (2 meals a day, 7 days a week)-----	\$3, 385. 00
Housekeeping services (3 services a month)-----	399. 60
Counseling (average one a month)-----	324. 00
	<hr/>
Total Cost of MAO Services-----	4, 008. 60
	<hr/> <hr/>
Nursing home costs from 1971-73:	
\$450 per month for 3 years-----	16, 200. 00
Less clients income of \$115/month for 3 years (client would be allowed to keep \$25 a month for personal needs)-----	-4, 140. 00
	<hr/>
Remaining cost to be paid by medicaid-----	12, 060. 00
	<hr/> <hr/>
Less cost of MAO services-----	-4, 008. 60
	<hr/> <hr/>
Total MAO saved the taxpayers over 3 years with respect to a patient ordered institutionalized-----	8, 051. 40

Case B

Costs if the client, J.R., had been institutionalized, from July 1, 1975 to December 31, 1977:

Average basic cost of nursing home care at \$725/month for above period (this is a conservative averaged estimate)-----	21,750
Less client's income of \$162/month for above period (client would have been allowed \$25/month for personal needs)-----	-4,860
Potential cost to medicaid would have been-----	16,890

COST OF MAO SERVICES FROM JULY 1, 1975 TO DEC. 31, 1977

Services	Number of services	Amount
(1) Counseling-----	4	\$26.12
(2) Homemaking-----	66	2,962.00
(3) Transportation—Provided by the volunteer; uses public transportation when able-----	85	234.00
(4) Volunteer-----		
Total cost of MAO services-----		3,222.12

Subtracting the total cost of MAO services-----	\$16,890.00
from the total cost to medicaid shows MAO-----	-3,222.12

Saved the taxpayer over \$13,000 in this case-----	13,337.80
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Mrs. Krause contends that the experience at MAO is typical of what would be discovered if similar clinics were opened in every American city. She raises her voice to speak for those who cannot speak for themselves.

Mrs. Krause again testified before the Committee on October 17, 1979. She reported on abuses in the nursing home field and pointed out that existing government policy still has an institutional bias. She noted that representatives from 59 countries have sent personnel to study the unique arrangement that MAO has with Abbott-Northwestern hospital but no one from the Department of Health and Human Services has visited the center.

What the MAO project has demonstrated underscores what the Committee has learned from seniors across the nation. In short, senior citizens feel that Medicare is like a candy bar shrinking up under the rigors of inflation: they feel they are paying three times as much for half as many benefits. Given the current state of the economy, many fear that the worst is still to come: they understand that Medicare will continue to cost more and more and pay less and less of the bill. To the elderly the bottom line is that they must look elsewhere for health protection. Unfortunately, the Medicare program has discouraged both the operation of the Minneapolis clinic and similar efforts elsewhere.

III. REVIEW OF MAJOR PROBLEMS WITH MEDICARE

The preceding section outlines the experience of senior citizens who participate in Medicare. Generally, the elderly are grateful for the program and feel that it has been helpful. At the same time, they feel that Medicare is paying less and less of the cost of covered services and that the burden of carrying the cost of uncovered services has become staggering. While the preceding section sets forth all of the problems seniors associate with Medicare, this section will attempt to highlight the major issues which must be addressed by the Congress and to suggest solutions. These major problems include (a) the growing reluctance of physicians to accept Medicare assignment; (b) the overutilization of hospitals; (c) difficulties with intermediaries; (d) the lack of comprehensive coverage and growing Medicare gaps with particular reference to the inadequate home health care coverage; and (e) the continuing presence of massive fraud in the program.

GROWING REFUSAL OF PHYSICIANS TO ACCEPT ASSIGNMENT

Under Medicare Part B, a physician may choose to bill Medicare directly and accept whatever Medicare pays or to bill the elderly and allow them to collect whatever portion of the charges they can from Medicare. Billing Medicare directly is known as "accepting assignment." There is a growing trend not to accept assignment for two reasons. First, physicians feel that Medicare simply does not pay enough. Second, the burdens imposed by completing Medicare forms are many and costly.

Physicians find it easier and more rewarding to bill the elderly and let them have the worry of the paperwork along with the anxiety that comes with learning that Medicare has determined that less than half of the physician's, say \$35 office visit, is "reasonable." Where major surgery or other costly medical treatments are involved physicians will generally accept assignment. This is particularly true if the physician has reason to believe that the senior citizen has limited resources. Some payment at Medicare's rates is thought to be preferable to little payments and bad debt writeoffs from the elderly. GAO has confirmed that there is a certain measure of philanthropy in that physicians will not accept assignment where they think the patient has some means, and are more likely to do so when the medical treatment itself is more costly or of a serious, life threatening nature.

Concerns about "assignment" and low fees continue even though fees to Medicare participating physicians were raised 5 percent in July of 1978 costing the taxpayer an additional \$1.4 billion a year. It should be noted that inflation factors are built into the billing profiles of physicians and these profiles are used to determine the amount that Medicare will pay to the doctor. Physicians question how often profiles are adjusted for inflation and argue that fees have not kept pace with inflation and that they are in effect once again being asked to subsidize the care of the elderly.

From the point of view of the patients, it is simple. They pay more if the physician does not accept assignment and they have to carry the burden of the paperwork which is almost more objectionable.

The General Accounting Office completed a study in May 1978 for the House Interstate and Foreign Commerce Committee examining the question of why fewer and fewer physicians were accepting assignment. GAO confirmed that some 50 percent nationwide were accepting assignment in 1977; the estimates are that 48 percent will accept assignment this year. In addition to their work, GAO analyzed other studies in an effort to advise the Committee on how to deal with this problem.

GAO set forth three possible approaches to the problem. First, a proposal introduced by Senator Herman Talmadge would change the administrative and reimbursement procedures currently used in Medicare and Medicaid programs. The bill would create a new section in the Medicare law entitled: "Agreements of Physicians to Accept Assignment."

Under the new section, the concept of "participating" physicians was introduced. A participating physician would be one who voluntarily and formally agreed to accept assignment for all Medicare patients. Those choosing not to participate could continue to elect to use the assignment method of billing on a claim-by-claim basis, as is the case under present law.

To encourage physician participation, the new section provides for expediting claims processing for participating physicians by having each physician submit his/her claims using one of several alternative simplified bases, including multiple billing listing of patients. Carriers would be required to process these claims expeditiously and, in addition, physicians would be paid \$1 for each claim submitted in accordance with the simplified billing procedure.

A bill introduced by Congresswoman Elizabeth Holtzman would require that Medicare's reasonable charge determinations be based on current charge data, rather than data that is 6 to 30 months old. Using current charge data would increase the amounts received by physicians taking assignment. It is anticipated that by using current data, the national decline in assignment rates will be reversed.

The bill would also require physicians to give patients advance estimates of the reimbursements they will receive for services rendered under the Medicare program. Such action would eliminate the uncertainty surrounding reasonable charge determinations.

A bill introduced by Congressman Toby Moffett would require that physicians participating in Part B of Medicare accept assignment.

GAO said it was difficult to tell which of these approaches would work best. They suggested that the Department of Health and Human Services undertake some demonstration projects to provide the Congress with more data. The 1979 Medicare Annual Report, in the section on demonstrations and pilot projects, reads as follows:

To develop a sound base for policy decisions on physician reimbursement, HCFA supports research into the costs and patterns of physicians' practices, physician prices and incomes, and participation in financing programs.

In February 1979, ORDS held its first annual conference on physician reimbursement to discuss the policy implications of the results of these descriptive and behavioral

studies. HCFA's data bases on physicians make possible the design of alternative reimbursement methods, such as fee schedules and service packages, and the simulation of their effects on the Medicare program. Information collected on practice costs and productivity directly contributes to the refinement of the Medicare economic index, the only current means to restrain Medicare payments for physician fees. Studies on physician participation in the Medicare program have supported the development, in 1979, of "assignment" demonstrations to encourage physicians to accept Medicare reimbursement rates as payment in full. These demonstrations also include elements to enhance professional relations, increase beneficiary education, and improve administration."

In its report, GAO pointed out that studies made were unanimous that if the option of collecting full fees directly from Medicare patients were taken away, doctors would desert the program in droves. Nelson Cruikshank, former Counsellor to the President, calls this a good bluff. He believes the amount of money going into Medicare is so large and so inviting that physicians could not pull away from the program even if they wanted to.

The proposal by Congresswoman Holtzman requiring the computation of physician's fees using current data instead of data which is 6 to 30 months old seems to have general acceptance. The major obstacle to the implementation of this idea is cost.

The Talmadge proposal is considered by many experts to be the most plausible in that it seeks to provide a financial inducement for physicians to accept assignment. A variation of this idea was suggested by Nelson Cruikshank in testimony before the House Aging Committee. He said:

It would be possible to provide strong incentives for doctors to use the assignment method. The strongest of such incentive methods would probably be for the Government in the case of assignment billings to reimburse the physician for 100 per cent of the reasonable charge including the coinsurance and deductible amounts. The Government would then take the responsibility for collecting the coinsurance and deductible amounts from the patient. Since practically all the patients are getting Social Security, Railroad Retirement, or Civil Service annuity benefits, it would not be too difficult for the Government to collect these amounts by deductions from these benefits. This would be somewhat complicated, but it would be no more complicated than the deductions from benefits now made under the Social Security program in cases where a retiree earns more than the allowable amount under the retirement test.

Mr. Cruikshank, however, indicated he had a clear preference for another method. He said:

A much less drastic plan would be to allow both methods of reimbursement, but to remove the choice in individual cases by physicians. Participating physicians would have to agree in advance either to accept assignment in all cases

with all patients or to rely entirely on the direct billing method. The first alternative, again would entail the Government making available lists of physicians accepting assignment, and requiring physicians to notify patients of their intent in advance.

It would also require negotiated fee schedule which would be developed by representatives of the medical profession and consumer groups with the government in a referee position. The agreed fee schedules should be fair, leaning even towards the generous.

Under this proposal, as at present, the reimbursement is 80 percent of the reasonable charge (as reflected in the fee schedule) and it would be sent directly to the physician. The like amount (80 percent of the reasonable charge after the coinsurance) would be sent to the patient under the direct billing method, leaving the doctor the problem of collecting both the coinsurance and the basic amount of the bill. It is important also that under this method, the government should inform the patient of the method of determining the amount of reimbursement; namely, the normal share of the reasonable charge. If the amount that the physician adds is above the reasonable charge, that amount should be identifiable and clearly indicated to the patient.

However, setting a fee schedule for those accepting assignment under Medicare does not go far enough. The price for a procedure under the assignment method may be set, but the choice of procedures is at the discretion of the provider, as well as the number of procedures employed. Thus, coupled with the existing inefficient medical delivery system, its emphasis on specialization and high-cost technology, and its bias towards financing of the most high-cost options available, constraining physicians' fees by using existing "reasonable charge" concepts is not likely of itself to have a significant impact. Constraining the fees of only some physicians—those who accept assigned reimbursement under Medicare—is clearly even less effective, since there is no significant mechanism which constrains price increases for private consumers of medical services. Thus, there may only be a shifting of costs from the publicly insured consumer to the private consumer, or creation of two levels of care, or both.

There is a simple step that could be taken which would work against such price discrimination. The negotiated fee schedules should be public information, available to all consumers, regardless of the source of their financing. The visibility of deviations in pricing policy would add a competitive element to the system and also stimulate debate on what the "reasonable" level of charges should be.

There is yet another alternative which should be considered. It has been suggested that physicians are more likely to accept assignment if they can receive some kind of tax break for doing so. With incomes placing them in very high brackets, physicians are in the position of shopping for tax shelters of various kinds. The idea is to allow physicians to subtract from their income tax some of the money they receive from Medicare.

One idea is that if a physician will agree to accept assignment from all of his patients and if he has reached a certain threshold of payment—perhaps receiving \$10,000 from Medicare in a year—then the physician might be allowed to deduct in that year up to \$25,000 which he receives from Medicare thereafter from his taxes. This incentive would serve to attract physicians into Medicare service. At the same time, the proposal is self-policing. Medicare is required to report to the Internal Revenue Service the name of any physician who receives more than \$25,000 from the program. There is great respect for the Internal Revenue Service and the threat of audits and the application of criminal sanctions would serve as a significant deterrent to abuse. Such an approach would be much more likely to work than efforts by the government to force physicians into either accepting assignment or not participating in the program.

INCREASING COSTS: RESULTS OF A COMMITTEE STUDY

Among the reasons given by physicians for refusing to accept assignment is that Medicare fees have not kept pace with the ever-increasing cost of health care. In order to learn more about the question, the Chairman directed an inquiry to 25 providers (physicians and pharmacists) in each of the following 10 States: Alabama, California, Florida, Michigan, Minnesota, New York, Ohio, Pennsylvania, Texas and Wisconsin. A total of 250 questionnaires were sent of which 118 or 43 percent were returned.

Asked if the growing concern over escalating health care costs was valid, 76 percent said yes. Asked to rank eight factors which most contributed to increasing health care costs, they responded as follows:

Most Important Reasons for Health Cost Increases:

1. Government regulation and red tape;
2. Increasing wages of professional and ancillary personnel;
3. Increasing demand for health care services;
4. Cost of new hospital equipment and technology;
5. Increasing malpractice premiums;
6. The enactment of Medicare and Medicaid and the increasing shift to third party reimbursement;
7. Fraud in government programs; and
8. Shortages of physicians.

In related questions, providers were asked if the fact that more and more Americans are covered by health insurance has had an impact on health care costs. Some 70 percent said a significant impact, 26 percent said some impact and 4 percent said no impact at all.

Asked if they thought hospitals had to continue to expand in order to remain economically viable, 60 percent said no, 21 percent said yes and the remainder were unsure.

The next question asked whether the providers thought hospitals were making a voluntary effort to cut costs. Some 57 percent said yes, 35 percent said no and the remainder had no opinion.

Asked if they thought there were economic forces at work on the hospital that were beyond control, 83 percent said yes, 10 percent said no and the remainder were unsure.

The providers were asked to what degree they thought the present system overutilizes institutional alternatives, some 57 percent answered "significantly," 34 said "to some degree" and the remainder disagreed with the premise.

When asked to what extent emphasis on preventive medicine will reduce future health care costs, 30 percent said "significantly," 41 percent said "to some degree" and the remainder said "marginally" or "not at all."

Asked to what extent they thought empty hospital beds resulted in increased costs, 21 percent said "marginally," 36 percent said "to some degree" and 47 percent said "significantly."

The same providers were asked whether they thought the imposition of fixed fee schedules for physicians would result in "a decrease in the spiral of health care costs." Some 66 percent said no, 16 percent said yes and the remainder were unsure.

Asked whether free enterprise or government was better at administering health care, a resounding 82 percent chose free enterprise, 6 percent said government and the rest were unsure.

When asked if health care costs would decrease if government got out of regulating the health care industry, 49 percent said yes, 19 percent no, and the remainder were unsure.

The providers were asked about the effect of HMOs on health care costs. Thirty-nine percent said HMOs would have no effect while 32 percent said costs would increase, 27 percent said costs would decrease and the remainder had no opinion.

Asked whether the increased use of physician assistants or nurse practitioners would reduce costs, 40 percent said yes. Some 37 percent said costs would stay the same and 20 percent said costs would even increase.

The doctors were asked about the effect of home health care on costs. Some 39 percent said home health care would reduce medical costs significantly, 37 percent predicted some degree of savings, while the remainder said there were no savings or perhaps increased costs.

Another question asked about the quality of health care and whether the improvements instituted in the last 30 years had contributed to increased costs. Fully 70 percent of those responding said yes, only 6 percent said no, and the remainder were unsure.

In answering yet another question, only 11 percent of the physicians said that Medicare coinsurance provisions have significantly served as a brake on increasing health care costs while 50 percent said there has been only a marginal effect, 27 percent said there was no effect and the remainder were unsure.

Finally, the providers were asked whether the reduction in health care costs by government intervention will inevitably result in a reduction of the quality of health care services offered to the American public. Some 65 percent answered affirmatively, 21 percent negatively, and the rest were unsure.

The following comments were taken from questionnaires completed by physicians and filed with the Committee:

- Physicians fees are not the important component to rising health costs. By handcuffing physicians, more patients will be forced to higher cost institutions for care.
- Without incentives, M.D.s will do (the) minimal required of their services. Patient-doctor relationships will deteriorate.
- Politicians . . . do not understand the majority of people. In treating 150,000 patients/year, there are less than 1 percent commenting on (my) fees.
- Hospitals are so regulated by government that they function in a bureaucratic style.
- Fraud is rampant in the Medicaid program. Any doctor convicted in one State, simply goes to another!
- It is essential to substantially reduce costs by emphasizing quality non-institutional settings. The nursing home becomes often the only alternative in many localities due to big monetary interests in nursing homes, and other "mini institutions," which preclude adequate staffing and coordination of homemaker and chore services, and adequate utilization or existence of programs that are significant alternatives to institutionalization, or inadequate home health services.
- What is "reasonable" is not well defined in its parameters or interpretation. Reasonable seems to be a term of art than a descriptive adjective related to cost. Federal regulations and intermediary newsletters are confusing, contradictory and usually unenforceable.
- As long as a hospital or other facility knows it will be reimbursed on a cost basis it has no incentive to be cost effective or even conserve.
- More people (especially the elderly) have greater need for health care today. If health care is left to the government, there will be a lag in efficiency due to red tape. As it so often happens no one moves until permission is given to act.
- More old people are now alive than ever before, these are the people that need hospital care and nursing homes more than others. Consequently, it follows that more money must be spent to care for them, no matter what system you use, the cost is there. This will naturally increase the cost.
- Increase government control and "programs" can only increase cost.
- I am for free enterprise; however, the Medical Industry (as every other) has not made any significant moves to hold costs or reduce them.
- Prevention is not available under Medicare, (and) increases risks for older people.
- If you, the government, could be more fair, you wouldn't need expensive watchdogs watching watchdogs, watching watchdogs, watching improperly processed computerized misinformation.
- The constant struggle to receive money for services rendered causes us to hire more and more people to handle it. We are still in need of additional people to handle the mess of paperwork and the rejections . . .
- As the cost of living rises and the cost of services also, people are afraid of illness because of the expense involved,

especially catastrophic illness. The elderly on fixed income are particularly affected. Sometimes elderly will not tell anyone they are ill due to fear of hospitalization and the accompanying expense.

- I am a physician—as such my charges by virtue of inflation, malpractice and increasing charges have risen 300 percent over the past 25 years.

- The “reasonable cost” is hardly ever reimbursed—in other words, the reimbursement is well below the reasonable rate necessary to maintain operation. Therefore, the private patients have to make up the cost differential.

- Low reimbursement cost forces providers to make profit by volume.

- Comprehensive home care as well as education and good preventive and early diagnosis can, in an integrated program, reduce cost; e.g., early discharge to good home care services.

- It is becoming more and more difficult for the average person to afford adequate insurance so that a severe illness does not bring with it a financial crisis.

- (There is) incredible greed on the part of many physicians.

- It PAYS to keep people sick (the sicker, the higher the reimbursement) . . . Health or its maintenance, which may require more effort, is not supported financially.

- Care centers for chronic conditions and development of services with intermediate care are needed, not more acute care services.

- Government reflects the schizophrenia of the electorate; i.e., in order to get re-elected the politicians demand more service for less money. In today's world that can only result in lower quality.

- I believe it (reasonable cost) encourages inefficiencies. I prefer an “incentive” reimbursement plan which rewards efficiency with a higher percentage reimbursement to low cost providers and a lower percentage to high cost providers.

- In the short term, costs may increase due to payment for prevention and care—in the long run, effective prevention programs will allow patients to live longer and therefore have higher risks of other disabilities.

- If government regulated health care in an ideally intelligent fashion, I would be for government regulation. But they seem to create more waste than they save. My guess is a sufficiently motivated private sector does a better job . . . I simply don't trust the government. It is well meaning in the beginning but it ultimately perpetuates bureaucracy, and rewards inefficiency.

OVERUTILIZATION OF HOSPITALS

The House Committee on Aging has been conducting hearings to learn why hundreds if not thousands of patients who need placement in a nursing home are being retained longer than necessary in hospitals. Congressman Don Bonker highlighted the problem in August 1979 hearings in Longview, Washington. The purpose of the hearing was to

discover why there were no Medicare approved nursing home beds in Southwestern Washington. Congressman Bonker directed a questionnaire to every nursing home in the State. The nursing homes told Bonker that red tape and arbitrary cutbacks in Medicare payments to nursing homes (which have been more aggravated over the last few years) create the situation where nursing homes do not want to participate in Medicare. Without an adequate supply of nursing home beds available, more and more patients are being retained longer than necessary in acute care facilities.

Congressman Bonker sent a questionnaire to all hospitals in his State asking for more information. Some 73 percent of the hospitals in the State responded. Of this number, fully 91 percent said they had routinely retained patients longer than necessary—in some cases for weeks or months—because they could not find appropriate Medicare certified nursing home beds. Here are some examples taken from the questionnaires:

- Valley Memorial Hospital of Sunnyside, Washington said that beginning in 1978, there was great difficulty finding space for patients. "During the three month period from January through March, it was necessary to keep patients up to two and three weeks in the hospital" (longer than they needed to be) and that they had been unsuccessful in finding room for patients in a radius of 30 miles from the hospital.
- Riverton General Hospital reports they currently have two patients who have been in the facility two months longer than necessary because no nursing homes will accept them.
- Auburn General Hospital offered the example of one patient kept in the facility 150 days longer than necessary at a total cost of \$13,451.13 because nursing homes would not accept the patient.
- Northgate General Hospital in Seattle said, "At times we have as many as 10 patients who remain in the hospital who should be placed in nursing homes."
- The North Valley Hospital of Tonasket said, "This hospital shares your concern regarding the shortage of Medicare certified nursing home beds and have been trying to solve the problem for the last five years."
- Allenmore Community Hospital in Takoma said that because of the shortage of Medicare beds, "the nursing homes can pick and choose the patients they desire. This has created a tremendous problem in finding a bed for patients who require heavier and more skilled care."

Said Congressman Bonker:

In our questionnaire we asked the hospitals for their average daily charge which ranged from \$89 to \$369 per day. The average charge for Medicare patients is \$174.66. I wanted to compare this with the average rate of \$34 per patient per day to keep someone in a Medicare certified nursing home bed in the State of Washington.

The obvious point that I am making is that because of our present short-sighted policy and discrimination toward nursing homes, we are retaining thousands of patients in

hospitals at more than four times what it would cost to transfer them to long-term care facilities which offer services more appropriate to their needs.

It is obvious that something is very wrong with the system.

Following the Longview hearing, Congressman Bonker began collecting data from other States. The best evidence of the severity of the problem came from the nation's Professional Standards Review Organizations (PSROs). PSROs are federally funded organizations of medical professionals who are responsible for assuring that Medicare/Medicaid patients receive services that are medically necessary and in accordance with professionally recognized standards. Mr. Bonker added:

New York State told us that at least \$216 million is being wasted each year because Medicare and Medicaid patients are staying in expensive hospital beds after their physicians have determined they need a different and less costly level of care. Everyday there are thousands of patients who could be moved, but in New York there are five patients for every one Medicare/Medicaid bed that is available. While Medicare and Medicaid patients might wait months, only one percent of those awaiting placement were private paying or privately insured patients. New York PSRO officials say the number is growing and soon we will be wasting \$1 million a day or \$365 million a year in New York alone.

The Nation's Capitol provides another case in point. The number of inappropriate hospital days in the 13 hospitals in the District of Columbia increased 35 percent from 1977 through 1978. In 1978 patients spent 40,857 inappropriate days in the hospital at an average cost of \$250 a day for a total cost of \$10 million a year. The cost of home health care or placement in a nursing home would cost less than one-fifth of this amount. There is a severe shortage of nursing home beds in the District of Columbia. Patients are commonly placed in neighboring States 50-100 miles from the Capitol.

California is another State which appears to have a severe problem. Medicare and Medicaid nursing home beds are non-existent within 50 miles of San Francisco and extremely scarce in Los Angeles and San Diego. The California state-wide PSRO council said that they were aware of the fact that numerous patients were being retained in California hospitals who more properly belong in nursing homes. They estimated that a minimum of 10 percent of the Medicare and Medicaid patients are awaiting placement in a long-term care facility.

Bonker also cited the results of a recent audit in the State of Ohio by the U.S. General Accounting Office. With only part of the hospitals in the State responding to its questionnaire, GAO documented \$58 million in unnecessary costs to the government in 1977. Information from one county welfare department showed that just 3 hospitalized patients had accumulated a combined bill of over \$130,000 while the county had unsuccessfully attempted to place them in nursing homes. GAO said that patients remained in hospitals because nursing homes were unwilling to accept them.

In May of 1980 Congressman Bonker joined Congressman Bill Ratchford in conducting hearings on the subject of hospital backup

in the State of Connecticut. At those hearings, Congressman Ratchford said:

The problems that you have outlined are particularly serious. We seem to have the same situation as Washington. I would say that when the data (from this hearing) is drawn it will be extremely helpful to us. It is obvious that something has to be done.

At about the same time, Chairman Claude Pepper directed questionnaires to the hospitals and nursing homes in Florida. The results were similar. Some 48 percent of the hospitals responded to the survey and fully 90 percent of them said that they were routinely keeping senior citizens longer than necessary. Following are comments from several Florida hospitals:

- The Medical Center Hospital in Punta Gorda, Florida said, "There is no incentive for nursing homes to take Medicare patients since reimbursement is below actual costs. This is also true of hospitals, so the difference must be made up from non-Medicare patients."
- The Florida Keys Memorial Hospital in Key West commented, "The great problem is the refusal of nursing homes to accept Medicaid patients or those Medicare patients requiring more than custodial care."
- Sebastian River Medical Center, Sebastian, Florida, "I am sorry to say that the Medicare program has been an administrative nightmare for the hospital. There is no incentive for us to control costs. It is a typical government bureaucracy program."
- Fort Walton Beach Hospital Extended Care Center said, "This facility has been converted to a long-term care facility. We feel that in many instances a hospital does keep a patient until Medicare has been exhausted, not because of a lack of Medicare beds in nursing facilities in this area. Also, stringent qualifying rules for Medicare patients cause many nursing homes to accept Medicaid and private pay patients only."
- Coral Gables, Hospital, Coral Gables, "We have encountered numerous and frustrating problems expediting the transfers of our Medicare patients to Medicaid nursing homes. In several instances, Medicare certification for acute care has been denied by PSRO while the patient waited for an available State bed."
- A hospital in Hollywood, Florida provided these comments: "Please note that we don't feel that this practice is fraudulent or abusive. When a patient needs some type of care, they cannot just be placed out on the street. If a nursing home bed or other facilities are unavailable, we don't want to keep them longer, yet what choice do we have. Only the patient suffers' from the poor reimbursement coordination between various levels of care facilities. We are interested only in helping these people get well and lead healthy normal lives. Please, don't look upon it negatively as fraudulent or abusive. Help us! "

COMMITTEE QUESTIONNAIRE TO PSROs

In July 1980, Chairman Pepper directed a questionnaire to all 186 of the nation's Professional Standards Review Organizations (PSROs). PSROs are charged with the responsibility of reviewing the care received by Medicare and Medicaid patients to ascertain if they are receiving the level of care that they need and if such care and service is in conformity with professional standards in the community.

At the time this report went to press, over half of the PSROs had responded.

Question 1 asked if the PSRO had evidence that significant numbers of Medicare patients in area hospitals are being retained longer than necessary because of the absence of appropriate Medicare certified nursing home beds. Some 77 percent of the responding PSROs answered in the affirmative. Asked the same question with respect to Medicaid patients retained in the hospital longer than necessary, 65 percent said yes.

Asked if they would characterize this as a serious problem in their area, 77 percent answered in the affirmative.

Question 4 asked PSROs for a rough estimate of what it costs the taxpayer annually to pay for unnecessary hospital stays. The typical response was that it was millions and millions of dollars a year in their area but that it was difficult to place a precise figure.

Question 5 asked PSROs to rank eight factors explaining why patients are being retained longer than necessary in hospitals.

The nation's PSROs said the primary factor was the fact that nursing homes refuse to accept Medicare/Medicaid heavy care patients. They ranked the shortage of Medicare/Medicaid nursing home beds second, and said the third ranking factor was the fact that Medicare/Medicaid reimbursement rates are too low and do not permit reasonable profits to nursing homes.

The red tape and excess paperwork associated with Medicare and Medicaid was the fourth ranking factor followed by the delay or uncertainty of payments from Medicare/Medicaid.

The sixth ranking factor was that the quality of nursing home care is poor and physicians are loathe to discharge patients to them. Seventh rank was given to the proposition that physicians do not understand Medicare/Medicaid provisions, and the least ranking factor is the proposition that nursing home regulations are too high.

Similar questionnaires have been sent to executives with hospital and nursing home associations of each State. Results were being tabulated at the time the report went to press but early returns confirm the pattern detailed above.

The following are comments from the PSROs:

The State of Massachusetts has conducted a study which found that the number of patients in hospitals who were there waiting for placement in post acute facilities (nursing homes) had increased 28 percent between 1977 and 1979. During the same period, the number of Medicare and Medicaid participating nursing home beds in the State had not increased. The average number of days that patients waited in the hospital for placement increased 55 percent from

30.7 days in 1977 to 46.7. The Massachusetts Hospital Association said in its report, "The problem is widespread and not limited to a few hospitals."

Over 70 percent of the patients waiting to be placed were age 75 or older. Three fourths of those waiting were on Medicaid, and Medicaid patients in Massachusetts had to wait three times as long for placement as private paying patients. The diagnostic characteristics of the patients were severe with heavy nursing and personal care requirements.

In some counties, the backlog of patients awaiting placement is actually making it difficult for other acutely ill persons to gain prompt admission to hospitals.

Genessee Region PSRO, Inc.,
Rochester, N.Y.

The existing situation is intolerable for a variety of reasons, i.e., those in need of acute-hospital care must wait an extended period of time until a bed becomes available, those who require a skilled nursing facility or health related facility need the services provided by these facilities and are negatively impacted by being required to remain at the acute-care level while awaiting placement and, finally, the cost to the taxpayer is staggering as you can see by the answer to your questionnaire.

Suffolk Physicians Review Organization, Inc.,
Central Islip, N.Y.

The current reimbursement system lacks incentives to move patients to less comprehensive and less costly levels of care. As a consequence, many patient days must be paid for by the Medicare and Medicaid programs at the more expensive acute hospital costs.

Santa Clara Valley PSRO,
San Jose, Calif.

Attached is a copy of a study conducted by a San Diego County hospital which estimates the cost for patients awaiting placement at a skilled nursing care facility. This is a 300-bed hospital and the cost for retaining these patients in the hospital environment was \$575,298.00 and had they been placed in a skilled nursing facility, the cost would have been \$95,883.00.

San Diego/Imperial PSRO,
San Diego, Calif.

The alleged shortage of Medicare/Medicaid nursing home beds probably is a result of the lack of alternative methods of care. . . . It is our opinion that the number of days spent waiting in acute care hospitals for a lower level of care represents just the "tip of the iceberg." We know unofficially that when lower levels of care are not available, physicians refuse to document that such patients are ready for a lower level of care because the hospital would either be reimbursed at a lower rate or not reimbursed for such care.

South Central PSRO,
Richmond, Va.

There may be sufficient Medicare/Medicaid beds, but Medicare/Medicaid patients have a low priority for these beds. Private pay patients at lower levels of care have the highest priority. . . . In reality the most significant problem is the shortage of quality alternatives to nursing homes available to Medicare/Medicaid patients and others of limited financial resources. An important corollary problem is the need to coordinate home care resources at all levels of government and especially for the individual person in need. . . .

Area VII PSRO,
Ann Arbor, Mich.

First, Medicare presently pays only for post-hospital extended care after there has been a three (3) day qualifying period in an acute care facility . . . it has become increasingly apparent to us that this requirement encourages physicians to admit patients unnecessarily to hospitals in order to "qualify" the patients for extended care coverage by Medicare when, in fact, the patient's medical needs are of a chronic nature which do not require treatment or evaluation at an acute care level. Patients of this type could be placed directly in skilled nursing facilities.

PSRO of Central New York, Inc.,
Syracuse, N.Y.

Lack of community alternatives (home health aids, day care, meal service, homemaker service, etc.) make institutionalization the only alternative for some patients.

Iowa Foundation for Medical Care,
West Des Moines, Iowa.

We have been informed that nursing homes are loath to accept Medicare patients from acute care hospitals in many instances when it is believed the patient may become a Medicaid recipient.

Eastern PA Health Care Foundation,
Allentown, Pa.

The shortage of SNF beds is such a problem that all the other reasons for lengthy awaiting placement problems are overshadowed. Our facilities have felt that the paperwork, time, and expense of processing Medicare patients was ridiculous for the limited (if any) coverage approved for the Medicare patient in the SNF.

New York Area IV PSRO,
New Hartford, N.Y.

That reason is that often nursing home beds are not available due to the fact that inappropriate patients are filling those nursing home beds. Our experiences have documented many cases where patients in nursing homes are not in need of skilled or intermediate care. Often they need only minimal supervision from a relative, neighbor, etc. Many patients in nursing homes could also be taken care of in adult foster homes not requiring any medical supervision. Unfortunately, such homes are not available.

Area VIII PSRO, Inc,
Zanesville, Ohio.

Congressman Bonker made an effort to quantify the size of this problem, he projected New York's \$365 million a year estimate of loss to the nation. He said:

Since about 20 percent of Medicare and Medicaid program outlays go to New York, we may be wasting as much as \$1.5 billion a year because of our myopic policies.

PROBLEMS WITH INTERMEDIARIES AND CARRIERS

Most benefits under Medicare are administered by the Department of Health and Human Services through contracts with private insurance companies. Contractors which provide this service with respect to Medicare Part A are called intermediaries. Contractors who administer Part B are known as carriers. There are presently 77 intermediaries and 46 carriers administering Medicare. HHS pays these contractors on a reasonable cost basis. In fiscal 1978, carriers and intermediaries were reimbursed \$342.9 million and \$199.1 million respectively for their administrative costs in paying claims.

When a provider elects to participate in the program, HHS gives him a list of the contractors that serve his geographic area. The provider then has a choice of which one he would like to use. In some instances there is little choice. For example, in Florida there are only two carriers: Group Health, Inc. is the carrier for the greater Miami area while the rest of the State is administered by Blue Shield. The intermediaries are Blue Cross, Aetna and Mutual of Omaha.

There have historically been a number of complaints associated with the use of intermediaries. Critics contend that intermediaries are inefficient and that the government should provide these services directly. Indeed, there is a subdivision of HHS called the Office of Direct Reimbursement (ODR) which does this work. In an audit carried out in 1975, the General Accounting Office compared the performance of the Office with four intermediaries reporting comparatively poorer performance for the government group. The average cost of processing a bill was higher when it was processed by government, said GAO. GAO added that higher salaries and lower productivity appear to be major reasons for higher costs in ODR which GAO said, "unlike the private intermediaries, had no production standards." Moreover, financial reports required by the private firms were not required by ODR.

A more valid criticism relates to the lack of apparent ability on the part of intermediaries to ferret out fraud and abuse. Intermediaries feel that their primary responsibility is to pay claims expeditiously. Since the provider selects them, it is argued that if they make the provider unhappy, he/she will simply dismiss the intermediary and look elsewhere. It is for this reason that HHS has asked the Congress for authority to eliminate the right of providers to nominate their own intermediary as well as the right of adversely effected intermediaries to appeal and obtain judicial review. HHS believes that this right should be eliminated so that the number of intermediaries can be reduced and their work consolidated. Part of HHS's thinking is the fact that the large number of intermediaries makes it possible for regulations to be interpreted in widely differing ways.

In its June 1979 audit, the General Accounting Office agreed that there were too many intermediaries and carriers administering the program. They said there would be significant advantages in distributing larger workloads to fewer contractors. Beyond cost savings, the reduction would allow HHS the opportunity to weed out the least efficient intermediaries.

GAO also agreed with HHS initiatives in asking the Congress to change the cost-plus reimbursement formula which is used to pay intermediaries. HHS wants to use competitive fixed price contracting. GAO said that moving to this kind of reimbursement would save the taxpayers about \$32 million in administrative costs. However, GAO cautions that experience with such fixed price contracts in the Department of Defense has not been overwhelmingly favorable. GAO urged a go-slow posture so that there would be no diminution in the quality of services if the transition was made. GAO added that it thought specific performance standards were mandatory in any fixed-price contracts which might be used. GAO added that HHS had not adequately experimented with incentive contracting suggesting that this method should be tested before cost reimbursement is abandoned for intermediaries.

As far as consolidating intermediaries, GAO believes that there is a sufficient legislative mandate available in Section 14 of P.L. 95-142. The Medicare/Medicaid Anti-fraud and Abuse Amendments of 1977 were enacted following disclosures of irregularities by intermediaries in California. In that instance, an auditor who worked for the intermediary found significant evidence of fraud with respect to one provider and was subsequently hired away by the provider, appearing before the review panel arguing against his own audit exceptions. Three other employees of the intermediary went to work for the provider. Thus, one of the provisions of Public Law 95-142 bars an individual who has worked for an intermediary from going to work for a provider he audited for at least a year following his termination of employment by the intermediary.

COMMITTEE QUESTIONNAIRE

In order to learn whether providers felt that their carriers were doing a decent job, the Committee sent some 3,000 questionnaires to physicians in six States: Florida, California, Colorado, Illinois, New York and Pennsylvania. About a third of the questionnaires were returned—950 to be exact. In general, the physicians complain they do not have sufficient input into the formation of regulations by their carrier and that rules are applied inconsistently within the same geographic region. They complain that Medicare rates are inadequate as compared with what they charge private patients and that Medicaid pays even less than Medicare. The overwhelming number of physicians said that the Federal efforts to fight fraud and abuse have had little or no impact. Finally, the majority of physicians would look favorably on a bill to allow them to exempt from their taxes a certain amount of Medicare monies as an incentive to encourage providers to accept assignment.

Question 1 asked how many physicians accepted assignment. Some 87 percent said they accepted assignment at least for some patients, but only 17 percent said they did so for all their patients.

Most physicians, 83 percent, do not use a professional billing service as evidenced by the answers to question 2.

Question 3 indicated that most physicians are satisfied with their carriers. Nationwide, 69.2 percent of all doctors rated their intermediary "Excellent," "Good," or "Fair." The remaining 30 percent scored them poor or unacceptable.

Interestingly, however, question 4 shows that most doctors do not believe that their bills are paid promptly. Some 54 percent of those in the six State survey said they were not paid promptly. This complaint is all the more interesting in view of the fact that about 60 percent of all bills are paid within 60 days according to the responses to question 5.

As shown by question 6, 76 percent of those responding said that the fees allowed by Medicare were not reasonable in relation to what they charged their private patients.

As question 7 indicates, two-thirds of all physicians said Medicaid fees were generally less than the fees Medicare paid for identical services.

Question 8 shows that 52 percent of all physicians responding said they experienced inconsistent application of regulations by carriers in the same geographic region.

Question 9 shows that 70 percent of the physicians in the six State study reported they did not have significant input with the carrier in the development of guidelines and policies.

Asked in question 10 if the national effort to ferret out fraud and abuse has been successful, only 14 percent of the physicians answered in the affirmative. Most physicians said they did not know what effect, if any, the Inspector General and the State Fraud and Abuse Units have had in eliminating fraud.

As question 11 shows, 55 percent of the physicians would support a bill which would allow them to exclude from income the first \$25,000 they receive from Medicare as an inducement to accept assignment. This proposal was subsequently modified as detailed in Section VII of this report.

Tabulations from the questionnaire follow.

COMMITTEE QUESTIONNAIRE TO PHYSICIANS

1. For what percentage of your Medicare patients do you accept assignment?

<i>Range</i>	<i>Physician response (percent)</i>
0.....	12.8
1 to 25 percent.....	48.7
26 to 50 percent.....	7.0
51 to 75 percent.....	4.2
76 to 99 percent.....	9.8
100 percent.....	16.8
Not available.....	0.7

2. Do you use a professional billing service?

	<i>Physician response (percent)</i>
Yes.....	16.2
No.....	83.1
Not available.....	0.7

3. How would you rate the performance of your Medicare carrier?

<i>Range</i>	<i>Physician response (percent)</i>
Excellent.....	4.1
Good.....	27.8
Fair.....	37.3
Poor.....	21.1
Unacceptable.....	7.7
Not available.....	2.0

4. Are your bills paid promptly?

	<i>Physician response (percent)</i>
Yes.....	40.3
No.....	53.9
Not available.....	5.8

5. After you have submitted your bills, are most of them paid?

<i>Range</i>	<i>Physician response (percent)</i>
Within 30 days.....	13.7
In 30 to 60 days.....	44.9
In 60 to 90 days.....	25.2
90 days or more.....	11.8
Not available.....	4.4

6. Are the Medicare fees allowed by the carrier reasonable in relation to your charges to private paying patients?

	<i>Physician response (percent)</i>
Yes.....	21.3
No.....	76.0
Not available.....	2.7

7. If you participate in Medicaid, are the fees allowed more than, equal to, or less than those allowed by Medicare?

	<i>Physician response (percent)</i>
More than.....	4.6
Equal to.....	5.6
Less than.....	66.3
Do not participate.....	18.2
Not available.....	5.3

8. Some physicians have complained about inconsistent application of regulations between carriers in the same geographic area. For example, one carrier may allow \$50 for a certain bill while a second allows only \$10. Is this a significant problem in your area?

	<i>Physician response (percent)</i>
Yes.....	52.2
No.....	37.1
Not available.....	10.7

9. Does the medical community in your area have significant input with the carrier in the process of developing guidelines and policies?

	<i>Physician response (percent)</i>
Yes.....	17.8
No.....	69.5
Not available.....	12.7

10. Some time ago, the Congress enacted legislation creating the Office of Inspector General in HEW, and State units to fight Medicare and Medicaid fraud. We are now spending about \$75 million a year on this effort. How successful have these units been in reducing fraud? ¹

	<i>Physician response (percent)</i>
Very successful.....	1. 9
Moderately successful.....	12. 7
No effect at all.....	12. 1
Don't know.....	71. 2
Not available.....	2. 1

11. I plan to introduce legislation to encourage physicians to accept assignment from Medicare. My bill would allow those physicians who agree to accept assignment from Medicare patients to exclude from their Federal income tax the first \$25,000 in income they receive from Medicare. Could you support this legislation?

	<i>Physician response (percent)</i>
Yes.....	55. 4
No.....	37. 3
Not available.....	7. 3

GROWING MEDICARE GAPS

The House Select Committee on Aging has held numerous hearings and issued several reports over the last few years highlighting Medicare's ever-growing gaps. In September of 1976, the Committee issued a report relating to the need for Medicare to cover eyeglasses, dental care and hearing aids. This report is summarized below. The Committee has held more than a dozen hearings since 1975 which have highlighted the importance of liberalizing Medicare's home health care benefits to provide the elderly with some alternative to institutionalization. In this respect, the Committee requested and received a report from the U.S. General Accounting Office which underscored the growing need. The Committee also issued a report dealing with most of Medicare's gaps called, "New Perspectives in Health Care for Older Americans," which is summarized below.

EYEGGLASSES, DENTAL CARE AND HEARING AIDS

The Committee's report prepared by the Subcommittee on Health and Long-Term Care, is entitled, "Medical Appliances and the Elderly: Unmet Needs and Excessive Costs for Eyeglasses, Hearing Aids and Dentures." The primary recommendation of the report is that Medicare should cover these gaps. The report concluded that the well-being of virtually all of America's elderly is dependent on one or more medical appliances. Presently, the massive needs of the elderly for appliances like eyeglasses, dentures, and hearing aids are unmet because, in many cases, the elderly cannot afford the devices and because public and private health benefit programs have provided only limited help in this area. The elderly who are able to afford needed

¹ In a similar questionnaire sent to all hospitals in Florida only 2 percent said that government fraud and abuse efforts have been very successful and 23 percent were willing to say they had been moderately successful. The remaining 73 percent said there has been no effect at all or that they did not know if the establishment of the Inspector General's Office and of State Medicaid fraud units has had any effect.

medical appliances are frequently the victims of abuses such as overpricing and unnecessary services.

With respect to vision care, the report said:

More than 20 million elderly Americans require and own eyeglasses. However, over five million elderly Americans are wearing glasses which need correction.

Serious evidence of abuse has come from a New York survey which demonstrated that one out of five eye examinations given by optometrists resulted in unnecessary prescriptions.

Numerous surveys of retail firms selling eyeglasses are conclusive evidence of overpricing. The surveys show a 200 to 300 percent variance in the cost of identical eyeglasses.

Medicare does not cover the cost of eyeglasses or related examinations. Medicaid is only slightly more helpful, paying for eyeglasses for those elderly people who are eligible in only half the states. Private insurance companies rarely cover any vision care expenses.

The report went on to say that:

Dental problems, such as tooth decay and periodontal disease, are so widespread among the elderly that half of all persons over 65 have no natural teeth.

Some 6.2 percent of those elderly people who are without natural teeth also have no dentures. An additional 30 percent of those without natural teeth do have dentures, but they are ineffective and require refitting or replacement.

The subcommittee found that identical dentures, including identical fitting procedures, range in price from \$100 to \$1,000, and concluded that this discrepancy, in large part, reflects overpricing.

Medicare covers only selected forms of dental surgery, but not routine dental care or dentures. Medicaid programs in 36 states do cover dental care and dentures, but that number continues to decline as many states strive to cut back their expenditures. While dental insurance is the fastest growing line of private health insurance, dental costs remain the least insured major health cost in the United States.

With respect to hearing care, the report concluded that:

More than one half of all persons over 65 suffer from impaired hearing. For 8 percent of the elderly, the problem is so severe that they are unable to hear words spoken in a normal voice.

The report continues:

The hearing aid delivery system, as presently structured, fosters a clear and continuing conflict of interest that pits the profit orientation of the businessmen who sell hearing aids against the health and economic interests of elderly consumers. Studies have demonstrated that the result of this system of allowing the hearing aid dealers, rather than physicians, to determine the need of elderly consumers for aids, is frequent recommendations by dealers for hearing aids that cannot help buyers.

According to three different panels of hearing experts, the training that hearing aid dealers receive is totally inadequate. To compound this problem, many States have no law which set up minimum educational standards that dealers must meet. Many other States do have these laws, but they are often ineffective and frequently lead to the hearing aid dealers regulating themselves.

There is almost a total lack of oversight and scrutiny of the hearing aid industry. The subcommittee heard evidence from the Federal Trade Commission of numerous instances of misrepresentation and anti-trust violations such as price-fixing in the hearing aid industry.

The cost of hearing aids is excessively high (two and a half times the wholesale price) and represents a formidable barrier to those elderly people who need the devices.

Medicare does not pay for hearing aids at all. Medicaid pays for hearing aids for the elderly in only 11 States. Private health insurance policies rarely cover hearing aids.

Finally, the report includes these conclusions about prosthetic devices and other durable medical equipment:

There is evidence of significant overpricing of pacemakers. The Public Citizen's Health Research Group has reported that the actual cost of a pacemaker is "several hundred dollars." Yet, these prosthetic devices generally sell for \$1,300. The Department of Health, Education, and Welfare continues to ignore the overpricing and to pay these unreasonably high prices to manufacturers for pacemakers that are purchased by those eligible for Medicare. Pacemakers are big business—endorsed for investment by a reputed Wall Street firm because of 30-50 percent annual profits—despite Medicare requirements for HEW to reimburse only "reasonable cost." The subcommittee found that since Medicare pays for most pacemakers, patients and doctors are not concerned with price, providing little if any incentive for manufacturers to cut prices.

There is also conclusive evidence of the waste of 10 million taxpayer dollars per year because Medicare allows excessive payments, as opposed to cheaper methods of acquisition or leasing of hospital beds, crutches, wheelchairs, and dialysis equipment, that are covered by Medicare. Four years ago, legislation was passed authorizing HEW to take the necessary steps to end that waste. Yet, the Department has progressed only to the point of conducting a "design of an experimental concept."

There is a serious controversy concerning home blood pressure monitoring kits. Manufacturers of higher-priced mercurial (using mercury level to measure) devices claim that this type of device is the only accurate way to measure blood pressure. On the other hand, distributors of inexpensive aneroid (using air pressure) devices argue that this type of device, while not as accurate as a mercurial device, is certainly accurate enough for home use since it meets the fed-

eral accuracy standard of .3 millimeters. Thus, the aneroid distributors argue that any difference in accuracy does not justify the higher cost of mercurial devices.

An anomaly in wording of Section 1861(s) of Title XVIII of the Social Security Act has led to denials of coverage of oxygen tents and other durable medical equipment to patients in skilled nursing facilities and residents of intermediate care facilities while elderly people living outside these institutions do receive this coverage.

The subcommittee recommendations to Congress read as follows:

1. *Medicare part B should be extended to cover eyeglasses, hearing aids and dentures and related medical care*

Because of the great need of the elderly for eyeglasses, hearing aids, and dentures, and because of the hardship that paying for these expensive appliances represents to them, the subcommittee considers it essential that federal assistance be increased to meet those needs. This should be done either as part of a comprehensive national health insurance program or separately, as an extension of the Medicare program.

The subcommittee believes that in the absence of national health insurance it is vital that the optional Part B section of Medicare be extended to cover the cost of hearing aids, eyeglasses, dentures, and medical care related to fitting those items. With the extension, elderly people who choose to enroll in the voluntary Part B program, would be covered for 80 percent of the reasonable charges for these health expenses once they had spent more than \$60 in that year on covered Part B medical care expenses.

2. *Medicare should utilize contract purchasing where feasible in providing eyeglasses, hearing aids, and dentures to the elderly*

While it is imperative that Medicare benefits be extended, it is equally imperative that the extension not be done in such a way as to allow the inadequacies and abuses of the present delivery system of medical appliances to continue. The subcommittee thus recommends that volume contract purchasing of eyeglasses, hearing aids, and dentures be utilized by the Department of Health, Education and Welfare to provide these appliances to those elderly people who opt to receive the Part B coverage. HEW should begin to experiment with contract purchasing immediately. Within 5 to 10 years, it should be the official HEW policy that contract purchasing be utilized wherever feasible in the purchase of eyeglasses, hearing aids, and dentures for those covered. The subcommittee also recommends that states consider making use of contract purchasing of medical appliances as part of their Medicaid programs. Existing government contract purchasing programs are conclusive proof that this recommendation would result in a reduction in the actual cost of medical appliances from the excessively high levels of the present.

Under contract purchasing, manufacturers of medical appliances would submit bids to the Department of Health, Education and Welfare. HEW would on the basis of competitive bidding, award contracts to selected manufacturers. The manufacturers would then distribute the agreed on devices to retail outlets. The retailers would provide the health aids to those elderly people who have paid the Part B premiums and would receive reimbursement from Medicare.

The following comments from experts at Committee hearings further highlighted the problem:

They pay but not in dollars. They pay in the quality of life. Some cut down on food requirements. Some go without the proper type of shelter. Some cut off their social life. Many just do without (eyeglasses, hearing aids, and dentures) and fall back into more and more seclusion and live a restricted life because these appliances are not available to them as they should be.

Mr. Nelson H. Cruikshank,
President, National Council of Senior Citizens.

The only way out is to make impossible choices. It is impossible for senior citizens to decide whether or not they want to hear what goes on in the world or whether they want to eat.

Dr. Sidney Wolfe,
Director, Public Citizen's Health Research Group.

If we are lucky, we will all grow old. But how frightening to grow old and not be able to see clearly, hear distinctly, or eat properly because we cannot afford the necessary medical appliances to aid our failing faculties.

Dr. Robert B. Lytle,
American Dental Association.

NEED FOR LIBERALIZING MEDICARE HOME HEALTH BENEFITS: ALTERNATIVES TO INSTITUTIONALIZATION

In January of 1976, the Committee issued an important report through the Subcommittee on Health and Long-Term Care which highlights the need to liberalize home health benefits. The case for doing so has been demonstrated in previous pages of this report. The Committee considered it important to restate the findings it reached. The report entitled, "New Perspectives in Health Care for Older Americans," is summarized below.

In its investigation, the subcommittee found extreme proliferation and fragmentation in both HEW and the Congress concerning the delivery of health services to the elderly, to the detriment of the patient who requires a continuum of care. The subcommittee further found institutional bias both in the Department of HEW and under current health benefits statutes, which is largely responsible for the current inappropriate and unnecessarily costly placement of hundreds of thousands of the nation's nursing home patients.

The recommendations include both incremental and long-range proposals. They focus on the very serious unmet need for home health services for approximately two million chronically ill elderly; the need to reduce inappropriate institutionalization of elderly patients with cost-effective alternatives; the need to develop better methods of assessing long-term care patients; and the need for better methods of referral to the proper level and type of care. While recognizing that there is more to long-term care than nursing homes and home health care, these components are major, and this first report of the subcommittee focuses principally on them.

Recognizing the lack of priority for home health care for the elderly in the Federal health dollar—approximately 1 percent of Medicare and Medicaid—the recommendations not only suggest extension of current home health benefits under existing and additional programs, but propose innovative alternatives to institutionalization: outpatient clinics specializing in geriatrics, multipurpose senior centers including health and nutritional facilities; elderly day health care centers; community care organizations; mobile health units; and other approaches utilizing a “consortium of partners,” where Federal, State, local, and voluntary agencies cooperate in maximizing patient care. The subcommittee has recommended a system of community long-term care centers to coordinate the provision of health services for older Americans in order to provide linkage in the current fragmented delivery system.

The subcommittee believes the present acute-medical orientation of the Nation’s health policy, largely based upon compromises in the 1965 Medicare and Medicaid statute, should be changed. A preventive and medical-social model needs to be developed to avoid later costly curative care and allow the elderly to be productive in the community . . . It is hoped that the recommendations will lead to alteration of the fragmented approach of the past, which has kept hundreds of thousands of older Americans inappropriately institutionalized and has denied to still others inadequate care.

The report recommended the liberalization of Medicare’s home health benefits, Medicare coverage for day care and HMOs for the elderly, and called upon the Congress to help end the fragmentation in the delivery of health care services to the elderly. As noted in Section IV of this report, many of this report’s recommendations are close to implementation today.

DRUGS

The Committee has held several hearings which underscore the need for Medicare to cover outpatient prescription drugs. One hearing held in October 1977 highlighted Medicare’s gaps with particular emphasis on the need for prescription drug coverage. In November 1977, Congressman Pepper joined Senator Edward Kennedy, Chairman of the

Subcommittee on Health of the Senate Labor and Human Resources Committee in hearings held in Miami. Chairman Pepper said:

The lack of outpatient prescription drug coverage was listed as one of the most glaring gaps in the program which was intended to give older people a hedge against the overwhelming cost of health care. At the present time, only those drugs which are given in a hospital or administered by a physician are covered at all under the Medicare program. Consequently, those who suffer from hypertension, diabetes, arteriosclerosis, and so on, must meet the cost of treatment for these conditions out of their own pockets.

Americans over 65 comprise only 11 percent of the population, but account for about 25 percent of total drug expenditures annually. In fiscal 1976, the total bill for drugs and drug sundries for the elderly was \$2.78 billion. Medicaid and other sources paid some 14.1 percent of this bill, but the bulk, almost 86 percent, came out of the pockets of those least able to pay—the elderly themselves.

Experts before our Committee pointed out that efforts to provide coverage for drugs under Medicare have met with opposition for the last 10 years. Such opposition has prompted me to join Senator Kennedy in sponsoring legislation which would provide free drug benefits for all the 24 million elderly persons in the country, not just those who qualify for Medicaid, Medicare or Social Security. This bill would fill in this recognized gap in the Medicare program; it would pave the way for universal drug coverage for the elderly under national health insurance. It is a rational proposal, with cost controls, a separate and efficient administrative mechanism, and a reasonable timetable which allows adequate time for setting up the administrative apparatus.

I am particularly gratified to learn that this legislation is currently pending before this subcommittee, Senator Kennedy. You know I will be pleased to assist you in any way I possibly can to report this important measure out of your subcommittee at the earliest possible time. The failure of Medicare to provide coverage for these prescription drugs is one mistake I believe we should urge the Congress to correct before the enactment of national health insurance.

It is some measure of the importance of the problem that even during hearings highlighting drug misuse in nursing homes, held by the Committee in June 1980, witnesses again emphasized the importance of expanding Medicare's benefits to cover out-of-hospital drugs for the elderly.

MENTAL HEALTH CARE

No listing of gaps in Medicare would be complete without mention of the grossly inadequate coverage for mental health care. The Committee has highlighted the problem as noted in Section II of this report, through hearings and with a National Conference on Mental Health and the Elderly, opened by First Lady Rosalynn Carter. At that conference, Mrs. Carter said:

Our Commission was shocked to find that while as many as 25 percent of our older citizens may suffer from significant

mental health problems, very few actually receive adequate treatment. For example, only 2 percent of all the patients seeing a private psychiatrist are elderly, and less than 3 percent of the budget of the National Institute of Mental Health has been spent on the plight of older Americans. The mental health problems of old age have many complex roots. Financial worries, unhappiness over the loss of social status, grief over the death of loved ones all can lead to depression, even suicide. Twenty-five percent of all suicides reported are committed by the elderly. The stigma of mental illness coupled with the stigma of old age can have devastating results. Our Commission found a woeful lack of professionals, doctors, nurses, mental health practitioners trained to address these special circumstances; and so we have more than 1 million people over the age of 65 leading lonely and unproductive lives in nursing homes. Because we failed to develop professionals to do outreach and home health care, many older people are not even brought into contact with existing mental health and other social services. Our Commission called for new effort to include courses in geriatric medicine in medical schools, schools of nursing, clinical psychology and social work, and in the training of paraprofessionals and other health providers. This is so important. . . . Nowhere are the deficiencies in Medicare more apparent than in its mental health benefits. The program has set an unfortunate precedent in public financing efforts for the discriminatory treatment of people with mental disabilities. As restrictive as the original Medicare legislation was in paying for mental health treatment, today because of inflation Medicare would provide for less than half the services the elderly would have been able to receive a decade ago.

Chairman Pepper said:

Our country is in the Dark Ages in its attitude toward mental illness, especially among the elderly. I do not know why we seem to have handicaps in our vision, in our feeling, in our spirit, limitations upon our understanding of people who are burdened with problems. For example, with respect to Medicare, only \$250 a year is available for aid to the mentally ill aged. Whereas, if the illness were not mental, there would not be a limitation on the amount of reimbursement allowed under the Medicare program.

Congressman John Paul Hammerschmidt, Ranking Minority Member of the Subcommittee on Housing and Consumer Affairs, said:

There is great need for expanding the base of knowledge of mental health problems. At present, the amount of mental health research focuses exclusively on the elderly is far less than research that addresses the needs of the other age groups.

Congressman Mario Biaggi, Chairman of the Subcommittee on Human Services, commented:

As far as the United States is concerned, it is clearly failing in its commitment to respond to the mental health needs of

our senior citizens. And one of the areas where it fails is in the practice of age discrimination in the provision and delivery of Federal mental health services.

Congressman Charles Grassley, Ranking Minority Member of the House Aging Committee said:

I stress the need of a comprehensive approach to mental health which overspans the medical field and includes the social and economic stimuli that have shaped the mental well-being of the individual over his or her lifetime.

Seen in proper context, it is evident that most mental illness is induced over a period of time by the accretive effects of conditions that erode individual resistance and maim the human spirit. This cumulative process accounts for the high incidence of mental illness among the elderly and especially the institutionalized elderly. However, it would be a grave injustice to the elderly to equate mental illness with age.

Because of this Committee's interest, legislation pending in the Congress which will soon be enacted, would triple the amount of Medicare coverage for mental health services.

FRAUD: THE CONTINUING PROBLEM

Disclosures of massive fraud in Medicare and Medicaid have surfaced in the media since 1975. Major Congressional investigations have confirmed estimates that 10 percent or more of the two programs is being lost to fraud. Among the Congressional Committees which have conducted hearings on this problem are the House Committee on Government Affairs, the House Ways and Means Committee, the House Interstate and Foreign Commerce Committee, the House Aging Committee, the Senate Finance Committee, the Senate Permanent Investigations Subcommittee of the Government Operations Committee, and the Senate Aging Committee. The General Accounting Office has also conducted numerous audits which verify a significant amount of fraud in the two programs.

Congress acted in 1976 to create the Office of Inspector General in the Department of Health and Human Services to fight fraud and abuse. The next year, Congress enacted provisions, making an attempt to defraud the programs a felony instead of a misdemeanor, creating State fraud and abuse units, and requiring that those providers found guilty of fraud be expelled from the program.

The Inspector General's 1978 report estimated that up to \$7 billion may be lost to fraud and waste from all HHS programs with just over \$2 billion (about 10 percent) of the Medicare program being lost to fraud. The 1979 report from the Inspector General reports major inroads developing capabilities to deal with the problem. Some 152 cases of suspected fraud were opened in that year by HHS, 52 of which related to fraud in government health programs. The report describes one Department initiative called Project Integrity which utilized the computer to point investigators towards those who were defrauding the program. The report is also candid in the admission that the Department has a huge backlog of unsettled audits which could result in repayment of funds to the Treasury and perhaps to more prosecutions.

In August 1979, the Senate Aging Committee conducted hearings which highlighted the continued fraud among for-profit and private non-profit home health agencies in the State of Florida. Coming two years after Congress enacted the anti-fraud and abuse amendments, the disclosures of widespread fraud were truly shocking. Similar hearings on this same subject were held by the Oversight Subcommittee of the House Ways and Means Committee. The Senate Finance Committee held hearings on fraud and abuse in health maintenance organizations in May of 1978 and the House Aging Committee conducted hearings on fraud and racketeering in Medicare and Medicaid in October 1978 and in May of 1980.

Hearings by the House Select Committee on Aging in May 1980 were most significant. Francis Mullen, Assistant Director of the Criminal Investigation Division of the Federal Bureau of Investigation told the Committee of the Bureau's undercover investigation in California and its expanded effort to stop Medifraud nationwide. Mullen told the Committee that "corruption has permeated virtually every area of the Medicare/Medicaid health care industry." He said that illegal kickbacks have "become a way of life" for clinical laboratories, nursing homes and other providers in the Medicare/Medicaid programs. The FBI said that no segment of the health care industry and no section of the country is free from these kinds of fraud.

Mr. Mullen said that abuses as outlined in Congressional hearings in 1976 were "still occurring and apparently are becoming more widespread." He said the only competition that the Bureau found in the health care field was the level of the kickbacks paid to providers. He said that dishonest providers have absolutely no fear of being caught and prosecuted and that they believe that even if they are caught, the worst that will happen to them is that they will have to pay back funds that they have stolen.

Mullen said that the FBI had developed over 600 cases nationwide and that virtually every one of the 59 FBI field offices has found significant problems with the integrity of the government health care programs.

Also testifying at the hearing was Richard Lowe III, Acting Inspector General of the Department of Health and Human Services, who stressed his cooperation with the FBI and noted the shortage of manpower in his office caused by the transfer of sizable numbers of investigators to the new Department of Education.

Congressman Pepper urged the Inspector General to continue his efforts, noting with some sympathy that the Inspector General has responsibility for over 300 programs in addition to Medicare and Medicaid. Congressman Bonker said the FBI testimony was one of the strongest indictments he had heard. Congressman James Abdnor, Ranking Minority Member of the Health Subcommittee, lamented the loss of millions of dollars which he said could be used to provide expanded benefits to the elderly.

Following the hearings, Congressman Bonker called upon the Justice Department to establish units fashioned after the organized crime strike forces to deal with the problem. He also suggested expanding the funding for the FBI. Chairman Pepper noted his sponsorship of legislation, H.R. 5170, to continue funding for the State fraud units to help ferret out fraud and abuse. He called upon the Congress to pass the measure before the end of September 1980.

IV. ANALYSIS OF PENDING REFORM LEGISLATION

There are currently several bills working their way through the Congress which have bearing on the primary problems with Medicare as identified in the last two sections of this report. Among these reforms is H.R. 4000, the Medicare and Medicaid Amendments of 1980. The bill was referred to both the House Ways and Means Committee and the House Interstate and Foreign Commerce Committee. Both Committees have approved highly similar versions of the bill and ordered it reported to the Floor. Companion legislation, H.R. 3990, was also jointly referred and approved by both Committees.

In order to insure passage in this session of the Congress, Congressmen Henry Waxman, Chairman of the Subcommittee on Health of the House Commerce Committee and Charles Rangel, Chairman of the Subcommittee on Health of the Ways and Means Committee have added the most important provisions of the two bills as amendments to H.R. 7765, the Omnibus Reconciliation Act of 1980. That bill is referred to hereinafter as the House Reconciliation bill. It passed the House on Sept. 4, 1980.

The Senate Finance Committee added its Medicare and Medicaid reforms to a House-passed private bill, hence the number H.R. 934. This legislation has been reported to the Senate floor. However, the Senate moved more swiftly passing its own Reconciliation bill, S. 2285, on July 30, 1980.

As will be noted, the pending reforms make some inroads towards closing Medicare's gaps: there is little attempt to deal with the fact that few physicians will accept assignment; there is some effort to reduce overutilization of hospitals and to help improve the quality of nursing home care as well as to reduce the pervasive fraud which has marked the Medicare and Medicaid programs. On balance, the pending reforms will be helpful but obviously will fall short of what is needed.

CLOSING MEDICARE'S GAPS

Pending reform legislation would provide, to a very limited extent, for compensation to dentists and optometrists as well as liberalizing home health care and ambulance services.

Dentist's services.—Those dental services which were serious enough to require hospitalization and surgery by a dentist would be covered by Medicare. Under present law, such surgery would be covered if performed by an M.D. but not by a dentist; dentists are presently excluded from the definition of "physicians" for purposes of being compensated under the Medicare law. Similar provisions are found in H.R. 934—which is the Senate Finance Committee's vehicle—and in the House Reconciliation bill.

Optometrist's services.—The House Reconciliation bill will authorize Medicare Part B reimbursement to optometrists for services related to the diagnosis of "aphakia" which relates to patients without a lens in one or both eyes. Under present law, these services are covered only if rendered by a physician.

Increased mental health benefits.—The House Reconciliation bill would increase the outpatient mental health benefits under Medicare from \$250 to \$750 annually and reduces the copayment for such services from 50 to 20 percent of reasonable charges. The expansion will include services provided by community mental health centers and qualified clinical psychologists. No similar provision is contained in the Senate bills.

Ambulance services.—The Senate bill, H.R. 934, permits payment for ambulance services to a more distant hospital when the nearest hospital does not have staff qualified to undertake the required care. Ambulance transportation to receive radiation therapy and other specialized services could also be covered under certain circumstances. The inclusion of this provision will cost \$1 million in the first year. This amendment is not included in either of the House bills, however, report language to effectuate this intent is included in the report accompanying the House Reconciliation bill.

Liberalized home health benefits.—H.R. 934 in the Senate and the House Reconciliation bill both include provisions to liberalize home health benefits as delineated below. The cost of these reforms is estimated at \$16 million next year. The reforms are similar to those suggested by Congressman Claude Pepper in his bill, H.R. 2567. The provisions of the Senate versions as taken from the report accompanying H.R. 934 read as follows:

Elimination of limitations.—The bill removes the provisions in existing law that limit Medicare home health benefits to 100 visits per spell of illness under part A and 100 visits per year under part B. In addition, the bill removes the requirement that a beneficiary has to be an inpatient in a hospital for at least 3 days before he can qualify for part A home health benefits.

Under present law, a beneficiary is eligible for 100 home health visits per spell of illness under part A of Medicare following an inpatient stay in a hospital of at least 3 days. Beneficiaries are also eligible for 100 home health visits per calendar year under part B of Medicare whether or not they have been hospitalized previously. By removing the numerical limit on home health visits and the 3-day prior hospitalization requirement, the Committee believes that the home health benefit will become more widely available to eligible persons in need of such care. The provision would be effective with respect to services provided on or after July 1, 1980.

Plan of Care.—Under current law, a plan of care must be established by a physician in order for a person to receive home health benefits under Medicare and Medicaid.

The bill requires that in establishing the plan of care, the plan must include a program for patient education aimed at achieving, to the extent possible, maximum independence from the need for care provided by other persons. The amendment would also allow physician assistants and nurse practitioners providing services in rural areas who are under the general supervision of a physician to establish plans of care for home health patients.

Reasonable costs.—The bill requires the Secretary of HHS, within six months after enactment, to establish guidelines for determining direct and indirect incurred costs of home health providers to serve as a basis for determining the reasonable cost of home health services. The guidelines would apply to specific line item costs of home health services.

Services in adult day care centers.—Some Medicare patients, though essentially homebound, are taken to an adult day care center as a means of enriching their lives. An amendment accepted by the Finance Committee would cover home health services provided in such centers on the same basis as when provided in the patient's home where the center: (1) is a nonprofit center which is eligible for funds under title XX of the Social Security Act, and (2) meets standards prescribed by the Secretary and applicable State and local health and safety requirements.

Homemaker-home health aides.—The bill amends the reference to "home health aide" in the Medicare home health benefit coverage provisions. The proposed new reference, to "homemaker-home health aide," is more descriptive of the services performed by these personnel.

Report on costs and utilization.—The bill requires the Secretary of HHS to monitor the costs of home health services and to report to the Congress within thirty days if such costs are increasing faster than other medical indices.

One troubling difference between the House and Senate versions of the home health amendments is that the House Omnibus Reconciliation bill would remove the provision requiring State licensure of proprietary home health agencies as a prerequisite to their participation in Medicare. The Committee on Aging has been on record as opposing this change. See Proprietary Home Health Care, Joint Hearings of the Senate and House Aging Committees, October 22, 1975. Present law allows for-profit home health agencies to participate in the program only when the States agree to license and accept responsibility for them. It should be noted that State licensure is a prerequisite for nursing homes and other providers to participate in Medicare. There are valid reasons why this provision exists in current law and why it should be retained.

MEDICARE REIMBURSEMENT TO HMO's ¹

The House Reconciliation bill includes a provision to provide Medicare reimbursement to health maintenance organizations (HMOs) on the basis of a prospectively determined per capita rate equal to 95 percent of the cost of providing Medicare benefits to beneficiaries outside the HMO. (See similar provisions in Chairman Pepper's bill, H.R. 638.) No similar provision is contained in the Senate legislation.

Under present law, health maintenance organizations may contract for Medicare reimbursement on either a cost or risk basis. However, only one HMO has opted to be reimbursed under the existing risk formula. HMOs have generally found the risk reimbursement formula

¹ To avoid confusion, this section is taken directly from the Ways and Means Committee report on this subject.

unacceptable because retroactive adjustments are made which take into account the costs actually incurred by the HMO. The new risk formula would provide a prospectively determined per capita payment for each enrollee. This payment per enrollee acts as a limit on HMO revenues, creating financial incentives for the organization to control costs and to provide only the least expensive service appropriate to the enrollee's needs. These incentives are passed on to the physician by paying him on a salary basis, providing a bonus or profit sharing arrangement when costs are kept low, or providing other meaningful incentives for him to control costs and utilization.

The rates of Medicare payment under the risk contract would be set at 95 percent of the per capita amount that would be paid by Medicare for services provided to an enrolled beneficiary (classified by actuarial factors such as age and sex) by other providers in the geographic area of the HMO. For example, the rate of payment for a 65 year old beneficiary would be lower than the rate for an 85 year old beneficiary.

A second important feature of the bill's risk reimbursement formula requires the HMO to provide to enrolled Medicare beneficiaries increased benefits or reduced cost-sharing, to the extent that the Medicare reimbursement exceeds the amount an HMO would charge its Medicare members if that amount were determined using a community rating system (adjusted for the specific benefits covered by Medicare and the utilization characteristics of Medicare beneficiaries). This approach would create incentives for Medicare beneficiaries to enroll in HMOs and assure that the economies realized through HMO efficiencies, in excess of the HMOs usual profit and other retained funds, accrue to beneficiaries. The HMO would determine what additional benefits, reduced beneficiaries cost sharing or combination of the two are most appropriate for its Medicare enrollees. The Secretary would be required to report to the Congress three years after enactment on the type and amount of additional benefits which are being provided.

The bill also requires the Secretary to study and report to the Congress the causes for beneficiary disenrollment from HMOs under Medicare contracts, paying particular attention to the utilization and quality of services provided these beneficiaries and their medical condition prior to disenrollment.

In order to assure that an HMO makes a genuine effort to enroll Medicare beneficiaries, the HMO would be required to have an open enrollment period at least every year during which it accepts Medicare beneficiaries up to the limits of its capacity and without restrictions in the order in which they apply for enrollment. This requirement is necessary since most HMOs enroll only groups and Medicare beneficiaries, in many instances, would be enrolling as individuals; without assurance of open enrollment, such Medicare beneficiaries would have no access to the HMO. No HMO, however, would have to accept proportionately more Medicare enrollees than are represented in the population in the geographic area served by the HMO.

The cost of this measure is estimated at \$40 million in 1984.

ENCOURAGING PHYSICIANS TO ACCEPT ASSIGNMENT

There is only one provision in the pending bills which is intended to encourage physicians to participate in Medicare and to accept assignment. The Senate Finance Committee included a provision in

H.R. 934 which changes the criteria for determining "reasonable charges for physician services." The amendment has been carried in the new reconciliation bill.

Medicare currently utilizes more than 200 different "localities" throughout the country for purposes of determining part B "reasonable" charges. For example, one State has 28 different localities. The Committee notes that this has led in many instances to marked and unjustified disparities in areas of the same State in the prevailing charges for the same service. Additionally, under present law, increases in prevailing charges are limited to levels justified by changes in the costs of practice and wage levels. The Committee is concerned that the effect of present law is to further widen the dollar gap between prevailing charges in different localities.

The bill provides for the calculation of statewide median charges (in any State with more than one locality) in addition to prevailing charges in the locality. To the extent that any prevailing charge in a locality was more than one-third higher than the statewide median charge for a given service, it would not be automatically increased each year. This provision would not reduce any prevailing charges currently in effect. However, it would operate, to the extent given charges exceed the statewide average by more than one-third, to preclude automatically increasing those charges.

Under existing law, Medicare allows a new doctor to establish his customary charges at not greater than the 50th percentile of prevailing charges in the locality.

The bill would permit new physicians in localities which are designated by the Secretary as physician shortage areas, to establish their customary charges at the 75th percentile of prevailing charges (rather than the 50th) as a means of encouraging doctors to move into these communities. It would also permit doctors presently practicing in shortage areas to move up to the 75th percentile on the basis of their actual fee levels.

The Senate Finance Committee estimates that the proposal will even save money—\$15 million in fiscal 1981. No similar provision is carried in either of the House bills.

A related provision found in H.R. 934 but nowhere else would require the development of a uniform claims form. The Senate Finance Committee noted that Medicare and Medicaid have added to the paperwork burden carried by physicians, hospitals, skilled nursing facilities and other health care organizations as a result of the proliferation of forms. For several years, HHS has been working to develop standardized claims forms that might be used by physicians and institutions in billing both Medicare and Medicaid. This effort has been carried out in conjunction with provider groups, including the American Medical Association, the American Hospital Association, and the American Dental Association. The National Association of Blue Cross-Blue Shield Plans and the Health Insurance Association of America also participated. Standardized physician benefits forms now have been developed and are being used by Medicare, Medicaid and Blue Shield in several States. A promising uniform hospital benefit form has also been developed.

The bill requires the Secretary, within 2 years of enactment, to develop and require to be employed to the extent feasible, uniform claims that would be utilized in making payment for health services under Medicare and Medicaid.

OVERUTILIZATION OF HOSPITALS AND THE SHORTAGE OF MEDICARE NURSING HOME BEDS

H.R. 934 in the Senate and the companion House bills, including the House Reconciliation bill, contain several amendments designed to bring about a more effective use of hospital beds as well as attempts to deal with the shortage of Medicare approved nursing home beds.

First, the legislation permits a simplified cost reimbursement formula for Medicare and Medicaid reimbursement for small rural hospitals that wish to use acute care beds for long-term care services during periods of excess bed capacity.

Second, the bill provides that in certain cases Medicare and Medicaid payments to hospitals be made at the average skilled nursing facility, intermediate care facility or detoxification facility payment rate (as appropriate), rather than the higher hospital rate, for patients medically determined by PSRO reviewers to need the lower level of care rather than acute hospital care. The bill also authorizes that benefits be provided and payment be made under Medicare to qualified nonhospital inpatient detoxification facilities.

Third, the bill authorizes a program of grants and loans to facilitate the conversion of surplus acute care hospital beds to long-term care beds in public and nonprofit hospitals.

This so-called swing bed concept has received wide attention since it was introduced in legislation by Senator Frank E. Moss of Utah in 1974.¹ The concept was known as the Utah plan in honor of its progenitor, Dr. Bruce Walter, director of the State's Department of Health. Dr. Walter provided that small hospitals in rural areas with chronic low occupancy rates could provide long-term care to the community at low cost, obviating the need to build more nursing home beds which are in short supply in rural areas. He revised the applicable Medicare reimbursement formula and received funds to test his idea from HHS. The success of the program led other States to ask the Department for permission to implement the Utah plan in their States and ultimately to the inclusion of this provision in the pending reform legislation.

The Senate Finance Committee is also promoting a proposal in H.R. 934 which would promote the closure or conversion of underutilized hospital facilities. Says the Committee's report:

Studies have pointed to a national surplus of short-term general hospital beds ranging as high as 100,000 beds. Excess capacity contributes significantly to hospital costs since the initial construction and financing expenses have to be recovered by the hospital. In addition, there are the continuing expenses associated with maintenance, and nonpatient services involved in keeping an empty bed ready for use. Surplus beds contribute to cost escalation in other less obvious ways. Unnecessary or underutilized hospital facilities can drain scarce manpower and generate scarcities of trained personnel, which in turn drive up salaries and may even threaten the quality of care. Coupled with the availability of hospitalization insurance, bed surpluses tend to generate pressures to use high cost hospital beds rather than less expensive alternative forms of care. The development of alternatives to inpatient facilities, such as primary care and

¹ Chairman Pepper introduced the first House version of the bill in April 1975.

community home care programs, suffers when investment is needlessly diverted to underutilized hospital bed capacity. Estimates of the savings that would accrue from closure or conversion of unused or underutilized facilities range from \$2 billion to \$4 billion annually, depending on whether the change involves closure or conversion of a particular service department as opposed to a whole hospital.

The bill provides for including in hospital reasonable cost payments, reimbursement for capital and increased operating costs associated with the closing down or conversion to approved use of underutilized bed capacity or services in nonprofit short-term hospitals.

IMPROVING THE QUALITY OF NURSING HOME CARE

The pending reform bills contain several provisions to help improve the quality of nursing home care as follows:

The House Commerce Committee added an amendment to the Reconciliation bill to continue the present 100 percent Federal funding of the costs incurred by the States in conducting inspections of nursing homes on behalf of the Federal government. The Senate Finance Committee, which introduced the concept of Federal assistance to the States for this purpose, has no similar provision in its bills.

A positive provision contained in Reconciliation bill, but not in Senate language, would authorize alternatives to decertification of skilled nursing facilities. Under this provision, the Secretary of HHS would be permitted to deny payment for services furnished to Medicare and Medicaid beneficiaries after a specified date by a skilled nursing facility out of compliance with the provider conditions of participation if the deficiencies do not immediately jeopardize the health and safety of patients. The amendment further requires the Secretary to provide the facility the opportunity to correct its deficiencies, to provide a hearing for the facility before such denial of payment, and to provide notification to the facility and the public concerning such action.

Also contained in the House Reconciliation bill is an amendment which would allow the Secretary of HHS to promulgate new editions of the Life Safety Code as the fire safety standards for nursing homes participating in Medicare and Medicaid. Because the Secretary of HEW (now HHS) did not have fire safety expertise, the Congress in 1967, when it enacted the first Federal standards for nursing homes participating in the Medicaid program, incorporated a code of nursing home fire safety regulations as fashioned by the National Fire Protection Association (NFPA) (Public Law 90-248, Sec. 234). NFPA is a private, non-profit organization with unquestioned expertise. Its membership is made up of State fire marshalls and national and international fire safety engineers, police and other experts. Congress originally required facilities to comply with the 1967 edition of the code. The law was changed in 1974 to require compliance with the 1973 code. A 1980 code is in the process of being developed and the Committee report argues that the Secretary should be able to move to this and more modern codes (and successive editions) without waiting for the Congress to act. The report comforts that the Secretary would name one edition of the code to be complied with and would not select from among the provisions of these codes promulgated over several

years to develop his or her own fire safety code. This shows wisdom because the items in each code are interdependent and may not be switched without sacrificing the integrity of the code.

The House Committee on Aging is on record as supporting increased fire safety standards for residents in nursing homes. The Committee's recommendations flow from its investigation of several nursing home fires and from audits completed at its request by the U.S. General Accounting Office. GAO suggested and the Committee concurred in its own report that all nursing homes should be required to upgrade fire safety standards at least to the point of installing sprinkling systems. GAO proved conclusively that the costs of such systems are low and that they do indeed save lives. In fact, there has never been one single instance of multiple death occurring in either a nursing home or a hospital which was equipped with a sprinkling system.

The Committee report accompanying the House Reconciliation bill contains language which might lead to the unfortunate conclusion that all Medicare/Medicaid nursing homes need not be fully inspected each year. HHS has pushed for an amendment which was not accepted by the Committee which would have provided the Department with "administrative flexibility" with respect to inspections. The amendment would have given HHS the right to forego annual inspections of Medicare and Medicaid homes as currently required by law. Some facilities would have been permitted to go 24 months or longer without inspections. This change was justified by the statement that 30 percent of participating nursing homes are in full compliance with all Federal standards and that scarce resources should be spent improving conditions in poor facilities. Given the evidence which the Committee on Aging has received about the quality of nursing home care in the United States, it is easy to support the argument that poor facilities should be inspected more often, but it does not follow that even exemplary homes should not be inspected at least annually. Human nature being what it is, the absence of a regulatory presence for periods of two to perhaps five years cannot but encourage poor care and abuse.

The report language should not be interpreted as evidence of Congressional approval of less than annual inspections. Report language does not convey to HHS any new authority to move to partial or less than annual inspections. If a change of this serious nature is to be made, it must be made by the Congress in law.

FIGHTING FRAUD

The Senate Finance Committee bill and House Reconciliation bill both would extend the present 90 percent funding for State Medicaid fraud units for an additional two years.

Under current law, Federal matching payments are available to States that establish agencies to investigate and prosecute fraud in their Medicaid programs. To encourage the development of such Medicaid fraud control units, Congress in 1977 provided that States

would be reimbursed for 90 percent of the start-up and operating costs. This 90 percent matching rate was made available for only three years expiring on September 30, 1980. Thereafter, the Federal matching payment will drop to 50 percent, the usual rate provided in the Medicaid program for administrative costs.

Some 30 States now have Medicaid fraud control units in place and another 13 States are in the process of developing such a capability. However, some of the States that wish to establish such units have experienced delays in doing so and, under current law, would not be able to realize the full benefit of the increased Federal matching rate. The bill would eliminate this artificial deadline and substitute a Federal matching arrangement of 90 percent for a 3-year period and 75 percent thereafter. Thus, regardless of when a State began to develop its Medicaid fraud control unit, it would be eligible for up to 3 years of Federal funding at the 90 percent matching rate. It should be understood that this provision would not give States an additional three years of 90 percent Federal funding if they have already been receiving the higher matching payments; the total time a State could draw the 90 percent would be measured from enactment of the original provision. After three years of 90 percent funding, the rate would drop to 75 percent, a level designed to provide a continuing incentive for operation of these units. As under current law, Federal matching payments in any calendar quarter would be limited to the greater of \$125,000 or 0.25 percent of the total Medicaid outlays in the State for the previous quarter.

The Committee assumes that the expenditures to assure the development and continued operation of effective State fraud units constitute a highly effective use of Federal funds. The Inspector General has estimated that without a continuation of the higher Federal matching rate, some existing State fraud agencies would cease operation and other States now interested in establishing units would not do so.

All of the reform bills, including the Omnibus bill, call for common audits of providers participating in Titles V, XVIII, and XIX of the Social Security Act. Sixteen States presently do not have coordinated audit programs. Cost savings owing to the implementation of this provision in fiscal 1980 are estimated at \$28 million for Medicaid and \$6 million for Medicare. Says the Finance Committee's report:

The Committee has been concerned that the duplication of identical or similar auditing procedures used for the purpose of determining reimbursement under various Federal health benefit programs is costly to both the programs and the entity (such as a hospital, skilled nursing facility, or home health agency) participating in the program.

The Committee bill therefore requires that, if an entity provides services reimbursable on a cost-related basis under title XVIII and titles XIX or V, audits of books, accounts, and records of that entity for purposes of the State Federal programs are to be coordinated through common audit procedures. Ordinarily, it is expected that the common audit would be performed for the purposes of reimbursement under title XVIII. However, in those cases where the Secretary finds, in the interest of efficiency and economy, that a State audit would be more appropriate, the State could, if it agrees to do so, perform the common audit for the three programs.

When a State declines to participate in a common audit, the Secretary is to reduce payments that would have been made to the State under title V or XIX by the amount attributable to the duplicative State audit activity. A State participating in the common audit procedure would continue to receive Federal matching for administrative costs associated with any additional or supplemental audit data or audits that may be necessary under their Medicaid and maternal and child health programs.

Committee Members have belatedly suggested that Title XX of the Social Security Act should be added to the list. This conclusion grows out of March 8 and 9, 1977 joint hearings which the Ways and Means Committee conducted with the Senate Committee on Aging, examining alleged fraud and abuse by several California based providers of in-home services. (See Medicare and Medicaid Fraud, Parts 8 and 9, published by the U.S. Senate Special Committee on Aging). The providers used Titles XVIII, XIX and XX in combination. All overhead for the several corporations involved in these enterprises was passed on to Medicare which allowed the provider to underbid all others in the competition for Title XX contracts in that State. Beneficiaries were first enlisted as Medicare patients until that entitlement ran out. Then they were shifted to Medicaid until that program ruled them ineligible at which time they were enrolled for homemaker-chore services under Title XX until they were once again eligible for Medicare. Despite the presence of widespread fraud, it was not discovered by the fiscal intermediary which audited Medicare ledgers, or the State which audited the Medicaid books, or by the county, or by a different division of the State which audited the Title XX books. Only when GAO auditors examined the entire corporation as an entity and all three programs at once, was the full dimension of the fraud and abuse apparent.

The House Reconciliation bill also would exclude health care professionals convicted of Medicare or Medicaid related crimes. The provision of present law relating to the exclusion from participation in the Medicare and Medicaid programs of physicians and other practitioners convicted of program-related crimes would be broadened so as to apply to other categories of health professionals, such as administrators of health care institutions.

Under present law, Medicare and Medicaid payment may be denied for goods and services furnished by a physician or other practitioner convicted of a program-related crime. However, similar action cannot now be taken with respect to other health professionals (such as operators or administrators of health care facilities) who are convicted of program-related crimes. The bill would rectify this deficiency in the law. In the case of those professionals who do not directly furnish medical care or services, payment would not be made to the provider for the cost of any services furnished to or on behalf of the provider by the convicted professional in connection with either program. (The provision of present law relating to a right to a hearing on a determination of the Secretary to bar an individual from participation would be retained.) The bill also clarifies the intent of present law that the Secretary is authorized to bar a professional who may have participated only in the Medicaid or Medicare program from participation in both programs.

In sum, most of the provisions in the House Reconciliation bill, H.R. 7765 (as taken from H.R. 4000 and H.R. 3990), and in H.R. 934 are positive. There is a serious omission in that title XX was not included in the provision for coordinated audits. Another provision with potentially negative consequences which would remove the requirement of State licensure of home health agencies as a prerequisite to participating in Medicare and Medicaid. It should also be apparent that these proposals do not go far enough toward encouraging physicians to accept assignment and providing senior citizens with the comprehensive reforms they so desperately desire. The provisions which begin the liberalization of home health care, mental health care and for reimbursement to HMOs should be helpful.

V. HEARINGS ON MEDICARE'S 15TH ANNIVERSARY

On July 30, 1980, the House Select Committee on Aging conducted hearings to mark the 15th anniversary of the enactment of Medicare. In his opening statement, Chairman Pepper said the purpose of the hearing was to determine if Medicare has been a success and to help outline what changes must be made to improve the program. The witnesses at the hearing included Wilbur Cohen, former HEW Secretary, and Wilbur Mills, former Chairman of the House Ways and Means Committee—two of the men most responsible for the enactment of the program. The perspective of the beneficiary was provided by Bertha Wolman of Washington, D.C., Lawrence Hibbard of Rochester, New York, and Raymond Reul of Cocoa Beach, Florida. The physician's perspective was offered by Dr. Michael B. Miller of White Plains, New York and Dr. Victor Kassel of Salt Lake City, Utah. Following is a summary of their presentations.

Wilbur Cohen and Wilbur Mills both concluded that Medicare has been an unqualified success. They made a special point of saying that the fears that opponents voiced at the time of enactment have not been realized. They noted that early sponsors of the Medicare bill and similar measures were denounced as socialists or communists. They pointed out that opponents had argued Medicare would undermine the quality of medical care in America; that it would remove freedom of choice from the American health care system and that there would be strikes and protests by physicians who would boycott the program.

Mr. Cohen noted that there is no socialized medicine in the United States today; he credited the nation's physicians for implementing the law. He said Medicare is one of the most efficient government programs, calling it a "model of medical administration." He noted that only 3 percent of Medicare Part A's costs were lost to administrative expenses and only about 7 percent of Part B's costs were lost in this same way. By contrast, private health insurance companies return 80 cents on the premium dollar to the insured with the remaining 20 percent being lost in administrative expenses.

Mr. Cohen also credited Medicare with helping to eliminate racial discrimination in the health care field:

I consider the application of Medicare to the minority group access to health care resulted not only in increased utilization but in the elimination of discriminatory treatment . . . It is the application of the principle of equal treatment under law of medical care (which) has been developed under both Medicare and Medicaid and it is one of the achievements of which I am the most proud.

Mr. Cohen noted that the National Commission on Social Security will report to the Congress on January 11, 1981 with its recommendations for changes in Social Security and Medicare. However, he did offer the Committee several suggestions which he felt were necessary to improve the program.

Mr. Cohen concurred with the sentiments expressed by several Members of the Committee that Medicare is in need of substantial improvement. He said he favored the expansion of Medicare to cover the gaps in the program, including hearing aids, eyeglasses, prescription drugs and unlimited home health care visits. He favored the repeal of the \$60 Medicare Part B deductible and the extension of Medicare benefits made in H.R. 3990. (As noted in Part IV, these reforms have been added to the Omnibus House Reconciliation Bill, H.R. 7765) which passed the House on Sept. 2, 1980.)

Mr. Cohen continued:

The most important thing is to take Social Security and Medicare out of the unified budget. The big problem we are having today on the reconciliation and why Congress is forcing itself to cut back on Social Security and unemployment insurance and Medicare is because of the grave mistake we made years ago to include these trust funds into the unified budget so that every time you can cut Social Security or unemployment insurance or Medicare, you reduce the deficit.

But you can't ask a single person—I ask you to do this: ask a person whether they think Social Security is involved in the Federal deficit. They say, what has it to do with balancing the budget? That is a separate program to which I pay and contribute.

The net result, ladies and gentlemen, you are not only going to get yourselves in substantive difficulty but political difficulty if you are going to try to balance the budget by cutting back on trust fund programs which people feel they have contributed to as a matter of right to which they are entitled.

It might be noted that Secretary of State, Edmund S. Muskie, former Chairman of the Budget Committee and of the Senate Aging Committee's Subcommittee on Health, is among a host of other experts who have made the same point. On December 4, 1974, Senator Muskie said:

There is another hidden point that I should like to raise. In 1968, the "unified budget" concept was developed, incorporating Social Security and Medicare trust funds into the budget. Most of the money in our annual budget is, of course, general revenues. But some further distinctions need to be drawn.

Social Security and Medicare are almost entirely self-financed. Benefits are funded by payroll taxes paid by American workers and employers in previous years. The Federal government acts as a trustee of these funds. Incorporating these funds in the unified budget provides the opportunity for political manipulations which could diminish the vested rights of America's workers. To many experts, the Administration's proposal appears to be cutting back on Medicare payments to the elderly in order to make the projected budget deficit look a little less severe.

I object to this notion. It is unfair and it is unwise.

Mr. Cohen also endorsed a proposal being developed by Chairman Pepper to create a new Part C of Medicare which would cover eye-glasses, dental care, hearing aids, a bi-annual physical examination and prescription drugs. As proposed, Part C would be voluntary and supported by a premium equal to the Medicare Part B premium. Mr. Cohen said:

I would like to see a Medicare program that eventually covered practically all of the medical costs of older people and the disabled. . . I not only approve your idea of developing some kind of Part C which would be another package including prescription drugs and a number of other things. . . I have insured myself voluntarily but I have done that because Congress has given me no alternative. I would rather see Part C in which a person could get almost complete coverage of major items that we are talking about and I would even go so far as to make it financed on the same principles as Part B is to get it started.

Mr. Cohen said that another serious problem with which the Congress must deal is the refusal of an increasing number of physicians to accept assignment. He said that fixed fee schedules would be one approach to the problem and if they were developed with the aid of physicians, he felt that they would be accepted by the medical community. He endorsed Chairman Pepper's idea of some financial incentive to encourage physicians to accept assignment. He suggested other alternatives to the \$25,000 tax credit idea, saying that the government could provide physicians who accept assignment with a \$100,000 malpractice policy or that they might be given \$2 extra per claim on assignment cases.

Former Ways and Means Chairman, Wilbur Mills, began his statement by commending the Committee for its proposed Part C bill, "I want to commend you for this hearing today and certainly for the thought that you have advanced in Part C of Medicare." Mr. Mills also endorsed the idea of removing Medicare from the unified budget. He said he had originally supported the idea of incorporating the trust funds in the unified budget. However, at the hearing he stated, "As I look back on it, I know I made a mistake." When Chairman Pepper asked if he agreed with Mr. Cohen's suggestion about removing Medicare from the unified budget, Mr. Mills said, "I agree completely with what Mr. Cohen said."

Former Chairman Mills said he never contemplated hearings of the nature which were being held on July 30, 1980 with evidence that such a "small percent of the total costs are being paid by the program We did not fund it properly to begin with. That is Part A. We have had some troubles with Part A ever since."

Mr. Mills said the great mistake that the Congress made with Medicare was only covering hospital care. He suggested that Congress enact provisions placing greater emphasis on preventive care and on outpatient care. He said that making prepaid payments to HMOs on behalf of Medicare beneficiaries was a good idea and he endorsed expanding home health benefits which he said would cost more in the long-run but which would help reduce unnecessary hospitalization.

Mr. Mills said that he could foresee Congress changing the funding base for Social Security and related programs perhaps going to a sales

tax or some other approach to insure the solvency of the program. His preference was for Congress to increase its support from general revenues. He noted that one-third or more of the Social Security trust funds are welfare payments, adding that people are being taxed (he implied the tax is regressive) for someone else's benefits. He said the retirement and disability payments in the trust fund which are essentially welfare in nature should be funded instead by means of the progressive Federal income tax—that is through general revenues.

Dr. Victor Kassel is a physician who specializes in geriatrics. He is also a writer and lecturer who is well known among experts in the field of long-term care. Dr. Kassel said that Medicare penalizes geriatricians.

He emphasized that Medicare regulations are designed to bring about quality of care and yet the term is not defined. He said this lack of knowledge is compounded by the fact that regulations are written by bureaucrats and not by geriatricians. He added that Medicare payments to physicians are inadequate. Honest physicians cannot afford to accept assignment, he added. He made a particular point that fee schedules are geared to the amount of time it takes to provide care to younger patients. Dr. Kassel said it takes longer to provide care to the elderly, for example, it might take one half hour to do a physical on a person of 21 while it would take three times this long to complete a physical on a person age 65 or over.

Dr. Kassel said that physicians do not accept assignment because it means bankruptcy. He said they must bear the burden of the paperwork for which they are not reimbursed. He added he could never decipher what Medicare was and was not paying for. He said those physicians who accepted assignment from most of their patients could do so only because they raised their fees for other patients. Private paying patients are subsidizing Medicare patients, he contended.

Dr. Michael B. Miller serves as medical director for two nursing homes in White Plains, New York. The thrust of his remarks related to the failure of families to care for their elderly. He said the current problems they face are a result of the successes in expanding the life span over the past 40 years. The life span has been extended but there has been an increase in morbidity among the survivors. He says the United States lacks a comprehensive policy with respect to long-term care. He said that Medicare has been a failure because it has not addressed the problems of the infirm elderly.

Bertha Wolman of Washington, D.C., helps senior citizens solve complaints with Medicare. She said one of the primary failings was Medicare's failure to pay for long-term care. She said the Explanation of Medicare Benefits forms are confusing and need to be redrafted. She said that better ways must be found to police Medicare because providers sometimes paid their billings. She added that toll-free numbers established by intermediaries were not helpful and that checks sent in payment to the elderly are often discarded because they don't look like checks.

Raymond Reul had harsh words for a Florida carrier that paid \$230.55 or 56 percent of a \$543.50 bill. He said that because he is an expert systems analyst, he was able to show duplication and errors in the billings. Ultimately, he was paid \$313.55 or 76 percent of the bill. He said that other senior citizens who do not understand computers are not likely to fare as well.

Lawrence Hibbard is a retired attorney. He works with a program sponsored by the National Retired Teachers Association/American Association of Retired Persons. The Department of Health and Human Services trained Mr. Hibbard and other volunteers to help senior citizens with their Medicare claims problems. The program has been a great success in Rochester, New York. Mr. Hibbard suggested that Congress establish a national program which would employ senior citizens to do this kind of work. Like Mrs. Wolman and Mr. Reul before him, he complained that toll free numbers established by the intermediaries are not often helpful.

Mr. Hibbard said that senior citizens do not understand why their claims are being refused and they do not know they have the right of appeal when they are turned down for payment. He said that only about 20 percent of the physicians in his area accept assignment. He provided two examples of individuals whose claims had not been paid for almost a year despite his efforts.

Chairman Pepper termed the hearings an excellent addition to the record. The testimony lends support for the need to protect the integrity of the trust fund, expand Medicare's benefits, and to institute other reforms.

VI. CONCLUSION

The purpose of this report has been to examine the effectiveness of the Medicare program since its enactment by Congress 15 years ago. The overwhelming conclusion among senior citizens is that Medicare has been a success. Senior citizens are grateful to have the benefits of the program. They are comfortable with the notion of paying taxes in their younger years so that they might benefit in old age when they need it most. It is this notion of contribution and vested interest—the right to health care coverage and universal entitlement—which is Medicare's strongest point. The Committee found no support among older Americans for the notion that the Medicare program has been such a dismal failure that it should be abolished.

Seniors, however, feel that Medicare's benefits have been rapidly shrinking. There is a growing gap between their perception of what Medicare will cover and what it actually covers. Part of the problem may be that Medicare's virtues were exaggerated or it may simply have been wishful thinking on the part of the elderly which has led to the widespread opinion that Medicare will cover 80 percent of all their health care costs. Since its inception, Medicare has not covered all or even 80 percent of the health care costs of the elderly but the point has never been brought home to America's senior citizens.

Both senior citizens indulging in wishful thinking and those with more realistic views have become increasingly disappointed with Medicare. They feel that Medicare has become another in a long list of broken promises made to them by politicians in Washington. The question which this report asked in Section I is pertinent here. Is Medicare paying less of the senior citizens bill in 1980 than it did in 1966? The answer is yes, about 10 percent less. As noted in Section I, in 1966, Medicare was paying about 50 percent of the total per capita health care costs of the elderly. This year, after subtracting the premiums which they pay to participate in Part B of Medicare, the program pays only about 40 percent of the total. An analysis of statistics indicates that seniors continue to pay about 50 percent of their health care bills themselves just as they did 15 years ago. The remaining question is: who is paying for the 10 percent reduction in Medicare payments between 1966 and the present? The answer, of course, is that more and more of the burden of providing health care to the elderly is being shifted to the Medicaid program.

Obviously, one advantage of shifting utilization from a program of universal entitlement like Medicare to Medicaid, a welfare-grant-in-aid program, triggered by a means test, will be cost savings. Further savings come from the fact that Medicaid is a Federal-State program and the shift to Medicaid serves to place more of the burden of providing care for the elderly on the shoulders of the States.

From the point of view of the elderly, the sharp reduction in Medicare benefits has been damaging in several ways. First and foremost, they have been denied benefits to which Congress said they were

entitled. Second, the quality of services available under Medicaid, which are only available to the poor, are often not equal to those provided under Medicare. Third, there has been severe psychological damage which grows out of their perception of Medicare as something they have worked for and their perception that Medicaid is a hand-out for indigents.

Little wonder the elderly watch as every year Medicare pays less and less of their average health care bill while it costs them more and more in premiums, deductibles and coinsurance to participate in the program. While their Medicare coverage goes down, their health expenses continue to skyrocket. Caught between these twin buzz saws, elderly persons are finding that their so-called Golden Years have become years of anxiety. They live in desperate fear of getting sick, of going broke, of going into a nursing home, going on welfare or becoming dependent on their loved ones. Senior citizens all across the country have written to Members of Congress asking for some redress in what seems like the beginning of a living nightmare.

The primary concern expressed by senior citizens is that Congress do something to encourage physicians to accept assignment. Many letters have expressed the thought in simplistic terms: "Medicare Part A works OK but Part B is terrible." There is a certain truth to the Statement since Medicare pays about 75 percent of the costs incurred by seniors who are hospitalized. However, under Part B, it pays for only about 55 percent of their doctor's bills. The problem with Part B appears to be that low Medicare fees and red tape have caused fewer and fewer physicians to be willing to accept assignment. There are many unfortunate consequences. For example, physicians understand that one way to increase the likelihood that they will be paid is to put their patients in the hospital. This fact together with a de-emphasis on the Medicare nursing home program has resulted in the retention of thousands of older Americans in American hospitals for days or even weeks longer than necessary. Estimates place the cost of this unnecessary utilization at \$1.5 billion a year. Ironically, this money could be used to expand Medicare benefits or to increase fees paid to Medicare physicians by 5 percent across the board.

The single most aggravating part of Medicare to the elderly is the responsibility to bill Medicare and collect sums that they have paid following the physician's refusal to accept assignment. The elderly increasingly feel that they are being cheated—not by the doctor but by Medicare. The elderly do not understand the computation of "reasonable charges" under Part B. All they know is that on a \$35 bill which they must pay in cash, they must fill out forms, wait at least two months, and then they will be lucky if Medicare pays them \$15 of the bill. Unless they have satisfied the \$60 annual Part B deductible, it won't pay them anything.

Senior citizens also lament the failure of Medicare to cover eyeglasses, dental care and hearing aids. They wish Medicare provided greater home health, and nursing home coverage. They plea desperately for some coverage for prescription drugs.

The Committee is on record as favoring the expansion of Medicare services to close these growing gaps and to keep faith with the elderly. A covenant was made with the elderly in 1965 and it must be kept. The question is what means can be found to pay for these expanded benefits. One answer lies in the reduction of fraud and abuse which apparently infects many government programs. An aggressive fraud program such as that led by Deputy Attorney General Charles J. Hynes in New

York can produce up to \$6 in recovered funds for every \$1 spent for an investigator's salary. Another answer lies in reducing unnecessary hospital stays and encouraging alternatives to institutionalization. Still another answer would be the creation of a new self-financing Part C of Medicare. The program, like Part B could be voluntary and funded in part with a premium equal to the Part B premium. Instead of the additional revenues for the program coming from the general revenues, funds could be raised, as suggested by various of the members on the Senate Finance Committee, through a small excise tax on alcohol and tobacco. In order to encourage physicians to accept assignment, the Congress might allow them to deduct from their income for tax purposes a certain portion of the funds they receive from Medicare but only in the case where they agree to accept assignment from all of their patients.

These alternatives look very attractive but they are not the only answers. The Committee believes that something must be done and soon. The Committee commends the Ways and Means and Interstate and Foreign Commerce Committees for their initiatives in improving Medicare's coverage through H.R. 7765 which passed the House on Sept. 2, 1980. These long-awaited improvements in expanding home health and mental health benefits and making available Medicare payments to HMOs are necessary and important. However, the Committee believes that much more can be done to bring Medicare into conformity with the promises made to the elderly in 1965.

VII. RECOMMENDATIONS

The House Select Committee on Aging recommends that the Congress immediately enact legislation to broaden the scope of the Medicare program so that it will become a truly comprehensive national health insurance program for the elderly. The Committee concludes that Medicare has been a successful program and that it provides the basis for broader health protection for the elderly. It is clear that the Congress must act at once because a genuine health crisis exists among older Americans faced with accelerating health care costs and decreasing incomes and decreasing Medicare payments for health care.

The Committee notes that the necessary changes can be made either incrementally or in one broad stroke. The Committee believes that adequate funding can be found to support an expanded Medicare program from making available less expensive and more appropriate health care alternatives and from instituting major crackdowns on fraud and abuse.

With respect to the incremental approach:

- *The Committee recommends that H.R. 7765, the Omnibus Reconciliation Act of 1980 (which contains the medicare provisions of H.R. 3990 and H.R. 4000 as approved by the House Ways and Means Committee and the House Interstate and Foreign Commerce Committee) be enacted at once. The Omnibus Reconciliation Act liberalizes home health benefits, authorizes Medicare payments to health maintenance organizations, increases outpatient mental health benefits, extends the current 100 percent funding for the inspection of nursing homes participating in Medicaid conducted by the States, and provides for new sanctions which can be brought against nursing homes found abusing the Medicare and Medicaid programs as an alternative to closing them down.*

The Committee recommends that the proposal in H.R. 7765 which allows for coordinated common audits of providers participating in two or more of Titles V, XVIII, and XIX of the Social Security program be amended to include Title XX as well.

- *The Committee recommends with respect to medicare part A, that the coinsurance provision which requires the beneficiary to begin paying \$45 a day starting with the 61st through the 90th day of hospitalization be repealed. The General Accounting Office has recommended this change to the Committee suggesting that the cost of repeal is comparatively low since very few elderly are hospitalized for 60 consecutive days. GAO says the removal of this provision will do much to end confusion among the elderly with respect to their part A benefits. GAO pointed out that some insurance companies have been using the requirement of coinsurance following the 60th day in the hospital as leverage to sell insurance policies to pay coinsurance amounts beginning with the 61st through the 200th day of hospitalization, or even longer. Since less than one percent of the elderly are hospitalized beyond 90 days, there will be little, if any liability on these policies.*

(See H.R. 4590 introduced by Chairman Claude Pepper). (Also see "Abuses in the Sale of Health Insurance to the Elderly: A National Scandal," report by the House Select Committee on Aging, November 1978).

● *The Committee recommends, with respect to part B, the enactment of tax incentives to encourage physicians to accept assignment.* In 1966, two out of every three doctors accepted Medicare assignment. Today, less than one out of every two physicians in the program will do so. The Committee recommends that the Internal Revenue Code be amended to allow those physicians who agree to accept assignment from all of their Medicare patients, and who have received at least \$10,000 in any year from treating Medicare patients, to deduct from their taxes such sums as they receive thereafter from Medicare, up to a maximum of \$25,000 in any single year. Carriers should also be encouraged to make prompt payment so that physicians do not encounter cash flow problems.

● *The Committee also recommends that the Congress establish a new Part C of Medicare which would cover outpatient prescription drugs, dental care, dentures, eye care, hearing aids and examinations, and the cost of biannual physical examinations.* Part C would be optional; beneficiaries who are eligible for Medicare Part A could elect to participate not only in Medicare Part B which pays for physician services but also for Part C which would cover the items mentioned above. The beneficiary would be required to pay a monthly premium equal to the Part B premium to participate in the program. Premiums under Part C would increase at the same level as those under Part B. A separate trust fund would be created for the Part C funds which would be supplemented not by general revenues, but by a Federal excise tax on tobacco and alcoholic beverages. Part C would mirror Part B in requiring a \$60 deductible and in that it would pay 80 percent of reasonable charges established by the program thereafter.

Part C would be essentially self-financing and would not require disbursements from the Federal Treasury. The addition of Part C to the existing Medicare program together with the other suggestions above will, for the first time, provide older Americans with the comprehensive coverage they need and deserve.

As noted in Section V, the concept of a new Part C of Medicare was supported by former Ways and Means Committee Chairman Wilbur Mills and former HEW Secretary Wilbur Cohen at the Committee's July 30, 1980 hearing. It should be clear that the Part C proposal need not be tied to a Federal excise tax. Congress may wish to fund Part C of Medicare exactly on the same basis as the present Part B, that is 30 percent from premiums paid monthly by beneficiaries and the remaining 70 percent from general revenues. Both men also supported removing Medicare from the unified budget. The Committee concurs in this recommendation.

With respect to more comprehensive reforms which could be implemented at once:

● *The Committee recommends that the Congress consider the enactment of more comprehensive measures, such as H.R. 4168, as introduced by Congressman Don Bonker.* The specifics of the bill as compared with existing Medicare benefits are carried as appendix one of this report.

With respect to the continuing problem of fraud and abuse:

● *The Committee recommends that the Justice Department establish medicare/medicaid strike forces, increase funding for the FBI and increase the number of assistant United States attorneys to prosecute those that would defraud government programs. Funding for State Medicaid Fraud Units should also be continued. (See H.R. 5170 introduced by Congressman Pepper.) Similar provisions are contained in H.R. 4000 as reported out by the House Commerce Committee and carried in H.R. 7765, the Omnibus Reconciliation Act of 1980.*

The Committee emphasizes that the need is critical and that it is vital that Congress act at once to restore confidence in Government and to keep medicare from becoming yet another broken promise made to the elderly.

VIII. SUPPLEMENTAL VIEWS

SUPPLEMENTAL VIEWS OF REPRESENTATIVE CHARLES E. GRASSLEY, RANKING MINORITY MEMBER, AND REPRESENTATIVE WILLIAM C. WAMPLER, RANKING MINORITY MEMBER, SUBCOMMITTEE ON RETIREMENT INCOME AND EMPLOYMENT

I have read the supplemental views submitted by Congressman James Abdnor, Ranking Minority Member on the Subcommittee on Health and Long-Term Care, and associate myself with his analysis of the study.

The research underlying the study is effective in showing that many older persons expect more of Medicare than it provides. It makes clear that Medicare patients are often disillusioned by the limitation on services provided by doctors, hospitals and nursing homes. It provides data on the rising costs of medical services to the patients and lays out other findings to support a thesis that Medicare is a broken promise.

I agree with the majority of the committee that improvements are needed in Medicare. Congress should support every feasible measure to insure that America's senior citizens have simple access to proper and affordable medical attention. To that end, I have expressed my support for several of the legislative actions cited in the study. There are, however, some aspects of the study which preclude my unqualified endorsement.

I do not subscribe to the implication that Medicare is a broken promise. Its benefits and its conditions are expressed in law and regulations. In general, it delivers what it promises. The objective of the study is to demonstrate that it should promise more and deliver more at less expense to the patient. The research accomplished in developing the study is confined solely to that which leads to recommendations supportive of its objective. This isolates the issue from any other social or budgetary consideration and leaves the committee lacking data which are essential to intelligent decisions on the study recommendations.

I am firmly committed to the correction of deficiencies in the laws designed to protect the elderly from hardship and neglect. To that end, I reaffirm my support for these recommendations contained in the study that I have supported and, in some instances, cosponsored in the past. On the others, I defer judgment pending further information regarding their cost and relative merit within the confines of a balanced federal budget.

SUPPLEMENTAL VIEWS OF REPRESENTATIVE JAMES ABDNOR

I commend Chairman Pepper and his staff for undertaking this study of Medicare and I support the release of the Committee report. However, I am constrained to do so with some reservations.

The title of the report raises hopes of a major retrospective of the Medicare program, but the report itself provides only a surface examination of very complicated issues. Perhaps the Committee's intent was to give a broad overview of problems faced by older Americans, but it should also be our responsibility to ask some larger questions and to offer an in-depth analysis of the Medicare system's ailments.

The report poses the question "Has Medicare Become A Broken Promise To The Elderly", but the answer to that question remains elusive. As the many letters indicate, the answer is definitely "Yes" in the eyes of many elderly Americans. However, it is also noted that those eyes have been colored by "misunderstanding" and "wishful thinking." The report specifically states, "Members of Congress understand Medicare was never intended to cover all or even 80% of the health care costs of the elderly, but the point has never been brought home to America's senior citizens."

There is absolutely no question that wide gaps exist between the overall health needs of the elderly and those covered by Medicare. What do we want Medicare to cover? 100% of elderly health bills? 80%? 50%? Should Congress try to fill in the "gaps," or should we improve public information so people don't reach 65 with the idea that Medicare will pay nearly all of their health bills? What has private insurance done to fill in the gaps? These are very basic questions that need to be addressed in any comprehensive look at Medicare.

The Committee's questionnaire, which was sent to physicians in six states, raises some questions. For example, the first question asked, "For what percentage of your Medicare patients do you accept assignment?" Since the physician decides whether or not to accept assignment on a case-by-case basis (not a patient-by-patient basis), the results are subject to question. Even if the results were accurate, however, the conclusion that "Some 87 percent said that they (accepted assignment)" is grossly misleading. In fact, according to the figures presented, less than 40% of the physicians who responded accept assignment for more than one-quarter of their patients. In regard to question number three, even though the question itself doesn't show a distinct bias, to state in the conclusion that the result "was a surprise" indicates a less than objective approach to the survey.

COMMENTS ON THE REPORT'S RECOMMENDATIONS

1. I support the enactment of H.R. 4000 and H.R. 3990. Much of this legislation passed the House a couple of years ago, and has since been improved. The bills include many provisions that would greatly

benefit senior citizens, such as expanded home health coverage and Medicare/Medicaid coverage for swing beds in rural hospitals.

2. I support the repeal of the \$45 coinsurance provision under Part A of Medicare. The repeal of this provision would simplify the Medicare program and serve the needs of these few elderly persons who need hospitalization after the 60th day. In addition, it would address the insurance problems identified in the report.

3. The low physician assignment rates have been one of my biggest concerns, and I commend the authors of the report for the attention that has been given to that issue. However, I question the proposal to allow large tax deductions for physicians who agree to accept assignment. Although it would probably improve assignment rates, it ignores the real causes of the problem. Physicians fail to accept assignment primarily because of what they consider low reimbursement rates, and to a lesser extent, because of the paperwork burdens involved. Instead of passing over these problems, the Committee should support legislation which makes the system more responsive to begin with.

4. There is no question that the elderly are often hurt most by large expenses for outpatient drugs, eyeglasses, hearing aids, and dental care. The proposed Part C for Medicare is particularly attractive because it would not be funded from general revenues. In addition, the concept of transferring a greater share of health costs to those who practice unhealthful living habits (through the use of tobacco and alcohol) is intriguing. However, financing health programs through excise taxes is a new approach, and I do think the concept warrants further study.

In addition, it seems questionable to develop another Medicare program based on Part B when much of this report stresses the failures and shortcomings of Part B.

5. I fully support renewed efforts to crack down on Medicare and Medicaid fraud and abuse. We wouldn't have such a difficult time expanding some benefits if we didn't lose millions, and perhaps billions, of dollars every year to fraud, waste and abuse. However, increased funding may not necessarily be the only answer for addressing this problem. Perhaps a look at existing investigational priorities within the Department of Justice would show that funds could be redistributed for a greater concentration on Medicare and Medicaid fraud cases.

In addition, the recommendation makes no mention of the Health and Human Services Inspector General, who has responsibility for rooting out fraud in the Medicare and Medicaid programs. Although the FBI's efforts in this area are more impressive, we should not ignore the potential contributions of the Inspector General's office.

SUPPLEMENTAL VIEWS OF REPRESENTATIVE MARY ROSE OAKAR

I want to commend our Chairman, Senator Claude Pepper, for holding hearings to evaluate the strengths and weaknesses of Medicare on its 15th anniversary. I also want to applaud the superb Committee Report, "Medicare After 15 Years: Has It Become a Broken Promise?"

Letters to the House Select Committee on Aging, surveys, and the thousands of reports from my own constituents indicate that the vast majority of our senior citizens view Medicare as valuable and necessary. However, many of these same people also feel that Medicare has not lived up to its potential. When Medicare was created in 1965, it was hoped that no senior citizen would be denied medical care for reasons of cost alone. Government would share the burden of payment. Over the last 15 years, though, the escalating cost of Medicare has meant that our seniors have actually had to pay more to participate in the Medicare program. For example, in 1966 the per capita health care bill for older Americans was \$445 per year. In 1977 the per capita health care bill for older Americans had increased by 300 percent to \$1,738 per year. While much of this increase has been absorbed by Medicare, the average out-of-pocket expenses for every older American averaged \$563 per year in 1977—more than the total health care bill for every older American in 1966. In this day of double-digit inflation which bears down so hard on our seniors who must live on fixed and limited resources, this increase is unacceptable.

The Report details other difficulties confronted by the elderly under Medicare, and they are confirmed by the many thousands of cases my district office handles. The shifting of the burden of payment from Medicare to Medicaid, a means-tested program, reduces the federal tax burden but also forces seniors in many instances to pay more while also placing them in the category of welfare recipient. Equally as disturbing is the overutilization of hospital services because nursing homes are reluctant to participate in Medicare.

Another area of concern to many of my constituents, and which is highlighted in The Report, is the fact that so few doctors accept assignment. Today only one-half of physicians accept assignment, while 66 percent of the physicians accepted assignment in 1966 when Medicare first began. The failure of Medicare to adequately cover expenses for eye glasses, hearing aids and dentures, medical appliances that millions of older persons must have to function adequately, is another serious deficiency. Because of these shortcomings, our nation's tax dollars are sometimes wasted while the high expenses for medical care and the gaps in the Medicare program force our seniors either to forego medical treatment or sacrifice other necessities in order to receive it. This, too, is unacceptable, and raises the question of whether Medicare has become a broken promise.

Our senior citizens are the best judges of the strengths and weaknesses of the Medicare Program. I would like to represent my own senior citizen constituents by citing one of the many thousands of cases handled by my district office. Mr. Arthur Wilhelm is one of the millions of senior citizens who do not receive adequate reimbursement for their medical care provided under Medicare Part B. As is all too common, the full amount of billed services was not approved for 80 percent coverage under Medicare Part B. However, in the case of Mr. Wilhelm, the Medicare intermediary had previously approved the same amount for the identical medical service provided in April and May of this year. What I found to be astounding was that the Medicare intermediary explained that as of July 1, 1980 the approved amount for house calls by physicians had been decreased. Mr. Wilhelm is fortunate enough to have a doctor who will make a house call and change his catheter for only \$18 a visit. But as of 1 July the allowable charge is \$10 per visit. Where will Mr. Wilhelm find a good doctor who will make a visit for only \$10? This is but one of the innumerable cases our office handle regarding low reimbursement for Medicare Part B services.

Medicare currently assists our elderly with about one-third of their medical needs. Preventive health care is not comprehensively addressed. Therefore, I want to announce my support for the recommendations appearing in the Committee Report. I have just spoken with Chairman Claude Pepper, and want to announce my wholehearted support for his Medicare reform package. This package will fill a serious gap in the Medicare program by creating a new Part C. The proposed Part C will provide older Americans with the comprehensive coverage they need and deserve, and has the additional virtue of being practically self-financing. I am pleased to be able to serve as a prime co-sponsor of this necessary and valuable legislation.

SUPPLEMENTAL VIEWS OF REPRESENTATIVE DON BONKER

I would like to commend Chairman Pepper for calling hearings on the 15th anniversary of the enactment of Medicare. Health care for the aged is an extremely important topic. It is the one subject in the field of aging that I am most concerned about.

I think that most of the Members of the Committee know that I had a role in bringing about the enactment of Medicare. I served on the staff of the Senate Committee on Aging in 1964 and 1965. I remember the fight. I remember the prophets of doom. I remember our joy and I remember the lingering concerns which weighted our best hopes for the program's success.

In retrospect, I agree that Medicare has been a real blessing for older Americans. I know that older Americans are grateful for it. I think Medicare has served to bring senior citizens into the mainstream of American medicine. Before the enactment of Medicare there was a two-track system in this country—one for those who could pay and another for the poor and elderly.

I have been fortunate to chair four hearings on Medicare in the past two years. At these hearings we heard from literally hundreds of older Americans. I have the strong impression that today we are at high noon with respect to Medicare. I think seniors would be evenly divided on the question of whether they are happy with Medicare. I think the tide is running strongly in the direction of dissatisfaction. My constituents tell me that fewer and fewer physicians will accept assignment and that Medicare is slow in making payments and that Medicare does not pay enough.

Senior citizens ask why it is that they must pay the doctor in cash and then have to wait for months for repayment.

At our hearing in San Diego, California, senior citizens outlined their dissatisfaction with the interpretation of the term "reasonable charges." One man gave us a case history. He said the physician charged \$5,000 and Medicare determined \$1,000 was reasonable. Medicare then paid 80 percent of what was determined reasonable or \$800. He said he felt cheated. He felt the government and physicians were taking advantage of the aged.

At another hearing in Longview, Washington, we proved that our current policy to cutback payments to Medicare nursing homes has resulted in keeping patients longer than necessary in hospitals at four times the daily cost to the government. We estimated the cost of the nation from this myopic policy may be \$1.5 billion a year.

At a recent hearing in Connecticut we recently heard about the growing gaps in Medicare and their effects on senior citizens who often ignore obtaining the medical care they need because they cannot afford it.

It is clear to me that Medicare is sick. Future hearings will help us to begin to diagnose the problem and then we must begin reforms. I also think we need to examine reform proposals. I think we must make an effort to provide older Americans with the health care that they need and deserve. I have introduced a bill, H.R. 4186 with this purpose in mind. I think that it is imperative that we act and act soon if we are to keep the promise we made to our nation's elderly in the preamble to Medicare where we declared that good quality health care is the right of all Americans.

SUPPLEMENTAL VIEWS OF REPRESENTATIVE WILLIAM R. RATCHFORD

I am pleased to have the opportunity to reflect upon the Medicare program over the last fifteen years and to reiterate my support of the legislation to expand home health coverage which is close to being enacted.

My experience in the aging field tells me that the value in extending the elderly's access to home health care is a very real and desirable alternative to institutionalization. This point cannot be understated.

Since the enactment of the Medicare program in 1965, millions of our nation's elderly and disabled have been able to protect themselves against financially debilitating and catastrophic illnesses. Though well-intentioned, the program has now reached the unfortunate stage at which the elderly must now pay more for health care than when the program was first adopted 14 years ago. Costs are once again locking the elderly out from the medical care they so desperately need. The system has developed many problems, which this committee is so boldly examining. The current program of coverage either denies benefits to many of our 24 million elderly citizens who need it most, or provides little in the way of benefits for acute or chronic illnesses.

President Lyndon Johnson documented the special health care needs of the elderly in his February 1963 Special Message. He reported that "The elderly are sick more frequently than the rest of the population. Of every 100 persons age 65 or over, 80 suffer some kind of chronic ailment, 10 impaired vision, and 17 have hearing impairments. Sixteen are hospitalized one or more times annually." Approximately 7 million elderly today urgently require home health services of some kind to avoid either costly and inappropriate consignment to nursing homes, or unnecessary hospital stays required to ensure benefits. Despite this clear demonstration of need, we have failed in our commitment to extend the availability of in-home care to underserved areas. Though we have time and again highlighted the need for expanding access to home health services through such agencies, there are still some 650 counties, where almost 10 million people live, that do not have a Medicare-certified home health agency.

In 1977, less than 3 percent of Medicare's expenditures, or \$493 million, could be attributed to home health care benefits. Efforts to liberalize these benefits, as embodied in H.R. 3990, is a major step toward meeting the total health care needs of our elderly, and toward making the Medicare program all that it should be.

Let me now turn to the specific provisions of H.R. 3990. First, the legislation would increase the number of home health visits allowed under both Parts A and B of Medicare. Presently, beneficiaries are only eligible for 100 visits during the year following a qualifying inpatient hospital stay under Part A, and only 100 visits per calendar year under Part B. This restriction, prevents the delivery of health

care on a need basis. This restriction forces the elderly to turn elsewhere after they have exhausted the limit, though they continue to require care in the home. Most often, either institutionalization is then required or Title XX funds are sought. The latter alternative has had the effect in many instances of shifting the nature of coverage from health to social services benefits, when indeed the health care need should be preeminent.

In that Medicare requires the administration of skilled nursing or professional therapy care, many cannot even maintain eligibility until the 100 visit limit has been exhausted. This skilled care requirement precludes many preventive and maintenance services required to keep the elderly out of hospitals or other institutions. Most importantly though, is the fact that so many of our elderly are subject to chronic long-term illnesses, and often the 100 visit limitations under Part A and B do not allow sufficient time for the person to recover. Though the estimated cost of the elimination of the 100 visit limits is high, in the long run I am confident we could demonstrate a savings by providing a more attractive and less costly alternative to institutionalization. In its 1977 report to the Congress entitled: "Home Health—The Need for a National Policy to Better Provide for the Elderly", the General Accounting Office estimated that this action would cost an additional \$12.5 million for an anticipated increase of 300,000 visits per year, or a 2 percent increase in home health benefit costs. This estimate assumes that about 3,000 people would exhaust Part B benefits and use an additional 100 visits a year, which is very minimally the case.

A second major provision of H.R. 3990 would eliminate the three-day prior hospitalization requirement under Part A. Presently, the 1.1 million Part A-only beneficiaries do not have access to this home care benefit unless they have been hospitalized for three consecutive days. I'm afraid that, contrary to the conclusions of the previously mentioned GAO report and the claims of the Department of Health, Education and Welfare this requirement clearly has led to a pattern of physicians unnecessarily admitting patients into a hospital not to administer the most cost-effective care he or she knows how, but merely to comply with the law. This added expense comes at a time when over 75 percent of Medicare expenditures have been made for hospital and nursing home care. It is unfortunate that the Medicare program is still patterned after traditional health concepts, which purport that if we merely treat a patient, he or she will get better. The reality of today's growing elderly population is that they are more fragile than others, and require unique and longer care for their chronic illnesses. A vivid example comes quickly to mind: The arthritic patient that generally needs sustained and skilled home care, yet does not require three days hospitalization. GAO has estimated that the cost of eliminating the three-day prior hospitalization provision would be \$12.5 million, but again the costlier alternative of

hospital care or institutionalization would dictate a real long-run savings.

These are very positive steps, yet I would propose that we go farther in meeting the home care needs of the elderly. I submit to you today, that the next action of this committee in the home health field must be to develop means of fostering better coordination between the many federal, state and local agencies which provide or administer home care services. If I may indulge the committee one moment, I would like to point to two nationally acclaimed programs developed during my tenure as Commissioner on Aging in Connecticut, to ensure that new home health services provided at the local level are indeed delivered in the most cost efficient manner and based upon individual needs.

The notion of a new mechanism for case management derived from a largely federal funded demonstration research program called Triage. Now concluding its service and study, the Triage experiment tested the provision of appropriate care for Medicare-eligible persons by focusing on alternatives to inappropriate institutionalization. The action component of Triage made assessments of client needs and arranged for services to follow up on existing service agencies. Via special arrangements, Triage was able to make available a wide range of services using Medicare funds to some 1550 clients in 1978 in seven central Connecticut towns. The research component of Triage is under the direction of the University of Connecticut Health Center, and is now completing its study of client health status, client functioning in daily living activities, and on the costs of care.

Connecticut's other fine program is SAIL (Strengthened Assistance for Independent Living). This home care development program provides home care service to functionally impaired older persons to avoid unnecessary care in nursing homes. Using both state and federal Title XX funds, SAIL has developed a service plan based on individual needs and then purchased those services for clients from the appropriate agencies, after making maximum use of family and other resources. Preliminary figures show that the average cost per SAIL client of \$240.60 per month is 75 percent below the State Department of Social Service's average approved Medicaid rate for care in a skilled nursing facility, which is \$989.80 per month.

These pilot programs in Connecticut demonstrate the effectiveness of home health service coordination. Such "Coordinating Assessment and Monitoring Agencies" or CAM's could serve as a legitimate Medicare provider and in a systematic way tend to the assessment, monitoring and coordination functions of home health care. I urge the committee to further examine the lead that Connecticut has provided in this area.

I would like to sincerely commend the Committee and its Chairman for this opportunity to explore whether the covenant between the Congress and our older Americans has in fact been kept.

