We are all very proud of you and thank you for your hard work.

With Love,

GRANDPA.

Mr. Speaker, Jim Rice will be missed, but not forgotten.

INTRODUCTION OF THE COMMODITY EXCHANGE ACT AMENDMENTS OF 1997

HON. THOMAS W. EWING

OF ILLINOIS

IN THE HOUSE OF REPRESENTATIVES

Tuesday, February 4, 1997

Mr. EWING. Mr. Speaker, today I am reintroducing legislation to reform the Commodity Exchange Act [CEAct] which governs the regulation of futures and options on U.S. commodity exchanges and other risk management financial instruments that are traded in over-the-counter markets.

This legislation is identical to H.R. 4276 introduced in the 104th Congress. Briefly, the legislation provides a conditional exemption for certain transactions involving professional markets, clarifies the effect of the designation of a board of trade as a contract market, simplifies the process for submission and disapproval of contract market rules, regulates audit trail requirements, establishes cost-benefit analysis requirements, repeals the Commodity Futures Trading Commission's deficiency order authority, and clarifies the impact of the section 2(a)(1)(A)(ii) of the CEAct commonly known as the Treasury amendment.

The purpose of the legislation is to assure the competitiveness of the U.S. futures industry, to preserve the vitality of price discovery and hedging functions of the futures markets and to recognize the impact of technology on our markets. The legislation I am introducing today is designed to serve as a discussion document as the House Agriculture Committee prepares to debate the many issues involved in reform of the CEAct.

In an effort to further discussion, the committee has requested comment from industry representatives directly and indirectly impacted by the CEAct including producer groups, self-regulating organizations, exchanges, the Commodity Futures Trading Commission, and the U.S. Department of Agriculture. I look forward to working with interested entities in the industry and with my colleagues on both sides of the aisle as we proceed with this necessary reform.

TRIBUTE TO THE MINNESOTA VETERINARY MEDICAL ASSOCIATION ON ITS 100TH ANNIVERSARY

HON. JIM RAMSTAD

OF MINNESOTA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, February 4, 1997

Mr. RAMSTAD. Mr. Speaker, I rise today to pay tribute to the members of the Minnesota Veterinary Medical Association and its members' 100 years of faithful service to Minnesotans.

Over the years, the members of the association have provided exceptional animal health care, food safety, and public health services through the adherence to the highest professional standards of veterinary medicine.

The association was founded in 1897 by 13 veterinarians to further cultivate the science and art of comparative medicine and to promote livestock production as a branch of the agricultural industry. They also worked to protect high educational and ethical standards within their profession and to promote educational opportunities for the veterinarians of Minnesota.

Mr. Speaker, the veterinarians of Minnesota have been a crucial health care provider for the animal population in my State for the last 100 years—making consumers, pets, their owners, and the rural economy of our State a healthier place. I wholeheartedly applaud the 1,400 current members of the association for their dedication and service to the people of Minnesota.

TRIBUTE TO LIA B. BOWLER

HON. JAMES M. TALENT

OF MISSOURI

IN THE HOUSE OF REPRESENTATIVES

Tuesday, February 4, 1997

Mr. TALENT. Mr. Speaker, I rise today to honor the outstanding accomplishments of 2d Lt. Lia B. Bowler. In December, Ms. Bowler successfully completed Marine Corps Officer Candidate School. In the fine tradition of the corps, she persevered through the rigors of the training and was accepted into the elite group of Americans that serve our country as officers in the Marine Corps.

Yet, Mr. Speaker, I rise today not only to congratulate Ms. Bowler on her commission, but also to recognize her outstanding work for the Second Congressional District of Missouri. We had the honor of her service first as an intern and later as our system administrator. In the almost 2 years she worked in the Washington office, she exhibited a dedication, diligence, and professionalism which were highly valued by everyone who worked with her. Although her loss to the Marine Corps will be felt by our office, it will be a gain for the Marines. Therefore, it is with great confidence that I can say her service as an officer will be in the highest traditions of the corps.

INTRODUCTION OF LEGISLATION TO CORRECT MEDICARE BENEFICIARY OVERCHARGES IN HOSPITAL OUTPATIENT DEPARTMENTS

HON. FORTNEY PETE STARK

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, February 4, 1997

Mr. STARK. Mr. Speaker, I am today introducing with Representative WILLIAM COYNE a bill to correct a glaring failure in the Medicare program—the massive over-charging of beneficiaries in hospital outpatient departments [HOPD's].

This bill will save Medicare disabled and senior beneficiaries about $35.7 billion between 1999 and 2003. It will stop the steady, upward climb in the percentage of HOPD costs that beneficiaries have to pay. Usually beneficiaries pay 20 percent of a set fee schedule for part B services. The way the HOPD law was drafted, however, has caused the beneficiary share of HOPD costs to climb to about 45 percent of outpatient department revenues. If the law is not corrected, seniors will pay an ever-increasing percentage.

Our bill will stop the rise in the beneficiaries' effective percentage payment and return it to the 20 percent that Medicare beneficiaries were promised. There are reports that the President's Medicare budget proposal will include a correction of the HOPD problem, but over a 10-year period. The President is to be congratulated for finally addressing this issue. We believe it should be done more quickly, and would like to work with interested parties to find the best way to pay for this program improvement at the same time we are making other savings to extend the life of the Medicare part A trust fund.

The HOPD problem is a serious one, with no easy solutions. In 1995, the Secretary of HHS presented a lengthy report to Congress that discussed a number of possible solutions—see attachment No. 1. We have adopted the basic ideas from that report and establish an HOPD prospective payment system and a correction of what is known as the formula-driven overpayment [FDO].

How did this problem arise? Hospital outpatient departments do all kinds of things like tests, x rays, and surgeries that the Secretary of HHS has determined can be safely done in an outpatient setting. HOPD services are paid under Part B. The key to the problem lies in the fact that Medicare pays HOPD's on a reasonable cost basis and not based on a prospective payment system [PPS] or fee system. Since costs are determined retroactively, the hospitals get paid retroactively by Medicare, but bill the patient at the time of service. At the time the patient gets the service and leaves the HOPD, we are unable to say for sure what the patient's 20 percent copayment is, since there is no set schedule of fees. As a result, the system was established in such a way that coinsurance is calculated based on charges at time of service. The charges, of course, may have little or no relation to costs and have crept up over time relative to what Medicare ends up actually paying for the cost of the service. So instead of paying 20 percent of a set and known fee, the seniors and disabled are paying 20 percent of charges. In 1996, this has become the equivalent of about 45 percent of the total payment to the hospital, Medicare plus coinsurance.

There is often a complication in the payment system I've just described for certain types of services provided in HOPD's, which results in what is called a formula-driven overpayment. If the surgery done in the HOPD is one that could have been done in an ambulatory surgery center and ASC's do about 2,700 different kinds of procedures, so there is a lot of overlap, then the amount of the Medicare payment is calculated differently. The payment calculation is also determined differently for radiology and diagnostic services performed in hospital OPD's compared to other services. For these services, the payment is either the lower of: One, reasonable cost as I've described in the previous paragraph, or two; a blended amount that is based partially on the reasonable cost in No. 1 and partially on either the ASC payment rate, for surgical services, or the physician fee schedule, for diagnostic and radiology services.

Because of a drafting error in the payment formula, however, Medicare payments for the services paid on the basis of the blended amount are higher than they should be. This is because the computation of the Medicare payment is done in such a way that it is not reduced by the full amount of the actual coinsurance paid by the beneficiary. In contrast, for OPD services other than surgery, radiology, and diagnostic, every dollar a beneficiary pays in coinsurance results in a decrease of $1 in what Medicare pays. As a result of this erroneous payment formula, Medicare payments are higher than intended. Furthermore, hospitals have an incentive to increase their charges because they will receive more from Medicare. This bill would correct this formula-driven overpayment. Attachment No. 2 explains the math in a specific example that makes the problem clearer than my words can describe.

We will be submitting a detailed explanation of how this bill will work to restore the proper balance between hospital billings and the obligations of beneficiaries. We hope that this legislation can be enacted soon, before the burden on seniors and the disabled becomes even more unfair.

THE SECRETARY OF HEALTH
AND HUMAN SERVICES,
Washington, DC, March 17, 1995.

Hon. ALBERT GORE, Jr.,
President of the Senate, Washington DC.

DEAR MR. PRESIDENT: I am respectfully submitting the report on Medicare hospital outpatient prospective payment as required by section 4151(b)(2) of the Omnibus Budget Reconciliation Act of 1990 (P.L. 101–508). This section requires the Secretary of Health and Human Services to develop a proposal to replace the current Medicare payment system for hospital outpatient services with a prospective payment system.

The report presents a phased approach to the establishment of a hospital outpatient prospective payment system. For the first phase, a prospective payment system would be for hospital outpatient surgery, radiology, and other diagnostic procedures. As further research is completed, the payment system could be expanded to cover all hospital outpatient services.

The report discusses an issue with the amount of coinsurance that Medicare beneficiaries pay for outpatient surgery, radiology and other diagnostic procedures. Current law requires that beneficiaries pay 20 percent of *submitted charges.* However, in the recent past, hospitals' submitted charges have substantially exceeded Medicare's *payment* for these services, so that most of the time beneficiary coinsurance payments substantially exceed 20 percent of Medicare's payment. If Congress chose to set beneficiary coinsurance at 20 percent of Medicare allowed payments, this act would require a substantial increase in program expenditures and also could affect payments to providers. Even incremental modifications in the coinsurance percentage can have substantial impacts on Medicare program expenditures. Should Congress decide to modify current coinsurance arrangements, the report presents a number of alternatives and displays their costs to the Medicare program.

In addition, the report discusses a related problem with the current payment formula that results in an unintended increase in Medicare payments—the so-called ''formula driven overpayment.'' We believe this result was not intended by Congress. If Congress chooses to address this issue, the correction can be made separately or as part of the implementation of a prospective payment system.

I am also sending a copy of this report to the Speaker of the House of Representatives.

Sincerely,

DONNA E. SHALALA.

Enclosure.

FORMULA-DRIVEN OVERPAYMENT TO HOSPITALS

As mentioned in previous sections, there is an anomaly that occurs with Medicare's payment when payment is made under the blended rate for hospital outpatient services. Beneficiaries pay 20 percent of hospital charges as coinsurance on most hospital outpatient services. Generally, every dollar a beneficiary pays in coinsurance results in a corresponding decrease of $1 in Medicare payment. To illustrate, assume a beneficiary receives a hospital outpatient service for which the Medicare payment is based on the lower of the hospital's reasonable costs or its customary charges. The hospital charges $1,000 and its costs are $750. Payment is determined as follows:

Total payment to the hospital	$750
Beneficiary payment ($1,000 20%)	−(200)
Medicare program payment	$550

If the hospital increases its charges, the beneficiary's coinsurance will increase, the Program payment will decrease, but the total amount realized by the hospital will not change.

This is not the case for coinsurance paid for procedures that are paid on the basis of a blended rate. For example, the blend for ASC approved surgical procedures consists of 42 percent of the hospital's costs or charges net of coinsurance, whichever is less, and 58 percent of 80 percent of the ASC payment rates. Because the blend is determined net of the coinsurance that would have been paid to an ASC (20 percent of payment rates), instead of the 20 percent of charges the beneficiary actually paid, Medicare does not get the full benefit of the actual coinsurance when the hospital's charges exceed the ASC payment rates. That is, to the extent that 20 percent of hospital charges exceed 20 percent of the ASC payment rates. Medicare's payment is higher than it should be since the formula assumes a lower copayment than is actually provided. Medicare does not receive the benefit of 58 percent of the difference between 20 percent of charges and 20 percent of the ASC rate, and the hospital retains the amount. For purposes of this report, this amount is called the formula-driven overpayment.

The following example illustrates how the blended payment method transfers a portion of the benefit of coinsurance away from the Medicare program to the benefit of hospitals. The result is that hospitals receive more payment than intended by statute, while the Medicare program pays more:

Assume a Medicare beneficiary receives an ASC procedure in a hospital outpatient department. The hospital charges $1,000, its costs for performing the surgery are $750, and the ASC payment rate for the procedure is $585. Assume the annual deductible has been met. The beneficiary's coinsurance payment is $200 (i.e., $1,000 20%). The Medicare program payment is calculated as the lower of:

1. The lower of the hospital's reasonable cost or its customary charges, net of deductible and coinsurance amounts:	
$750 − $200	$550
or	
2. A blended amount comprised of:	
42 percent of the lower of the hospital's costs or charges, net of deductible and coinsurance (see 1 above):	
42% $550	$231
and	
58 percent of 80 percent of the ASC payment rates, net of deductible:	
58% (80% $585)	271
Total	$502

The blended amount is the lowest and, therefore, the amount the Medicare program pays. The hospital receives:

From the Beneficiary	$200
From the Medicare program	+502
Total	$702

Medicare payment would be lower if the payment were calculated the way it is for other hospital outpatient services and, instead of removing coinsurance and deductibles at each step of the payment calculation, the total payment is calculated first and then is reduced by the amount the beneficiary actually paid. For example:

Determine the lower of:	
1. The lower of the hospital's reasonable cost ($750) or its customary charges ($1,000)	$750
or	
2. A blend of:	
42 percent of the lower of costs or charges:.	
(42% $750)	$315
and	
58 percent of the ASC payment rate: (58% 585)	+339
Total	$654

Then reduce by beneficiary copayments to arrive at the Medicare program's payment:	
Total Payment	$654
Beneficiary Payment (20% 1,000)	−(200)
Medicare program Payment	$454

The difference between $502 and $454, or $48, represents the formula-driven overpayment which occurs under the current blended payment formulas.

Moreover, because of the way coinsurance is accounted for under the current blended payment methods, the hospital can further increase its total payment by simply increasing its charges. For example, if the hospital increased its charge to $1,300 for the procedure, the hospital would still be paid under the blended payment amount but it would receive:

From the Beneficiary (20% $1,300)	$260
From the Medicare program	+477
Total	$737

Program payment would be computed as follows:	
42 percent of the lower of the hospital's cost or charges, net of deductibles and coinsurance:	
42% ($750 − $260)	$206

and 58 percent of 80 percent of the ASC payment rate net of deductible: 58% (80% $585)	$271
Total	$477

In the first illustration, the hospital charged $1,000 and received a total payment of $702. If the hospital merely increases its charges to $1,300, it will receive $737. As the example shows, for a hospital that is paid based on the blend, the more it charges, the more its total payment (beneficiary plus Medicare program payment) will be. As a result, the current payment system gives an incentive for hospitals to increase charges.

(Note: In order to simplify the examples in this section, the blended payment method is shown as it would apply to an individual procedure. In determining actual payments to hospitals, however, the blended payment calculation is applied in the aggregate to all of the ASC approved procedures a hospital performed during a cost reporting period, not on a procedure-by-procedure basis.)

The same situation exists under the current blended payment methods for hospital outpatient radiology and other diagnostic services. We estimate that the magnitude of the formula-driven overpayment that occurs under the blended payment method to be over $950 million in Medicare program payments to hospitals in 1993—approximately 14.8 percent of total payments for these services. This total includes $350 million for ASC approved surgeries and $600 million for radiology and other diagnostic services, respectively. For surgical procedures, this represents 10.8 percent of total payments to hospitals and 20 percent of Program payments to hospitals for these outpatient services. For radiology, the formula-driven overpayment represents 19 percent of total payments to hospitals and 38.7 percent of Program payments. By FY 2001, we estimate the formula-driven overpayment for surgery, radiology and other diagnostic services to be $6.7 billion.

We believe that these formula-driven overpayments were not intended by the Congress. If Congress chooses to address this issue, it could be enacted either as a separate change or as part of a prospective payment system for outpatient services. It should be pointed out that, if a prospective payment method for outpatient surgery, radiology and other diagnostic procedures is adopted, this change would automatically occur for those services. Indeed, we recommend that the prospective rates be set so that aggregate payments to hospitals for these services are no higher than current law payments net of the total amount of the formula-driven overpayment.

TRIBUTE TO JOHN MOONEY

HON. WILLIAM O. LIPINSKI

OF ILLINOIS

IN THE HOUSE OF REPRESENTATIVES

Tuesday, February 4, 1997

Mr. LIPINSKI. Mr. Speaker, I pay tribute today to an outstanding individual who represents hundreds of thousands of Americans who participated in the battle that was the beginning of the end of Nazi Germany—the invasion of Normandy.

Mr. Mooney, who served in the 2d Armored Cavalry Division, was part of the wave of brave Allied soldiers that stormed the beaches and cliffs overlooking the English Channel on June 6, 1944. Even after the Allies established a beachhead, it took more than 2 months of fierce fighting before the risk of the Germans reversing the invasion had ended.

During the last 3 years, Mr. Mooney and thousands of his comrades have been honored by the Regional Council of Normandy with the Medaille de Jubile, a decoration commemorating the 50th anniversary of the Battle of Normandy and the beginning of the liberation of Europe.

Mr. Speaker, I would like to remind our fellow members and all freedom loving people in America and the world of the debt of gratitude we owe Mr. Mooney and the heroic soldiers, sailors and airmen whose efforts at Normandy marked the beginning of the end of Nazi tyranny.

HONORING DR. MENASCHE-LANIADO

HON. ELIZABETH FURSE

OF OREGON

IN THE HOUSE OF REPRESENTATIVES

Tuesday, February 4, 1997

Ms. FURSE. Mr. Speaker, I rise today to recognize a very special woman who provides dental care for Soviet Union students who are participants in the programs created from the Freedom Support Act.

It is an unfortunate reality that these students arrive in our country with staggering dental problems. Dr. Sandra Menasche-Laniado of Portland, OR, has quietly taken it upon herself to provide the vital care that these students require, asking for no monetary compensation.

As an example of her incredible unselfishness, she currently is treating one young lady whose dental treatment will come to the staggering total of $3,780.

Dr. Menasche-Laniado is truly the essence of one person making a difference. She points the way in demonstrating the virtue of compassion and turning this compassion onto a path of positive, meaningful action. I applaud her work, and I am privileged to have this opportunity to recognize Dr. Menasche-Laniado before this body.

CELEBRATING A CENTURY OF INTEGRITY

HON. NITA M. LOWEY

OF NEW YORK

IN THE HOUSE OF REPRESENTATIVES

Tuesday, February 4, 1997

Mrs. LOWEY. Mr. Speaker, my distinguished colleagues, I rise today to call your attention to an important centennial anniversary that occurred in New York State last month.

On January 28, the New York State Society of Certified Public Accountants celebrated 100 years of distinguished service to the public.

In fact, the society is the oldest State professional accounting association in the Nation.

The founding members established the society to facilitate and support the establishment of the New York State CPA licensing law, the first such law in the United States.

The New York State Society of Certified Public Accountants represents the CPA profession, which was created to maintain the integrity of our Nation's capital markets.

The society has continuously served its members for 100 years by providing educational and professional information to enable them to better serve the public interest. Its code of conduct provides the framework for the highest ethical behavior and professionalism issues to protect the public interest.

The committees of the society have assisted state, local, and Federal regulators and other government groups in the discharge of their oversight of financial reporting, soundness, and integrity.

Please join me in wishing congratulations to the New York State Society of CPA's on its 100th anniversary.

INTRODUCTION OF THE MEDICARE HOSPICE BENEFIT AMENDMENTS OF 1997

HON. BENJAMIN L. CARDIN

OF MARYLAND

IN THE HOUSE OF REPRESENTATIVES

Tuesday, February 4, 1997

Mr. CARDIN. Mr. Speaker, I rise today with my colleague, ROB PORTMAN, and more than 50 additional colleagues to introduce the Medicare Hospice Benefit Amendments of 1997. This legislation will make technical changes and clarifications to improve the Medicare hospice benefit. This is a noncontroversial bill that has true bipartisan support and should be included as part of Medicare reform this year.

Hospice care is a vital Medicare benefit. It is a coordinated program of palliative medicine and supportive services provided mainly in the home but also in home-like settings that provides for physical, psychological, social, and spiritual care for dying persons and their families. Services are provided by a medically directed, interdisciplinary team of professionals and volunteers. Hospice recognizes dying as part of the normal process of living and focuses on maintaining the quality of remaining life. Hospice affirms life and neither hastens nor postpones death.

The concept of hospice care emerged in this country in response to the unmet needs of dying patients and their families for whom traditional medical care was no longer effective, appropriate, or desired. Hospice has become an effective alternative to there being ''nothing else to do.'' The Nation's hospice programs currently provide compassionate care to more than 390,000 patients and families each year. In 1994, one out of every three people who died from cancer or AIDS were cared for by hospice. Terminally ill Medicare patients who elect hospice opt out of most other Medicare services related to their terminal illness and instead receive all of their care through the hospice program.

Hospice is not only a compassionate and appropriate form of care for terminally ill individuals, it is also cost effective. A 1994 Lewin study comparing the relative cost of hospice care to conventional care for Medicare beneficiaries with cancer, found that for every dollar Medicare spent on hospice patients, it saved $1.52 in Medicare part A and B expenditures. Based on these findings, the growth and greater utilization of hospice care should be viewed in a positive light and should be encouraged.

The Medicare hospice benefit was adopted by Congress 1982. Since then, more and