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American Hospital Association

Max S. Baucus

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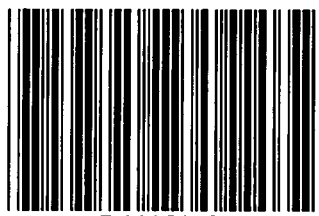

BAUCUS

We cannot dramatically increase our defense expenditures to respond to the Soviet threat and at the same time provide it with cheap food. We cannot expect our allies to drastically curtail their trade with the Soviet Union when we refuse to do so ourselves. Either we are serious about the Soviet threat or we are not. Either we remain consistent in our foreign policy objectives or we become the laughingstock of the world. Our rhetoric rings hollow if we are not willing to follow tough words with tough actions. This latest agreement with the Soviet Union is but one more example of a foreign policy gone awry. It is inconsistent; it is contrary to our security interests; it encourages the Soviet Union to continue its reprehensible behavior both at home and abroad and I cannot, in good conscience, support it.

WASTE-TO-ENERGY EXCEPTION TO SALE-LEASEBACK LEGISLATION

Mr. DURENBERGER. Mr. President, we have all heard a lot recently about what seems to be this year's favorite tax loophole—the sale and leaseback of property by tax-exempt entities. Although I am a cosponsor of S. 1564, Senator DOLE's bill to eliminate these abusive sale-leaseback arrangements, I believe the bill needs improvement in several areas. Two of these are solid waste disposal projects that produce energy—waste-to-energy (WTE) projects as they are called in the industry—and district heating and cooling projects. I wanted to let my colleagues know today that I will be offering amendments during Finance Committee markup of S. 1564 to exclude them from the legislation.

During the hearings last month in the Finance Committee, Senator DOLE indicated that WTE projects would be protected because the private developers are at risk. I am pleased by my colleague's statement, but I am concerned because the legislation has a number of tests. These projects could get tied up for years as we wait for Treasury regulations, and then, after the regulations are issued, the developers wait while interpretations are being made.

The private sector has traditionally been involved in developing WTE projects in the last 10 years. Typically the private sector has taken significant risks in their service contracts with local governments. These contracts result from hard bargaining that insures protection of the public interest. In order to assure that project development can continue, it is essential that we do not further complicate these projects by vague statutory language that would have the net effect of undermining a community's efforts to develop projects.

The far preferable route, I believe, is simply to exempt WTE projects entirely. This is what we did last year during TEFRA in exempting solid waste disposal units from the ACRS restrictions put on industrial development bonds.

The rationale then is the same as now: Without these tax incentives these projects will not be economically viable. Municipal governments will continue to be faced with only one alternative to solid waste disposal—landfill.

Landfills are not the answer. As we who are sensitive to political issues know, landfills can be hot potatoes. They may be an acceptable solution as long as they are in someone else's backyard. But it is becoming increasingly difficult to find that backyard.

Existing landfills that are environmentally unsafe are generally not shut down until alternative forms of disposal are available. As a result, it is important not to jeopardize or confuse WTE development at a time that many communities face solid waste disposal crises.

My amendment before the Finance Committee will also address district heating and cooling. District heating is the major form of thermal energy delivery in core city areas. Delivery systems for electricity and natural gas are not penalized for sales to tax-exempt organizations. Likewise, we should not penalize the delivery of energy in the form of steam or hot water sold to governmental entities and tax-exempt organizations. Such purchases of energy are not the public use of the district heating pipes just as the purchase of electricity is not the public use of the distribution wires.

District heating is an energy delivery highway that serves as the distribution system for energy-efficient projects such as waste to energy, cogeneration, and recovery of industrial waste heat. Private developers of district heating systems are at risk even though sales may be made to tax-exempt entities. Uncertainty in the interpretation of several provisions of the Tax Code has presented problems for capital formation for district heating projects. This amendment clarifies and codifies that the sale of energy to a tax-exempt entity by a district heating or cooling system does not constitute use of that delivery system.

Only last year were district heating and cooling included in section 103 under my amendment to TEFRA. We should give district heating a chance to grow in the United States. Now is not the time to put district heating in jeopardy.

SENATOR BAUCUS SPEAKS TO AMERICAN HOSPITAL ASSOCIATION

Mr. LONG. Mr. President, recently, my colleague from Montana, Senator BAUCUS, addressed the American Hospital Association convention in Houston.

Senator BAUCUS is the ranking Democrat on the Finance Committee's Health Subcommittee and is widely respected for his leadership in solving the problems facing rural hospitals.

His speech discusses the major health issues before the Senate and I urge my colleagues to read it. His comments are always thought provoking.

I ask unanimous consent that Senator BAUCUS' speech appear following my remarks.

There being no objection, the statement was ordered to be printed in the RECORD, as follows:

STATEMENT OF SENATOR MAX BAUCUS TO AMERICAN HOSPITAL ASSOCIATION

INTRODUCTION

Thank you very much for inviting me to be with you today. I'm particularly interested in the special problems facing small rural hospitals, and I'm pleased to be given the opportunity of discussing these issues with you today.

All too often, official Washington seems to govern in the conviction that "bigger is better", at least more important politically.

As a result, federal laws and rules frequently discriminate against smaller communities. Nowhere is this more evident than in federal regulations governing hospitals.

This was made painfully clear to me when I came to Washington as a newly-elected Congressman. You no doubt remember the national health planning guidelines established in the 70's by the Department of Health and Human Services.

These guidelines were tailored to the size, the functions, and the needs of metropolitan hospitals. They would have set unfair standards for hospitals in small towns. Many would have been forced to close.

These guidelines were not fair to rural areas. I'm sure Joe Califano, who ran the Department at that time, still remembers me delivering a pick-up truck full of angry letters from Montanans to his office. Enough of you banded together to see to it that the most inequitable sections of these guidelines were revoked.

But I learned an invaluable lesson from that experience. Like it or not, most policymakers in Washington have a hard time understanding that the solutions to health problems in Manhattan, New York, are not the same as they are in Manhattan, Montana.

Making sure federal health programs reflect that fact has been one of my top priorities. In the past couple of years, most of my time has been spent on Medicare's Section 223 Cost Limits, and—just this year—Prospective Reimbursement.

I would like to discuss these Medicare policies with you, but first I want to step back and look at the health system as a whole.

HEALTH COSTS

As you well know, today we are spending more than ever for health care, but getting less for our money.

Health expenditures—public and private—are continuing to increase even though the economy is showing very little

National health expenditures—the amount we Americans spend on health—rose last year to $287 billion. That's about 10 percent of the Gross National Product—up from 6 percent of the GNP in 1965.

Spending for hospital care is the largest component of these outlays. So, while the consumer price index tumbled from almost 13 percent to 5 percent last year, we find that progress against inflation stopped at the hospital door.

In 1982, hospital costs went up three times the national inflation rate. Federal outlays

for Medicare rose 21.5 percent last year. And the cost of private health insurance rose 16 percent in 1982—the biggest increase ever.

Rising health costs are a national problem. Federal, state, and local governments—who pay 42 percent of the health care bill—are wracking up record budget deficits to meet the soaring costs of Medicare and Medicaid.

Increased health expenditures affect the private sector. Workers draw lower wages because employers must pay higher health insurance premiums.

And patients pay higher prices because companies have to pass on much of the higher health insurance premium costs.

In some cases, these costs have contributed to American industry's loss of its competitive position. U.S. Steel, for example, estimates that the cost of health benefits add an extra $20 to the price of each ton of steel. And American auto companies figure the cost of employee health benefits to be as much as $400 on each car produced. That's more than one-quarter of the reported $1,500 cost advantage that Japanese cars have over ours.

In addition, I read recently that the major supplier for the Chrysler Corporation was not steel—it was Blue Cross and Blue Shield!

CONGRESSIONAL ACTION

My colleagues in Congress—Republicans and Democrats—read these statistics, and they are demanding change.

They want to see results.

That's why the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982—which extended and placed a year-to-year cap on Medicare's Section 223 Cost Limits—moved so quickly through Congress.

That's why the House Ways and Means Committee and the Senate Finance Committee drafted a new hospital prospective reimbursement plan this past Spring.

There is no doubt in my mind that Congress is committed to putting a lid on what the federal government pays for health care.

The key difference between the situation today—with TEFRA controls and the new DRG payment system—and the situation a few years ago when the Carter Hospital Cost Containment bill was defeated in this: The DRG system applies to medicare only, where Carter's Cost Containment plan applied to all payers, and, thus, represented wholesale regulation.

Congress and the Administration want Medicare to be a prudent buyer for the health services it purchases from hospitals. For the time being, federal policymakers are willing to let Blue Cross, commercial insurance companies, businesses, and private-pay patients fend for themselves in their dealings with hospitals. To the extent that these parties are dissatisfied with hospital charges, you can anticipate pressure on Congress for increased hospital regulation.

TEFREA/PROSPECTIVE REIMBURSEMENT

The point I am making is that Congress is interested in limitng federal expenditures for health by whatever means it can find. Congress will be guided less by ideological commitment to regulation or competition strategies than by pragmatism. If an approach saves money, Congress will give it serious consideration.

It's time each of us stopped blaming the other guy for the health care cost problem. I think it is fair to say that government, consumers, physicians, insurers, and hospitals are each responsible to some degree for the cost problem we have today. For the most part, we've only been acting the way the system encouraged us to act.

There is plenty of room for change. I think the new DRG payment system is a first step in the right direction. But more needs to be done.

For example:

We need to make sure that the new DRG system does not lead to excessive cost-shifting. I know my colleagues are following this issue closely. If such cost-shifting does occur, you can expect greater pressure for all-payor rate regulation.

The question will be: should the regulation be imposed at the federal level or allowed to develop at the state level?

We need to ensure that the DRG system, which creates incentives for additional hospital admissions and sophisticated treatment, does not lead to over-utilization, unnecessary admissions, and "DRG creep."

I think physician peer review can play an invaluable role here and I urge you to reconsider your opposition to the federal Physician Peer Review program. The large employers and commercial insurers who are most concerned with holding down their health costs are committed to this utilization review mechanism. They spend private sector dollars for physician peer review because it saves money. It is good business. That's a fair yardstick by which to measure public programs.

We also need to make sure that the DRG payments made to hospitals are set at the right level. These rates should be allowed to increase from year to year to permit the development and use of innovative technology. The DRG categories should be periodically recalibrated.

I was successful in convincing my colleagues of the need for a Prospective Reimbursement Assessment Commission to take on this job, and I intend to see that it is funded. I know that the AHA supports this Commission. If DRG payments are politicized—and I fear they may be—hospitals will be underpaid for the services they provide.

In addition, we need to make sure that physicians' costs are also addressed. I don't think very many people realize that Medicare Part B expenses are increasing at a faster rate than Part A hospital expenses. More work needs to be done in this area before we take legislative action. But I don't mind telling you that many of my colleagues would like to see the DRG system expanded to include payments to physicians when they practice in hospitals.

Finally, we need to come to grips with some very basic questions concerning access to health care. We need to decide what the public role should be in paying for care for those who have no insurance.

I know that "free care" and "bad debt" have a very real impact on your hospitals and their ability to remain afloat financially.

The problem is aggravated in rural areas where fewer people have insurance and where hospitals are extremely dependent on Medicare reimbursement dollars. I wish I could tell you what the future holds in this area, but I cannot.

I can only say that there is very great competition for the federal dollar—from the need to provide for national security, to the need to retire the deficit, to the need to maintain the Federal role in other social programs.

SMALL RURAL HOSPITALS

Before I leave you today, I want to share with you my thoughts on how the new DRG reimbursement system will affect rural hospitals. You may know that I have been particularly interested in how "sole community provider" hospitals are reimbursed by Medicare.

For those of you not familiar with Montana, I should mention that 49 of Montana's 60 hospitals have fewer than 100 beds. In fact, 45 of these hospitals have fewer than 50 beds, and most are in isolated rural areas. The problems facing rural hospitals are a major interest of mine. I pay special attention to how Medicare policies affect these hospitals.

Two years ago, when the Section 223 Cost Limits were squeezed to a lower level, I found that those Montana hospitals that were eligible for "sole community provider" exemptions from these limits were denied them.

I personally intervened in these cases, secured a GAO investigation of the matter, and got most of HCFA's denials overturned. And I was able to exempt small rural hospitals with less than 50 beds from Section 223 Cost Limits.

The Reagan Administration came to Washington promising to remove excessive federal regulation and to be responsive to local needs. But I have found that small community hospitals—those with the smallest financial, legal, and technical resources to wage a fight against unfair federal regulations and policies—were those that were most subject to unfair treatment.

This past year, during hearings on HHS's plan for prospective payment, I reminded HHS officials and my Finance Committee colleagues of my experience with how HCFA ran the Section 223 program. I found that it is better for Congress to draft detailed laws than to trust federal administrators. I refused to accept Secretary Schweiker's pledge that federal officials would take care of "sole community providers'" special needs on an administrative case-by-case basis.

I argued for statutory protections in the Finance Committee hearings and markup sessions, as well as in the House-Senate Conference on Prospective Payment.

I can tell you that I was surprised I did not get more support from my colleagues. The protections I wrote into the prospective payment legislation are the best I could get for small rural hospitals. I hope they are sufficient.

If a small rural hospital experiences a drop in utilization of more than 5%, Medicare is obliged to make additional payments to the hospital to compensate it for its additional costs. The HHS Secretary does not merely have *discretion* to act here—he is *obliged* to act!

My past experience with the discretion of HHS officials regarding "sole community provider" status was enough to prevent me from giving in to HHS on that point.

And what will the future hold?

As you know, small hospitals will soon begin the new DRG system—set to be phased-in this fall. Small rural hospitals will enter the first year of the DRG phase-in period and remain there indefinitely—receiving payment based 75 percent on the hospital's own cost experience and based 25 percent on DRGs.

The "safety net" of a 5 percent downturn in utilization will be in place. This will protect "sole community providers" from conditions beyond their control—like strikes, fires, inability to recruit physician staff, prolonged severe weather conditions, or similar unusual occurrences with substantial cost effects.

And these hospitals will have a one-time option of voluntarily giving up "sole community provider" status and electing to receive Medicare reimbursement under the regular DRG system.

Only time will tell us how well these small hospitals will fare.

I hope these hospitals prosper—the residents of small towns around the country deserve it.

OREGON HEALTH SCIENCES UNIVERSITY RESEARCH CENTER

Mr. HATFIELD. Mr. President, efforts concerned with the prevention of disease and the maintenance of well-being are the wisest possible investments of our Nation's financial resources. It is especially important that we pursue these efforts with the greatest efficiency, with the highest concern for quality, and with as broad and widely disseminated base of knowledge as possible.

Therefore, Mr. President, I am extremely pleased that the Congress agreed to provide $20.4 million in the fiscal year 1983 supplemental appropriations bill recently signed by the President, to establish the new Biomedical Information Communication Center at the Oregon Health Sciences University in Portland.

Of the total, $14.5 million will be funneled through the National Library of Medicine to the Oregon Medical School for remodeling and expanding the existing library space to house the computer and other technologies and to maintain an academic health resource network for the State of Oregon. It will include an addition of 50,000 square feet to allow for these additional activities. Another $5.9 million will come from the Department of Health and Human Services to enable continued planning of the project and for providing equipment locally for research and development, and for linking the system to hospitals, medical groups, other academic centers and libraries on a demonstration basis.

Through the center, biomedical literature available both at the health sciences university and in national data bases will be brought up to adequate quantitative volume and be converted to computer-readable form. In addition, a network will be developed with the Oregon Medical School as the hub to hospitals and the offices of health practitioners of all types. This network will disseminate information, provide opportunities for computer-teleconferencing for use in teaching, for consultation on clinical practice and development of creative approaches to continuing medical, dental and nursing education. It will also serve as a conduit to data bases in other scientific fields.

Information is the lifeblood of the health professions. The storage, retrieval, organization, selection, evaluation and presentation of biomedical information can determine the quality, cost-effectiveness, and the timeliness of the care that we provide to those who are sick and will expand our outreach prevention activities to the healthier population. The very real revolution now taking place in the management of information in our modern age offers unprecedented opportunity to merge evolving technologies and the library functions of academic health centers to produce new and infinitely more valuable capabilities.

Today, technology changes so rapidly that it is extremely difficult in the professional and academic setting to make maximum use of new developments in the health care field and the technology that communicates them.

In an excellent analysis of this subject conducted under the aegis of the Association of American Medical Colleges and the National Library of Medicine, the recommendation was made that several "prototype integrated library systems and academic information resources management networks" be established in this country. The Biomedical Information Communication Center in Oregon will be just such a prototype and a national model.

In the academic setting, this computerized health information system will bring an outmoded health sciences library into the modern age and, along the way, will convert a mass of disorganized material into an easily retrievable, cohesive form for the latest in research, information and state-of-the-art scientific developments.

It is clear that what we now call biomedical libraries must evolve expeditiously into such biomedical information communication centers serving students and practitioners in their local regions and providing them with easy entry into national information networks concerned with biomedical sciences. The challenge before us is to harness the benefits of new and emerging advances in microelectronics, in computerized thinking and in technologies yet to be conceived and to so with such skill that we assure high quality care and lifelong professional learning at the lowest possible cost.

This center will play a significant role not only in improving in health care delivery system in our State but will have far-reaching economic benefits in these areas as well.

Our Nation's health research effort has made and continues to make a major contribution not only to the well being of our citizens but also to the Nation's economy. I am convinced that the strengthening of our State's economic future is closely related to research and thus to successful commercial developments related to research discoveries. In specific ways, academic research and industry are closely linked in other than the obvious. For example, work on laboratory instrument systems contributed to the development of minicomputers. Laboratory freeze-drying techniques have led to modern day food preservation. Research in fiber optics has made possible major advances in telecommunications.

And in a significant but more general sense, research dollars have the greatest multiplier effect in our economy. For each $1 invested in research, an estimated $13 in savings are realized due to reduced incidence of illness and medical costs and increases in life expectancy. Examples: Eradication of polio—$2 billion annual savings; rubella vaccine—$500 million savings due to the prevention of congenital deformity occurring in children of pregnant mothers who develop German measles; and $4.3 million savings weekly in hospital costs from development and widespread use of the hepatitis B vaccine.

This newest project at the Oregon Health Sciences University along with the recently developed advanced Institute for Biomedical Research in Portland will play a significant role in attaining these results. The research and development to be conducted at the medical school and the transfer of biomedical information are certain to stimulate the growth of a depleted local economy by encouraging new ventures in technology, microelectronics and artificial information systems. Equally important, by improving the flow of information to the practitioners, the accomplishments at the new center will help to improve quality and to reduce the cost of health care in Oregon, in the Pacific Northwest, and in the Nation.

Since all of our academic health centers are extremely important to the vitality of this Nation, and since they are all mutually interdependent, enhancing one benefits them all. In my discussions with the leadership of the medical school establishment in Portland, I have received repeated reaffirmations of their commitment to excellence and their obligation to serve the Nation as well as their region. This will be accomplished in full partnership with all appropriate health professions and establishments, hospitals, physicians and other practitioners, scientific laboratories, colleges and universities, library personnel, and the business community.

This 21st century library system may be first in line, but is only one expression of my support for the strengthening of Oregon's postsecondary educational system in its role of increasing our State's contribution to research oriented toward the enhancement of the human condition.

The true meaning of our national defense is found in the type of venture which will be made possible through this Federal investment in our Nation's health care system. I am proud to have joined forces with the forward thinkers in my State and my congressional colleagues in the successful development of this plan.

AVERELL HARRIMAN ON THE NUCLEAR TEST BAN TREATY

Mr. KENNEDY. Mr. President, one of the most distinguished statesmen of this generation or any generation in American history, Averell Harriman, recently returned from a trip to the