The original documents are located in Box 22, folder "Medicare" of the James M. Cannon Files at the Gerald R. Ford Presidential Library.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
OFFICE OF THE SECRETARY
WASHINGTON, D.C. 20201

MAR 25 1975

MEMORANDUM FOR THE HONORABLE THEODORE C. MARRS

This is in further reply to your memorandum of February 24 concerning potential savings through transferring coverage of outpatient surgery and related services from part B to part A of Medicare. I am enclosing a report on the subject by the Social Security Administration.

I concur with the view that the encouragement of use of outpatient surgery would be a more feasible and appropriate goal within the context of the Administration's Comprehensive Health Insurance Plan. You may be assured that we will consider this objective as we proceed in our work of preparing CHIP for resubmission to the Congress in early 1976.

David H. Lissy
Executive Secretary
to the Department

Enclosure

bcc: Pam Needham

Considerations Concerning Providing Coverage of Outpatient Surgery and Related Services Under Medicare Part A

We agree that development of incentives under Federal health programs for expanding use of outpatient surgery is a worthwhile activity. Under authority provided in Public Law 92-603, the Department of Health, Education, and Welfare is currently conducting experiments with certain outpatient surgical facilities to determine whether additional Medicare coverage of services provided by such facilities offers promise of improved care or more efficient delivery of care and whether financial savings would result from such coverage. Results of these experiments will become available in 1976. Preliminary information provided by such facilities indicates that certain types of surgery now customarily provided on an inpatient basis could safely be provided at less overall cost on an outpatient basis, particularly where both the health status of the patient and the nature of the procedure reduce the potential for possible surgical complication.

However, inducing changes in basic health care delivery patterns is a time-consuming and complex process. Thus, the likelihood seems slim of substantially modifying traditional surgical practices in the short term through a limited program such as Medicare. The Office of the Actuary of the Social Security Administration believes that it is unlikely that there would be any savings in the foreseeable future resulting from removing coverage of outpatient surgery and related services from Medicare part B and including it under part A; nor would there be any immediate large-scale increase in the availability of beds for long-term care. In fact, the actuaries estimate that, due primarily to the loss of substantial beneficiary copayments, such a transfer of liability from part B to part A would cost $30 to $35 million in fiscal year 1976, unless significant offsets could be made in other program expenditures.

From a practical standpoint, the Medicare program, as a third-party payor, can influence the choice of outpatient surgery over inpatient care only insofar as there are financial incentives under the program to both patient and physician to make that choice. Under present law, a Medicare patient has a financial incentive to opt for outpatient surgery where feasible. If, for example, a patient who had not met any part of his part B deductible were to undergo surgery as a hospital inpatient, he would be responsible for a $92 part A deductible applied to the hospital services and the $60 part B deductible and 20-percent coinsurance applied to the physician's fee. For the same surgery on an outpatient basis, he would be responsible for only the part B deductible and 20-percent coinsurance on both the physician's fee and the hospital cost (usually $200 to $300)--thereby saving $30 to $50. The current Administration proposal to add a 10-percent-of-charges coinsurance for inpatient stays would provide further financial incentive for the patient to elect outpatient care.

Financial incentives to opt for outpatient surgery where feasible are certainly needed. However, probably the most important element in influencing a trend toward the greater use of outpatient surgery would be an educational effort, aimed at both physicians and patients, to inform them of the advantages of outpatient surgery both to themselves and to the health care system as a whole. This type of activity is not, per se, a function of a health insurance program such as Medicare; and even if it could be attempted through more appropriate programs, there is doubt as to its effectiveness with the aged Medicare population, most of whom can be expected to be unable or unwilling to accept a less-than-traditional approach to surgery.

Over the long run; we believe that an objective of stimulating greater use of outpatient surgery could best be accomplished through the national health insurance initiative. The Administration's Comprehensive Health Insurance Plan (CHIP) would provide much broader opportunities for effecting economies in the delivery of health care to all segments of the population. The much larger and more diverse coverage group under CHIP would, in our opinion, offer significantly more leverage in influencing medical care patterns and would constitute a more "receptive audience" to educational efforts.

THE WHITE HOUSE

WASHINGTON

February 24, 1975

MEMORANDUM FOR

SECRETARY, HEALTH, EDUCATION AND WELFARE

THRU: OMB

To what extent can medicare funds be productively diverted to catastrophic or other important areas by making outpatient surgery and outpatient diagnostic services attractive under medicare (e.g. Part B outpatient to Part A and adjusting co-insurance). The present system forces costly inpatient care which some believe is not essential.

Could this free existing beds for long term care needs?

Theodore C. Marrs
Special Assistant to the President

Penal copy 4/3
(orig att.)

THE WHITE HOUSE

WASHINGTON

April 3, 1975

MEMORANDUM FOR THE PRESIDENT

FROM: JIM CANNON

SUBJECT: Secretary Weinberger's Memorandum on Medicare Savings

When the 1976 budget was put together last fall HEW recommended, and you agreed, that the Medicare reasonable cost schedule for hospitals should be revised. This revision would provide that a hospital's costs above the 80th percentile of those at comparable hospitals would be considered unreasonable and therefore not reimbursable by Medicare.

The 90th percentile is the current reimbursable level. By reducing the level to the 80th percentile, the 1976 budget counts on a saving of $15 million.

Secretary Weinberger has submitted an information memo to you on this subject (at Tab A). He reports that HEW is about to issue regulations on this new rule so that it can take effect by July 1.

The Secretary points out that we can expect great protests when the regulation is issued. About 750 hospitals, including some of the country's most prestigious, will receive less than full reimbursement for their Medicare patients. A list of the major hospitals affected is attached.

While we've already received criticism from the medical community on this decision, you should be aware that we'll probably soon be hearing from the prominent citizens who serve on the boards of these hospitals. While they support your efforts to reduce Federal spending, they do not agree that hospital funds should be included in the cuts.

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DOMESTIC COUNCIL CLEARANCE SHEET

DATE: April 3, 1975

JMC action required by: COB 4/3/75

TO: JIM CANNON

VIA: DICK DUNHAM

JIM CAVANAUGH

FROM: PAM NEEDHAM

SUBJECT: Secretary Weinberger's Memorandum on Medicare Savings

COMMENTS: J.M.C. NOTE THAT Memorandum is ON THE LIST OF HOSPITALS

DATE: _____

RETURN TO:

Material has been:

_____ Signed and forwarded

_____ Changed and signed (copy attached)

_____ Returned per our conversation

_____ Noted

_____

Jim Cannon

THE WHITE HOUSE

WASHINGTON

April 2, 1975

MEMORANDUM FOR : PAM NEEDHAM

FROM : JIM CANNON

SUBJECT : Announcement of Medicare Savings

The attached memorandum for the President from Secretary Weinberger is forwarded to you for appropriate handling.

Please route your response back through the Deputy Directors in time to reach my office by end of the day on 4/3/75.

Thank you.

Attachment
cc: Jim Cavanaugh
cc Dick Dunham

THE SECRETARY OF HEALTH, EDUCATION, AND WELFARE
WASHINGTON, D. C. 20201

April 2, 1975

MEMORANDUM FOR THE PRESIDENT

SUBJECT: ANNOUNCEMENT OF MEDICARE SAVINGS

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Attached is a list of some of the major hospitals with the reduction in Federal funding caused by the 90th percentile regulation, adopted eight months ago, and the further reductions that will occur after we publish the 80th percentile regulation which is the subject of this memorandum.

If we do not make the reduction from the 90th to the 80th percentile, the savings of $15 million called for in the budget will not be achieved.

We are not recommending a change, but I did think you should know about this before the anticipated protests begin to roll in.

Caspar W. Weinberger

Anticipated Reimbursement Reductions For Selected Hospitals

Hospital Name	Reimbursement Reductions 80th Percentile	90th Percentile	
John Hopkins - Baltimore	$ 241090	-	241,090
Stanford University - Palo Alto	1524456	744525	779,931
University of Pennsylvania - Philadelphia	605412	-	605,412
Mt. Sinai - New York	1188000	-	1,188,000
University of Chicago - Chicago	677094	206206	470,888
Cook County - Chicago	1450785	927795	522,990
Philadelphia General - Philadelphia	635844	192198	443,646
San Francisco General	541662	287245	254,417
Long Island Jewish	203970	-	203,970
New England Medical - Boston	509640	221693	287,947
Peter Bent Brigham - Boston	163805	-	163,805
Memorial Hospital for Cancer - New York	2803194	2241040	562,154
Duke University - Durham	197816	-	197,816

50 cts.

22

22 title

34 36/ ~~58 60/~~

58 60 63

82 84

for file

THE WHITE HOUSE

WASHINGTON

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/s/ Cap Weinberger

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April 3, 1975

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Secretary Weinberger has submitted an information memo to you on this subject (at Tab A). He reports that HEW is about to issue regulations on this new rule so that it can take effect by July 1.

Because about 750 hospitals, including some of the country's most prestigious, will receive less than full reimbursement for their Medicare patients, the Secretary points out that we can expect great protests when the regulation is issued. A list of the major hospitals affected is attached. Since the publication of the budget, all have known the reduction would be coming. While we've already received criticism from the medical community on this decision, you should be aware that we'll probably soon be hearing from the prominent citizens who serve on the boards of these hospitals. While they support your efforts to reduce Federal spending, they do not agree that hospital funds should be included in the cuts.

Policy: ~~further~~

In the FY '76 Budget msg.,

the President's policy is "to

limit reimbursement for

medically necessary services

to reasonable costs."

(2)

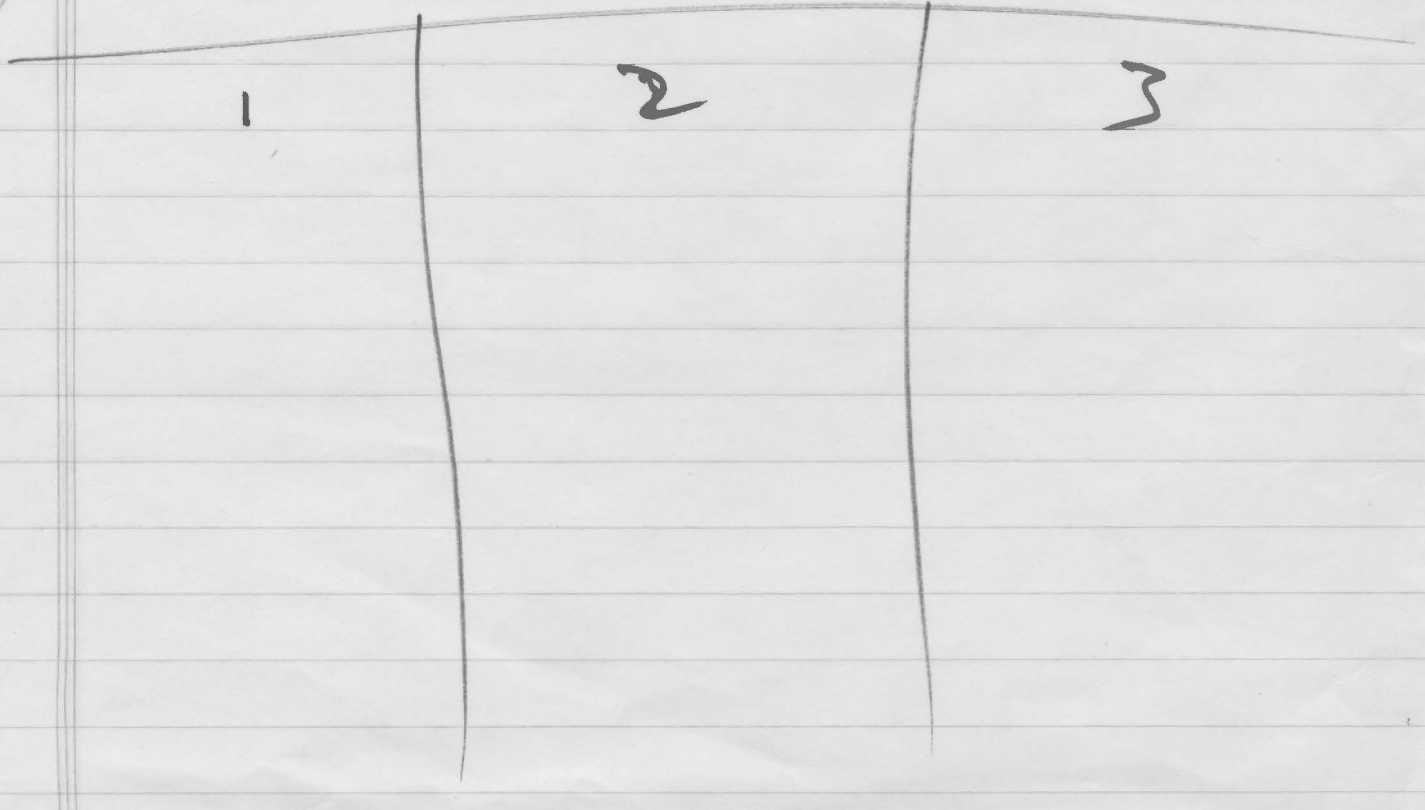
Cost to Hospital for medicare patients under the 80 TH Percentile

(1)

~~What~~ Percent Cost to Hospital for medicare patients under the 90 TH Percentile

(3)

Additional cost to Hospital



- Pres. policy is limit reimb for med. rec. services to reas. costs.

THE WHITE HOUSE
WASHINGTON

April 8, 1975

MEMO TO : PAM NEEDHAM

FROM : JIM CANNON

SUBJECT : Changes on Medicare Savings Memo

The attached is forwarded for

___Your handling

_X_ FYI

___Other _____

Attachment

INFORMATION

THE WHITE HOUSE

WASHINGTON

April 8, 1975

MEMORANDUM FOR THE PRESIDENT

FROM : JIM CANNON

SUBJECT: Secretary Weinberger's Memorandum on Medicare Savings

When the 1976 budget was put together last fall HEW recommended, and you agreed, that Medicare payments to hospitals should be revised. Your policy statement on Medicare hospital costs was "to limit reimbursement for medically necessary services to reasonable costs."

The decision at that time was that the cost of any hospital above the 80th percentile of costs at comparable hospitals would be considered unreasonable and therefore not reimbursable by Medicare.

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While we have already received criticism from the medical community on this decision, you should be aware that we will probably soon be hearing from prominent citizens who serve on the boards of these hospitals.

While they support your efforts to reduce Federal spending, they do not agree that hospital funds should be included in the cuts.

Attachment

THE SECRETARY OF HEALTH, EDUCATION, AND WELFARE
WASHINGTON, D. C. 20201

April 2, 1975

MEMORANDUM FOR THE PRESIDENT

SUBJECT: ANNOUNCEMENT OF MEDICARE SAVINGS

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Caspar W. Weinberger

MEDICARE REIMBURSEMENT REDUCTIONS FOR SELECTED HOSPITALS

HOSPITAL NAME	PRESENT COST TO HOSPITALS UNDER MEDICARE REIMBURSEMENT AT THE 90th PERCENTILE	ESTIMATED COST TO HOSPITALS UNDER MEDICARE REIMBURSEMENT AT THE 80TH PERCENTILE	ADDITIONAL COST TO HOSPITALS OF NEW 80TH PERCENTILE LIMITATION
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Hold for retyped version

Sally

THE WHITE HOUSE

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April 8, 1975

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Chron

Hold for stapled version

THE WHITE HOUSE

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Caspar W. Weinberger

MEDICARE REIMBURSEMENT REDUCTIONS FOR SELECTED HOSPITALS

HOSPITAL NAME	PRESENT COST TO HOSPITALS UNDER MEDICARE REIMBURSEMENT AT THE 90th PERCENTILE	ESTIMATED COST TO HOSPITALS UNDER MEDICARE REIMBURSEMENT AT THE 80TH PERCENTILE	ADDITIONAL COST TO HOSPITALS OF NEW 80TH PERCENTILE LIMITATION
Johns Hopkins (Baltimore)	-	$ 241,090	$ 241,090
Stanford University (Palo Alto)	$ 744,525	1,524,456	779,931
University of Pennsylvania (Philadelphia)	-	605,412	605,412
Mt. Sinai (New York)	-	1,188,000	1,188,000
University of Chicago (Chicago)	206,206	677,094	470,888
Cook County (Chicago)	927,795	1,450,785	522,990
Philadelphia General	192,198	635,844	443,646
San Francisco General	287,245	541,662	254,417
Long Island Jewish	-	203,970	203,970
New England Medical (Boston)	221,693	509,640	287,947
Peter Bent Brigham (Boston)	-	163,805	163,805
Memorial Hospital for Cancer (New York)	2,241,040	2,803,194	562,154
Duke University (Durham)	-	197,816	197,816

July

THE WHITE HOUSE

WASHINGTON

May 13, 1975

MEMORANDUM TO: ROLAND ELLIOTT

FROM: PAM NEEDHAM PN

SUBJECT: Letters on Nursing Differential

Per our conversation, attached is a draft response for, and a number of letters dealing with, the termination of inpatient routine nursing salary cost differential in the Medicare program.

You will be receiving more letters for response shortly. We are going through the stacks to be sure there are no letters dealing with another subject mixed in.

Many thanks.

go thru remaining ltrs.

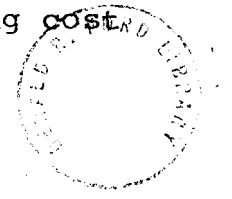
Dear _____:

Thank you for your recent letter in which you express concern about the proposed regulations to terminate the inpatient routine nursing salary cost differential in the Medicare program.

Since the nursing cost differential became effective in July 1969, there have been changes in the Medicare law, changes in the way services are furnished, and changes in the way in which Medicare reimburses for routine services. These changes gave rise to a decision to terminate recognition of the cost differential.

For instance, P.L. 92-603, the Social Security Amendments of 1972, expanded the scope of Medicare coverage to include certain beneficiaries in the below age 65 population. As a result, as of January 1975, approximately 8.5 percent of the total number of Medicare beneficiaries are below age 65. Also, it has been estimated that approximately 28 percent of all individuals currently entering on the Medicare rolls are under age 65.

Consequently, the larger the segment of the below age 65 population that is encompassed by the Medicare program, the more appropriate an average inpatient routine nursing cost per day amount for all beneficiaries becomes.



Furthermore, the studies originally used in establishing the inpatient routine nursing salary cost differential indicated that elderly patients received a greater

degree of nursing care than did younger ones. However, since July 1969, there has been a marked increase in the number of special care beds (intensive care, cardiac care, etc.), providing more intensive nursing care than is found in general routine care areas. As a result there has been a shift of the intensely ill from routine areas to these special care units.

Recent data shows that there is a higher percentage utilization by Medicare beneficiaries of the special care units than of general routine areas, indicating that the nursing care that brought about recognition of the routine nursing differential is now being given in special care units.

These findings, among others, led to changes in Medicare cost apportionment requirements, effective January 1, 1972, which authorized, for the first time, separate cost finding and apportionment for care furnished in special care units. Costs in special care units, such as cardiac care units, are substantially higher than costs in general care areas. Consequently, the separate apportionment for special care units increased Medicare reimbursement to providers for services furnished to the elderly in these units by reflecting directly their above-average use of such units.

Accordingly, the Department of Health, Education, and Welfare has proposed that the nursing cost differential no longer be considered an allowable cost under the Medicare program.

I have taken the liberty of sharing your letter with officials of the Department of Health, Education, and Welfare so that it may be considered as the final regulations are being prepared.

Sincerely,

Roland Elliott

Prof. Elliot
sign.
note

C-26

Thank you for your recent letter in which you express concern about the proposed regulations to terminate the inpatient routine nursing salary cost differential in the Medicare program.

The inpatient routine nursing salary cost differential to recognize the above average costs of inpatient routine nursing care furnished to Medicare beneficiaries became effective July 1969. Since that time there have been changes in the Medicare law, changes in the way services are furnished, and changes in the way in which Medicare reimburses for routine services. These changes gave rise to a decision to terminate recognition of this cost differential.

the nursing cost differential became effective in July 1969

For instance,
P.L. 92-603, the Social Security Amendments of 1972, expanded the scope of Medicare coverage to include certain beneficiaries in the below-age-65 population. As a result, as of January 1975, approximately 8.5 percent of the total number of Medicare beneficiaries are below age 65. Also, it has been estimated that approximately 28 percent of all individuals currently entering on the Medicare rolls are under age 65.

Therefore, it can be expected that the ratio of below-age-65

~~beneficiaries to the total Medicare population will continue to increase.~~ Consequently, the larger the segment of the below-age-65 population that is encompassed by the Medicare program, the more appropriate an average inpatient routine nursing cost per day amount for all beneficiaries ~~(excluding recognition of any differential)~~ becomes.

Furthermore, the studies originally used in establishing the inpatient routine nursing salary cost differential indicated that elderly patients received a greater degree of nursing care than did younger ones. However, since July 1969, there has been a marked increase in the number of special care beds (intensive care, cardiac care, etc.), providing more intensive nursing care than is found in general routine care areas. As a result ~~and~~ there has ~~thus~~ been a shift of the intensely ill from routine areas to these special care units. ~~In addition,~~ recent data ~~indicate~~ show that there is a higher percentage utilization by ~~program~~ Medicare beneficiaries of the special care units than of general routine areas, ~~thus reflecting to a significant extent~~ indicating that the nursing care that brought about recognition of the routine nursing differential is now being given in special care units. ~~These changes were not reflected in the original studies.~~

Some of these findings, among others, led to changes in Medicare cost apportionment requirements, effective January 1, 1972, which authorized, for the first time, separate cost finding and apportionment for care furnished in special care units. Costs in special care units, such as cardiac care units, ~~which are the most common type of such units~~ are substantially higher than costs in general care areas. Consequently, the separate apportionment for special care units increased Medicare reimbursement to providers for services furnished to the elderly in these units by reflecting directly their above-average use of such units.

Accordingly, the Department of Health, Education, and Welfare has proposed that the nursing cost differential no longer be considered an allowable cost under the Medicare program.

I have taken the liberty of sharing your letter with officials of the Department of Health, Education, and Welfare so that it may be considered as the final regulations are being prepared.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

OFFICE OF THE SECRETARY

WASHINGTON, D.C. 20201

May 12, 1975

rec'd. 5/13/75

MEMORANDUM FOR MRS. PAMELA NEEDHAM
THE WHITE HOUSE

I am enclosing a draft you may wish to use in responding to letters about the nursing cost differential regulations. I am also returning to you the originals of the letters to the President from James E. Pede and Gaston Herd.

This draft is perhaps longer than you will want to use, but I thought I would let you decide how much to edit.

It is my understanding that SSA intends to move rapidly on publishing the final regulations. The comment period ended May 5.

I understand that one effect of the termination of the inpatient routine nursing salary cost differential will be that Medicaid payments will increase, since the Medicare routine nursing cost differential is subtracted from the total allowable routine nursing service costs in determining reimbursement for Medicaid patients. I did not think you would want to include this information in your replies, however.

David H. Lissy
Executive Secretary
to the Department

Enclosure

Medicare

are discovered in the middle of the night, and you can't just get up and go at two or three o'clock in the morning and say goodbye and keep peace in the family if your wife doesn't understand.

The job makes it impossible for his wife Pat to depend on meal schedules or even days off.

"We used to go to the Rim or to Rocky Point sometimes," said Ysasi, "but we haven't been able to do that for some time."

In addition to investigating homicides, Ysasi has worked for the department as a diver, slipping on his fins and wet-suit to dive for bodies and, once, to dive into the Papago Park lagoon to recover loot from a major jewel theft.

He's played softball in the annual charity game between the police and firemen. He lectures, whenever and wherever possible, to law enforcement agencies and others on the Sudden Infant Death Syndrome, the mysterious circumstance that sometimes kills babies and which has sometimes left their parents under needless clouds of suspicion.

Ysasi says he'll retire from the department in December after completing 20 years. Most police officers who consider the welfare of their families retire at the earliest possible time, take their retirement pay and add to it whatever income they can earn in a new career.

Under state law there is no way in which a retiring police officer can be hired back by his department, even as a civilian, without losing his retirement pay, and so his experience is lost to the department.

POTENTIAL FOR $170 MILLION PER YEAR SAVINGS IN MEDICARE ADMINISTRATIVE COSTS

HON. CHARLES A. VANIK

OF OHIO

IN THE HOUSE OF REPRESENTATIVES

Friday, September 5, 1975

Mr. VANIK. Mr. Speaker, recently, the Social Security Administration released a report on the efficiency of various health insurance companies who help administer part A and B of the medicare program. The range of efficiencies is staggering and indicates a clear potential for savings in the medicare program.

Because of the importance of this issue, I would like to include in the RECORD at this point a letter which I sent to the Director of the Bureau of Health Insurance on August 28:

COMMITTEE ON WAYS AND MEANS,
U.S. HOUSE OF REPRESENTATIVES,
Washington, D.C., August 28, 1975.

Mr. THOMAS M. TIERNEY,
Director, Bureau of Health Insurance, Social Security Administration, Baltimore, Md.

DEAR MR. TIERNEY: Enclosed is a copy of a detailed letter which I have received from the Social Security Administration's Assistant Commissioner for Research and Statistics which describes the present status of Medicare research projects.

While I believe that there are a number of problems in the Medicare research program, I am particularly concerned by the report that no action has yet been taken to develop and test incentive contracts for Medicare intermediaries and carriers. As the letter states:

"The Bureau of Health Insurance (BHI) has the responsibility for experimentation in this area. BHI has engaged in dialogue with the contractor community, held meetings with other interested parties, and plans to issue a letter of solicitation shortly for the conduct of pilot projects involving cost plus incentive fees and fixed price contracts."

As you know, when Congress enacted the Social Security Amendments of 1972, specific emphasis was given to research projects to improve intermediary and carrier performance. As the Senate Report on P.L. 92-603 stated:

"Authority is also provided to experiment with the use of fixed price or performance incentive contracts to determine whether they would have the effect of inducing more effective, efficient, and economical performance by carriers and intermediaries."

I understand that the Advisory Committee on Medicare Administration, Contracting and Subcontracting (the Perkins Committee) released a report in the fall of 1974. Among their recommendations, the Committee suggested that Section 222 be "utilized extensively" 'to enter into intermediary and carrier incentive contracts. Nevertheless, apparently action still has not been taken.

I am very disappointed in Medicare's failure to make progress on incentive contracts for intermediaries and carriers, particularly since the Bureau of Health Insurance has documented evidence of the wide range of efficiencies—or inefficiencies—among the nation's health insurance providers.

For example, in June of this year, BHI issued an "Analysis of Intermediaries' and Carriers' Administrative Costs, July–March FY 1975." On page 18 of this report, you provide a ranking of Part A or Hospital Insurance Intermediaries based on adjusted unit cost and productivity, July–March FY 1975. According to this report, the Lima, Ohio Blue Cross Intermediary had an adjusted unit cost (the cost of processing a Medicare bill) of $2.69. The Los Angeles, California Blue Cross intermediary, on the other hand, had unit costs which were 227 percent higher, or $6.13 per claim. Mutual of Omaha is listed at $6.35 per claim, Aetna at $6.41, Travelers at $7.16, and Blue Cross for Jacksonville and Puerto Rico at an incredible $8.99. The report also lists adjusted production or processing of claims per 100 man-hours. It shows, for example, that Philadelphia Blue Cross is at 316 while Travelers is at 126, and Jacksonville and Puerto Rico are at 98. In other words, by this measurement, the most productive intermediary is three times as efficient as the most inefficient Medicare claims processor.

The same enormous variances in cost and efficiency occur in the Part B (or Physician Reimbursement) Carrier statistics. For example, on page 40 of the report, the adjusted unit cost per claim in Providence, Rhode Island is $1.91, but over 100 percent higher in San Juan where the unit cost is $4.34. The adjusted claims productivity per 100 man-hours shows an even wider variance. For example, in Providence it is 496 while in Jacksonville, Florida it is 168, or one-third as efficient.

I realize that BHI has found it difficult to establish criteria for health insurance provider efficiency. However, at the current time intermediary and carrier administrative costs are nearly $400 million per year. While I doubt if it could ever be achieved, if all claims were processed at the same level of efficiency as the present, most efficient intermediary and carrier administrative costs would be reduced by approximately $170 million per year.

In view of the tremendous potential for savings in this area and in light of the need to stabilize health care costs, I urge you to make a more vigorous effort to establish efficiency standards, provide guidelines for contract terminations, and conduct research on new forms of intermediary and carrier efficiency incentives.

Sincerely yours,

CHARLES A. VANIK,
Chairman.

NOVEL PLANS FOR OUR CITIES

HON. ROBERT J. LAGOMARSINO

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Friday, September 5, 1975

Mr. LAGOMARSINO. Mr. Speaker, my constituent, Mr. Leon Sager of Santa Barbara, Calif., has asked that I bring his article "Novel Plans for Our Cities" to the attention of my colleagues.

The article follows:

NOVEL PLANS FOR OUR CITIES

(By Leon B. Sager)

Americans are unhappy about what is happening to their communities and the areas surrounding them. Whether close to home or in travels about the country they observe the same conditions of deterioration and sprawl, pollution of air and water, racial and economic segregation. What has been widely overlooked is land use.

How we use our land affects most aspects of our lives—our homes, our jobs, our recreation and our transportation. Belatedly we have awakened to the fact that land is finite. As Will Rogers, one of America's most famous humorists, put it, "Get hold of a piece of land; they ain't making no more."

Granting that even the best use of land or other environmental legislation does not solve personal and social problems, substantial benefits are achievable. The environment in which we live, the amount of energy, time and cost of transportation, our very health—all are predetermined by land use.

At the federal level detailed environmental assessments of federal action are being made and a new federal land use law has been enacted. Several states have assumed responsibility for land use decisions.

Previously polluted rivers have been made usable for boating and swimming, unprecedented technological improvements in automobile design to prevent pollution are in process, compositing blocks instead of dumping are but a few of the changes that are occurring.

State legislation in California is protecting the entire coastline for 1,000 feet inland from further environmental harm. For this achievement it was necessary to by-pass the opposing legislature and use "the Initiative," a legal measure enabling voters to make the decision. In San Francisco aroused citizens stopped a freeway in midair to prevent obstructing the ocean view; new laws there also stopped high-rise buildings at 50 stories. Determined citizens of Portland, Oregon banded together and influenced the legislature to save the beautiful Wilamette River.

By building filtration plants for the city's own refuse and stopping industries from dumping, they brought the river into wholesome use again.

In Hawaii, America's fiftieth state, commercialization of the largest underdeveloped valley was scuttled and reconstruction of high-rise buildings on the shores of its largest lake was stopped. States across the nation are beginning to act in a manner similar to the cases cited. Significant land use changes in three areas may be singled out—existing cities, metropolitan areas and new cities.

DOWNTOWN IS STAGING A COMEBACK

An organization of business executives in 94 cities is bringing about unprecedented changes. Atlanta, Philadelphia, San Diego, San Francisco, among larger cities, Allentown, Dayton, Fort Lauderdale and Eugene, to name a few leaders among smaller cities, are all engaged in comprehensive rebuilding and revitalization of their downtown areas.

The city of Minneapolis, Minnesota is also an example. A revitalized city core that in-

Health - Medicare [1976]

FACT SHEET

MAJOR ELEMENT: Medicare Improvements of 1976

The President is proposing several significant modifications in the Federal Medicare program -- full catastrophic health cost protection for Medicare recipients, cost sharing modifications, and limits on the annual cost increases which will be reimbursed by Medicare.

BACKGROUND

The Nation's health care system continues to be one of the most inflationary sectors of the economy. Hospital costs have risen by more than 200 percent since 1965 (from $40/day to $128/day), and physicians' fees have risen more than 85% in the same period. Both rates of increase are significantly higher than the corresponding increases in the consumer price index. The impact of these increases is reflected in expected health insurance premiun increases of 35% or more this year, and additional Federal spending on health care of an estimated $7 billion. Medicare is a major component of Federal health spending. It provides protection to million Americans and paid out billion for health care in fiscal year 1975. Similarly, the health system fails to encourage patients to limit their consumption of medical services. Medicare currently tends to encourage patients and physicians to extend

hospital stays by paying 100% of all hospital costs after the first day through the 60th day. Similarly, the annual deductible for physicians' services has not changed in several years, resulting in a lower deductible in terms of real income.

One of the major failings of the current health system is its failure to provide protection against the financial catastrophy of serious, extended illness. Particularly vulnerable to this problem are the aged. Medicare limits coverage to 90 consecutive days of hospital care plus 60 additional days in one's lifetime. Not only does it cease paying benefits entirely after 150 days, but also it imposes an increasing co-payment requirement after the 60th day.

DESCRIPTION OF THE PRESIDENT'S PROPOSAL

The proposed "Medicare Improvments of 1976" are the following:

1) Catastrophic Cost Protection for Health Care. This provision would for the first time give Medicare recipients unlimited financial protection against catastrophic illnesses. It guarantees coverage beyond the maximums included in current law.

2) Cost Sharing Modifications

-Hospital Costs This provision would reduce the individual's annual cost share to $500 for hospital care. This represents significant savings compared to current law for persons suffering extended, serious illnes. Current law requires

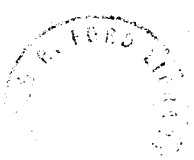
sharing of $884 for a 90-day stay,$1664 for a 150-day stay, and no Federal cost sharing whatsoever after 150 days. The individuals' co-payment will also be calculated differently than under current lay. The patient would pay 100% of the costs of the first day of care, and 10% of each additional day's cost up to $500. Under current law, the patient pays all the first days costs and then nothing up to the 60th day, whereupon co-payments begin. This provision provides improved protection to those with greatest financial need and also institutes a modest financial disincentive for persons to extend hospital stay beyond what is needed.

-Physician's Services

The President's proposal would limit Medicare recipients' annual liability for physicians' services to $250 with a $77 deductible. Currently, Medicare has a $60 deductible and a 20% co-payment without any annual upper limit. The deductible would increase with Social Security increases.

3) Reimbursement Limits.

In order to help counter the lack of incentives for health care providers to limit cost increases, the President proposes to limit Medicare cost reimbursement to annual increases of 4%, for physicians' services and 7% for hospital daily rates.



[1976]

MAJOR LAWS SIGNED BY PRESIDENT FORD THAT BENEFIT OLDER AMERICANS

o Older Americans Act Amendments of 1975 (P.L. 94-135)

These amendments extend the Title III Community Service Program, Title IV Research and Training Programs, Title V Senior Center Program, Title VII Nutrition Program, and Title IX Employment Program for three years. They also enact the Age Discrimination Act, which prohibits unreasonable discrimination on the basis of age. Also extends for one year Action volunteer programs for older persons. (Signed Nov. 28, 1975)

o Employee Retirement Income Security Act (P.L. 93-406)

The nation's first comprehensive pension reform legislation; it will protect an estimated 26 million worker's investments and provides tax incentives for workers to save who are not covered by private pension plans. (Signed Sept. 2, 1974)

o Housing and Community Development Act of 1974 (P.L. 93-383)

Provides Community Development Block Grants to communities for the development of decent housing and a suitable environment. Senior centers and housing for older persons, in addition to important social services, may be funded by communities with Community Development funds. Also re-authorized the Section 202 housing program for the elderly and handicapped. (Signed Aug. 22, 1974)

o Medicaid Eligibility Protection Act (P.L. 94-48)

Made permanent protection against the loss of Medicaid eligibility because of the 1972 Social Security benefit increase. (Signed July 1, 1975)

o Equal Credit Opportunity Act Amendments of 1975 (P.L. 94-239)

Prohibits discrimination on the basis of age in extending credit. (Signed March 3, 1976)

o Social Services Amendments of 1974 (P.L. 93-647)

Amended Social Security Act, establishing new Title XX, to provide $2.5 billion annually to the States for the provision of social services. (Signed Jan. 4, 1975)

o National Health Planning and Resources Development Act of 1974 (P.L. 93-641)

Amends the Public Health Service Act to assure the development of a national health policy and of effective State and area health planning and resource development programs. (Signed Jan. 4, 1976)

o National Mass Transportation Act of 1974 (P.L. 93-503)

Establishes an $11.3 billion, six year urban mass transit program, in addition to authorizing $500 million a year for non-urbanized areas. The law requires recipients of funds to charge no more than half-fare for the elderly and handicapped during off-peak hours. (Signed Nov. 26, 1974)

o Tax Reduction Act of 1975 (P.L. 94-12)

Provides a special $50 payment to each recipient of Social Security, Railroad Retirement, or SSI; refunded a portion of 1974 taxes; increased the minimum standard deduction and percentage standard deduction; provided a tax credit of $30 for each taxpayer, spouse, and dependent; liberalizes rules for claiming deductions for caring for a child or older relative. (Signed March 29, 1975)

o Swine Influenza Immunization (P.L. 94-266)

Made available $135,064,000 for a nationwide influenza program.

Made available an additional $1.728 billion for manpower assistance under the Comprehensive Employment and Training Act program of 1974, and $55.9 million to carry out Title IX of the Older Americans Act. (Signed April 15, 1976)

o Veterans and Survivors Pension Adjustment Act of 1974 (P.L. 93-527)

Increases and liberalizes benefits for veterans and their survivors. (Signed Dec. 21, 1974)

o Federal-Aid Highway Amendments of 1974 (P.L. 93-643)

Amended Federal-Aid to Highway Act to provide that any project receiving assistance under the Act shall be planned, designed, constructed and operated to allow effective utilization by the elderly and handicapped. (Signed Jan. 4, 1975)

- o Headstart, Economic Opportunity and Community Partnership Act of 1974 (P.L. 93-644)

  Extends programs under the Economic Opportunity Act through FY 1977, including the Senior Opportunity Service (SOS) program. (Signed Jan. 4, 1975)

- o Rehabilitation Act Amendments of 1974 (P.L. 93-516)

  Provides for particular emphasis to be placed on special projects and demonstrations for older blind individuals. (Signed Dec. 7, 1974)

- o FY 1975 Labor-HEW Appropriations Act (P.L. 93-517)

  Appropriates funds for FY 1975 for most Labor and HEW programs, including Titles III and IV of the Older Americans Act. (Signed Dec. 7, 1974)

- o Supplemental Labor-HEW Appropriations Act, 1975 (P.L. 93-554)

  Appropriates funds for several Labor-HEW programs, including Title VII of the Older Americans Act, for FY 1975. (Signed Dec. 27, 1974)

BILLS VETOED BY PRESIDENT FORD THAT WOULD HAVE BENEFITTED OLDER AMERICANS

- Health Revenue Sharing and Services Act of 1974 (H.R. 14214) - Vetoed December 21, 1974; Sustained.

  Would have authorized funds for a variety of health services, provided for startup funds for home health services, and established a Commission on Mental Health and Illness of the Elderly.

  Vetoed because of excessive appropriation levels.

- Health Revenue Sharing and Health Services Act of 1975 (S.66) - Vetoed July 26, 1975; Over-ridden July 29, 1975.

  Authorizes funds for a variety of health services, provides funds for startup of home health services, and establishes a Commission on Mental Health and Illness of the Elderly.

  Vetoed because of excessive appropriation levels.

- Emergency Employment Appropriations Act, 1975 (H.R. 4481) - Vetoed May 28, 1975; Sustained June 4, 1975.

  Would have appropriated emergency employment funds, including $30 million for the Title IX Senior Community Service Employment Program.

  Vetoed because it would exacerbate budgetary and economic pressures; accelerative influences of the bill would come much too late to give impetus to economic recovery.

- FY 1976 Labor-HEW Appropriations Bill (H.R. 8069) - Vetoed Dec. 19, 1975; Over-ridden Jan. 27, 1976

  Appropriated funds for most Labor-HEW programs, including the Title VII Nutrition Program.

  Vetoed because it would authorize excessive authorization levels, and because it would increase permanent Federal employment by 8000 people.

o Railroad Retirement Act (H.R. 15301) - Vetoed October 15, 1974; Over-ridden October 16, 1974. (P.L. 93-445)

Provided for restructuring the Railroad Retirement Benefit Program to reflect a basic social security covered employment and railroad service, and a pension based on a formula applicable only to railroad service.

Provided for elimination of dual benefit rights for future beneficiaries.

Vetoed because it would authorize excessive appropriation levels.

[1976]

TO THE CONGRESS OF THE UNITED STATES:

I ask the Congress to join with me in making improvements in programs serving the elderly.

As President, I intend to do everything in my power to help our nation demonstrate by its deeds a deep concern for the dignity and worth of our older persons. By so doing, our nation will continue to benefit from the contributions that older persons can make to the strengthening of our nation.

The proposals being forwarded to Congress are directly related to the health and security of older Americans. Their prompt enactment will demonstrate our concern that lifetimes of sacrifice and hard work conclude in hope rather than despair.

The single greatest threat to the quality of life of older Americans is inflation. Our first priority continues to be the fight against inflation. We have been able to reduce by nearly half the double digit inflation experienced in 1974. But the retired, living on fixed incomes, have been particularly hard hit and the progress we have made in reducing inflation has not benefited them enough. We will continue our efforts to reduce federal spending, balance the budget, and reduce taxes. The particular vulnerability of the aged to the burdens of inflation, however, requires that specific improvements be made in two major Federal programs, Social Security and Medicare.

We must begin by insuring that the Social Security system is beyond challenge. Maintaining the integrity of the system is a vital obligation each generation has to

those who have worked hard and contributed to it all their lives. I strongly reaffirm my commitment to a stable and financially sound Social Security system. My 1977 budget and legislative program include several elements which I believe are essential to protect the solvency and integrity of the system.

First, to help protect our retired and disabled citizens against the hardships of inflation, my budget request to the Congress includes a full cost of living increase in Social Security benefits, to be effective with checks received in July 1976. This will help maintain the purchasing power of 32 million Americans.

Second, to insure the financial integrity of the Social Security trust funds, I am proposing legislation to increase payroll taxes by three-tenths of one percent each for employees and employers. This increase will cost no worker more than $1 a week, and most will pay less. These additional revenues are needed to stabilize the trust funds so that current income will be certain to either equal or exceed current outgo.

Third, to avoid serious future financing problems I will submit later this year a change in the Social Security laws to correct a serious flaw in the current system. The current formula which determines benefits for workers who retire in the future does not properly reflect wage and price fluctuations. This is an inadvertent error which could lead to unnecessarily inflated benefits.

The change I am proposing will not affect cost of living increases in benefits after retirement, and will in no way alter the benefit levels of current recipients. On the other hand, it will protect future generations against unnecessary costs and excessive tax increases.

I believe that the prompt enactment of all of these proposals is necessary to maintain a sound Social Security system and to preserve its financial integrity.

Income security is not our only concern. We need to focus also on the special health care needs of our elder citizens. Medicare and other Federal health programs have been successful in improving access to quality medical care for the aged. Before the inception of Medicare and Medicaid in 1966, per capita health expenditures for our aged were $445 per year. Just eight years later, in FY 1974, per capita health expenditures for the elderly had increased to $1218, an increase of 174 percent. But despite the dramatic increase in medical services made possible by public programs, some problems remain.

There are weaknesses in the Medicare program which must be corrected. Three particular aspects of the current program concern me: 1) its failure to provide our elderly with protection against catastrophic illness costs, 2) the serious effects that health care cost inflation is having on the Medicare program, and 3) lack of incentives to encourage efficient and economical use of hospital and medical services. My proposal addresses each of these problems.

In my State of the Union Message I proposed protection against catastrophic health expenditures for Medicare beneficiaries. This will be accomplished in two ways. First, I propose extending Medicare benefits by providing coverage for unlimited hospital and skilled nursing facility days of care for beneficiaries. Second, I propose to limit the out-of-pocket expenses of beneficiaries, for covered services, to $500 per year for hospital and skilled nursing services and $250 per year for physician and other non-institutional medical services.

This will mean that each year over a billion dollars of benefit payments will be targeted for handling the financial burden of prolonged illness. Millions of older persons live in fear of being stricken by an illness that will call for expensive hospital and medical care over a long period of time. Most often they do not have the resources to pay the bills. The members of their families share their fears because they also do not have the resources to pay such large bills. We have been talking about this problem for many years. We have it within our power to act now so that today's older persons will not be forced to live under this kind of a shadow. I urge the Congress to act promptly.

Added steps are needed to slow down the inflation of health costs and to help in the financing of this catastrophic protection. Therefore, I am recommending that the Congress limit increases in medicare payment rates in 1977 and 1978 to 7% a day for hospitals and 4% for physician services.

Additional cost-sharing provisions are also needed to encourage economical use of the hospital and medical services included under Medicare. Therefore, I am recommending that patients pay 10% of hospital and nursing home charges after the first day and that the existing deductible for medical services be increased from $60 to $77 annually.

The savings from placing a limit on increases in medicare payment rates and some of the revenue from increased cost sharing will be used to finance the catastrophic illness program.

I feel that, on balance, these proposals will provide our elder citizens with protection against catastrophic illness costs, promote efficient utilization of services, and moderate the increases in health care costs.

The legislative proposals which I have described are only part of the over-all effort we are making on behalf of older Americans. Current conditions call for continued and intensified action on a broad front.

We have made progress in recent years. We have responded, for example, to recommendations made at the 1971 White House Conference on Aging. A Supplemental Security Income program was enacted. Social Security benefits have been increased in accord with increases in the cost of living. The Social Security retirement test was liberalized. Many inequities in payments to women have been eliminated. The 35 million workers who have earned rights in private pension plans now have increased protection.

In addition we have continued to strengthen the Older Americans Act. I have supported the concept of the Older Americans Act since its inception in 1965, and last November signed the most recent amendments into law. Funds available for programs administered by the Administration on Aging under this Act have increased from $44.7 million in FY 1972 to $270 million during the last fiscal year.

A key component of the Older Americans Act is the national network on aging which provides a solid foundation on which action can be based. I am pleased that we have been able to assist in setting up this network of 56 State and 489 Area Agencies on Aging, and 700 local nutrition agencies. These local nutrition agencies for example provide 300,000 hot meals a day five days a week.

The network provides a structure which can be used to attack other important problems. A concern of mine is that the voice of the elderly, as consumers, be heard in the governmental decision-making process. The network on aging

offers opportunities for this through membership on advisory councils related to State and Area Agencies on Aging, Nutrition Project Agencies and by participation in public hearings on the annual State and Area Plans. Such involvement can and will have a significant impact on determining what services for the aging are to be given the highest priorities at the local level.

The principle goal of this National Network on Aging is to bring into being coordinated comprehensive systems for the provision of service to the elderly at the community level. I join in the call for hard and creative work at all levels -- Federal, State and Area in order to achieve this objective. I am confident that progress can be made.

Toward this end, the Administration on Aging and a number of Federal Departments and agencies have signed agreements which will help to make available to older persons a fair share of the Federal funds available in such areas as housing, transportation, social services, law enforcement, adult education and manpower -- resources which can play a major role in enabling older persons to continue to live in their own homes.

Despite these efforts, however, five percent of our older men and women require the assistance provided by skilled nursing homes and other long term care facilities. To assist these citizens, an ombudsman process, related solely to the persons in these facilities, is being put into operation by the National Network on Aging. We believe that this program will help to resolve individual complaints, facilitate important citizen involvement in the vigorous enforcement of Federal, State and local laws designed to improve health and safety standards, and will improve the quality of care in these facilities.

Today's older persons have made invaluable contributions to the strengthening of our nation. They have provided the nation with a vision and strength that has resulted in unprecedented advancements in all of the areas of our life. Our national moral strength is due in no small part to the significance of their contributions. We must continue and strengthen both our commitment to doing everything we can to respond to the needs of the elderly and our determination to draw on their strengths.

Each generation of Americans is engaged in a tradition of growth and progress. Each generation can measure its progress in part by its ability to recognize, respect and renew the contributions of earlier generations. I believe that the Social Security and Medicare improvements I am proposing, when combined with the action programs under the Older Americans Act, offer a measure of progress for the elderly and thus provide real hope for us all.

THE WHITE HOUSE,

File

Medicaid

THE WHITE HOUSE

WASHINGTON

August 12, 1976

Dear John:

This is in further response to your letter concerning HEW's regulations proposed in April 1976 regarding Medicaid reimbursement payments to skilled nursing and intermediate care facilities.

You expressed concern that the proposed regulations would leave States with no alternative except to adopt the Federal Medicare payment system. This problem has, we believe, been eliminated in the final regulations published on July 1, 1976.

Let me assure you that it was not the intent of the Department to force States to use the Medicare formula. The final regulations provide the States with the needed flexibility and recognize that the intent of Congress was to encourage creativity among the States. These final regulations remove all limits from individual cost items and eliminate the Medicare ceiling for those States which elect to use a prospective reimbursement method. The Medicare ceiling does not apply in those States which use a retrospective cost reimbursement system.

If I may be of any further help, please let me know.

Sincerely,

James M. Cannon
Assistant to the President
for Domestic Affairs

The Honorable John Tower
United States Senate
Washington, D.C. 20510

ARMED SERVICES
BANKING, HOUSING AND URBAN AFFAIRS
JOINT COMMITTEE ON DEFENSE PRODUCTION

United States Senate

WASHINGTON, D.C. 20510

May 21, 1976

The President
The White House
Washington, D.C.

Dear Mr. President:

MF
Jud

I would like to bring to your attention comments I have made to Secretary Mathews about regulations for reimbursement on a cost-related basis for skilled nursing and intermediate care facility services under Title XIX of the Social Security Act of 1972.

The intent of these regulations is to reduce the costs of the Medicaid program while providing more efficient and higher quality care for nursing care recipients. It is my feeling that a careful examination of the proposed rules will illuminate that they will, in fact, have the opposite effect. I believe that these regulations will almost ensure greater Federal and State expenditures than would otherwise be necessary under a prospective rate-setting approach. Such an outcome would be contrary to the stated objective of your administration to restrain increases in health care costs.

I would, therefore, appreciate your assistance in bringing about the modifications necessary to implement regulations for Section 249 which will more effectively accomplish these goals.

Thank you very much for your consideration.

Very truly yours,

John Tower

John Tower

Enclosure

ACTION REQUESTED

October 2, 1976

MEMORANDUM FOR: JIM CAVANAUGH
PAUL O'NEILL
BILL BARODY

FROM: FRED SLIGHT

SUBJECT: Article Request

The President has been requested to submit his views on various concerns of older Americans for publication.

Attached is a draft response prepared by the Department of HEW's public information office for your review.

Inasmuch as the deadline for this publication has been extended to the evening of October 5, I would appreciate your comments and/or suggestions by 3:00 pm, Monday, October 5. I regret the consistently short turnaround requested, and appreciate your cooperation in meeting this time parameter.

Attachment

Aging

THE WHITE HOUSE

WASHINGTON

October 15, 1976

MEMO TO: BILL NICHOLSON
JERRY JONES

FROM: JIM CANNON

There is an event tentatively scheduled for Thursday, October 21 that I feel we should encourage -- the swearing-in of six new members of the Federal Council on Aging. (Bill Baroody has submitted the schedule proposal.)

The President has not addressed the "aging" population at all; this provides him an opportunity to make some remarks.

I recommend that you schedule it.

THE WHITE HOUSE
WASHINGTON

DATE 10/14/76

TO: ~~JIM CANNON~~ Jerry Jones
Bill Nicholson

FROM: ~~SARAH MASSENGALE~~ JIM CANNON

There is an event tentatively scheduled for Thursday, October 21 that I feel we should encourage -- ~~that is~~ the swearing-in of six new members of the Federal Council on Aging. Bill Baroody has submitted the a schedule proposal). The President has not addressed the "aging" population at all; this provides him an opportunity to make some remarks.

I recommend that you ~~encourage the President's participation.~~ schedule it.

~~Thank you.~~

cc: Art Quern
Allen Moore
Spence Johnson

10/421

THE WHITE HOUSE
WASHINGTON

Oct 18

TO: JIM CANNON

FM: ART QUERN

Unless you feel otherwise, we will let Baroody handle briefing papers, etc.

Attachment

handled w/ Quern by phone. Check on

10/8/14

cc: Art Quern
Allen Moore
Sarah Massengale

THE WHITE HOUSE

WASHINGTON

1976 OCT 15 PM 5 47

October 14, 1976

MEMORANDUM FOR: WILLIAM BARODY

FROM: WILLIAM W. NICHOLSON WWN

SUBJECT: Approved Presidential Activity

Please take the necessary steps to implement the following and confirm with Mrs. Nell Yates, ext. 2699. The appropriate briefing paper should be submitted to Dr. David Hoopes by 4:00 p.m. of the preceding day.

Meeting: Swearing-in Ceremony for Six Members of the Federal Council on the Aging

Date: Thurs., Oct. 21, '76 Time: 11:00 a.m. Duration: 15 mins.

Location: The Rose Garden

Press Coverage:

Purpose: To briefly discuss major issues concerning our aging citizens.

cc: Mr. Cheney
Mr. Hartmann
Mr. Marsh
Dr. Connor
Dr. Hoopes
Mr. Nessen
Mr. Jones
Mr. Smith
Mr. O'Donnell
Mrs. Yates
Col. Riley
Mr. Orben
Mrs. Gemmell
Mr. Keiser
Mr. Mitler
Mr. Cannon
Ms. Massengale