BARRIERS TO HEALTH CARE FOR OLDER AMERICANS

HEARINGS

BEFORE THE

SUBCOMMITTEE ON HEALTH OF THE ELDERLY

OF THE

SPECIAL COMMITTEE ON AGING

UNITED STATES SENATE

NINETY-THIRD CONGRESS

SECOND SESSION

PART 14—WASHINGTON, D.C.

JUNE 26, 1974

Printed for the use of the Special Committee on Aging

U.S. GOVERNMENT PRINTING OFFICE

46-546 WASHINGTON : 1975

For sale by the Superintendent of Documents, U.S. Government Printing Office
Washington, D.C. 20402 - Price 80 cents

SPECIAL COMMITTEE ON AGING

FRANK CHURCH, Idaho, *Chairman*

HARRISON A. WILLIAMS, New Jersey
ALAN BIBLE, Nevada
JENNINGS RANDOLPH, West Virginia
EDMUND S. MUSKIE, Maine
FRANK E. MOSS, Utah
EDWARD M. KENNEDY, Massachusetts
WALTER F. MONDALE, Minnesota
VANCE HARTKE, Indiana
CLAIBORNE PELL, Rhode Island
THOMAS F. EAGLETON, Missouri
JOHN V. TUNNEY, California
LAWTON CHILES, Florida

HIRAM L. FONG, Hawaii
CLIFFORD P. HANSEN, Wyoming
EDWARD J. GURNEY, Florida
EDWARD W. BROOKE, Massachusetts
CHARLES H. PERCY, Illinois
ROBERT T. STAFFORD, Vermont
J. GLENN BEALL, JR., Maryland
PETE V. DOMENICI, New Mexico
BILL BROCK,[1] Tennessee

WILLIAM E. ORIOL, *Staff Director*
DAVID A. AFFELDT, *Chief Counsel*
VAL J. HALAMANDARIS, *Associate Counsel*
JOHN GUY MILLER, *Minority Staff Director*
PATRICIA G. ORIOL, *Chief Clerk*

SUBCOMMITTEE ON HEALTH OF THE ELDERLY

EDMUND S. MUSKIE, Maine, *Chairman*

FRANK E. MOSS, Utah
HARRISON A. WILLIAMS, New Jersey
EDWARD M. KENNEDY, Massachusetts
WALTER F. MONDALE, Minnesota
VANCE HARTKE, Indiana
CLAIBORNE PELL, Rhode Island
THOMAS F. EAGLETON, Missouri
JOHN V. TUNNEY, California
LAWTON CHILES, Florida

PETE V. DOMENICI, New Mexico
CLIFFORD P. HANSEN, Wyoming
EDWARD J. GURNEY, Florida
EDWARD W. BROOKE, Massachusetts
CHARLES H. PERCY, Illinois
ROBERT T. STAFFORD, Vermont
J. GLENN BEALL, JR., Maryland

Barriers to Health Care for Older Americans:
Part 1. Washington, D.C., March 5, 1973.
Part 2. Washington, D.C., March 6, 1973.
Part 3. Livermore Falls, Maine, April 23, 1973.
Part 4. Springfield, Ill., May 16, 1973.
Part 5. Washington, D.C., July 11, 1973.
Part 6. Washington, D.C., July 12, 1973.
Part 7. Coeur d'Alene, Idaho, August 4, 1973.
Part 8. Washington, D.C., March 12, 1974.
Part 9. Washington, D.C., March 13, 1974.
Part 10. Price, Utah, April 20, 1974.
Part 11. Albuquerque, N. Mex., May 25, 1974.
Part 12. Santa Fe, N. Mex., May 25, 1974.
Part 13. Washington, D.C., June 25, 1974.
Part 14. Washington, D.C., June 26, 1974.
Part 15. Washington, D.C., July 9, 1974.
Part 16. Washington, D.C., July 17, 1974.

(Additional hearings anticipated but not scheduled at time of this printing.)

---

[1] Appointed January 25, 1974, to fill vacancy on committee by resignation of William B. Saxbe (R. Ohio) from the Senate, January 3, 1974.

CONTENTS

CHRONOLOGICAL LIST OF WITNESSES

APPENDIX

BARRIERS TO HEALTH CARE FOR OLDER AMERICANS

WEDNESDAY, JUNE 26, 1974

U.S. SENATE,
SUBCOMMITTEE ON HEALTH OF THE ELDERLY OF THE
SPECIAL COMMITTEE ON AGING,
Washington, D.C.

The subcommittee met, pursuant to recess, at 10 a.m. in room 212, Russell Senate Office Building, Hon. Edmund S. Muskie, chairman, presiding.

Present: Senators Muskie, Mondale, Hansen, Brock, and Domenici.

Also present: William E. Oriol, staff director; Val Halamandaris, associate counsel; Elizabeth Heidbreder and John Edie, professional staff members; John Guy Miller, minority staff director; Margaret Fayé, minority professional staff member; Gerald Strickler, printing assistant; Yvonne McCoy, assistant chief clerk; Donna Gluck and Joan Merrigan, clerks.

OPENING STATEMENT BY SENATOR EDMUND S. MUSKIE, CHAIRMAN

Senator MUSKIE. The subcommittee will be in order.

Yesterday, this subcommittee heard from witnesses from the Abbott-Northwestern Hospital and Minneapolis Age and Opportunity Center. They described what happened when a senior clinic opened its doors to older people with the promise that nothing would be charged to the patient above what Medicare would pay.

Daphne Krause, executive director of the center, told in very effecting terms of the people that overloaded the facilities of the clinic. She said: "Our staff were faced with the horrendous choice of choosing between the sick and the very sick and trying to decide who needed help the most urgently."

A large majority of the patients who came to the clinic did so because of the need for immediate medical attention. Yet many had gone without seeing a doctor for long periods of time because of their fear of bills. They had what she called "paper doctors" or doctors of record only who they did not see until a crisis situation arose.

The clinic filled an enormous need because of the very real fear of these elderly widows and retired people that their small incomes and savings could not bear the Medicare deductible and coinsurance charges.

While the hospital anticipated absorbing such costs, it found that after the clinic had been operating a while, it was being disallowed Medicare reimbursement for diagnostic services which before had been

paid without question. Blue Cross, as the Medicare intermediary, began to scrutinize every claim and deny many in an action that was described as discriminatory.

At the same time, older people were canceling their medi-gap insurance policies under Blue Cross as they signed up for the free clinic. This resulted in the reduction of premiums in Minnesota from 50 cents to $1.50 a month and an open enrollment period. This occurred just after the Medicare deductible was raised from $72 to $84 and an increase in the part A coinsurance from $18 to $21. Such decreases in insurance premiums are surely unusual—if not unprecedented.

The actions of the intermediary raises serious questions concerning the role of the fiscal intermediary in the Medicare program. They also raise questions of the dual role of an insurance company as intermediary and seller of health insurance policies.

We have Blue Cross here today to reply to some of the questions that were raised yesterday, and we also have representatives from the Social Security Administration to comment. I look forward to their testimony.

But yesterday's testimony raised even more serious questions about the Medicare laws themselves—whether they are being administered in cases like this according to congressional intent, and whether they need changing.

May I at this point express the regret of Senator Humphrey that he could not be here today.

Senator Mondale was here yesterday, he participated in the hearing and the questioning, and was most interested in being here today. Unfortunately, he is tied down in another hearing and might not be here, but his interest yesterday reflects his interest in the hearing today, and I am sure he will study the record closely, so I would now like to call our first witness, representing Blue Cross-Blue Shield of Minnesota, the director of Government programs, James L. Flavin, accompanied by Winton Johnson, vice president of finance.

STATEMENT OF JAMES L. FLAVIN, DIRECTOR OF GOVERNMENT PROGRAMS, BLUE CROSS-BLUE SHIELD OF MINNESOTA; ACCOMPANIED BY WINTON P. JOHNSON

Mr. FLAVIN. Thank you. Mr. Chairman, committee members, my name is James L. Flavin and I am the director of Government programs for Blue Cross and Blue Shield of Minnesota. Also with me today is Winton P. Johnson, vice president of finance for our organization.

It is a privilege and honor to address you today concerning the very important issue of health care for the elderly. As you are aware, there is a somewhat unique health program for certain senior citizens residing in Minneapolis, called the Minneapolis Age and Opportunity Center, Inc. This organization has an arrangement with Abbott-Northwestern Hospital and certain physicians in the Minneapolis area to carry out this program. The intent of the Minneapolis age and opportunity program is to offer comprehensive health and social services which some elderly citizens might not otherwise receive or seek out.

Blue Cross and Blue Shield of Minnesota's corporate policy is to enthusiastically support programs which attempt to provide needed medical and social services not only to senior citizens but to all segments of the population.

As a Medicare fiscal intermediary, we have certain contractual obligations with the Department of Health, Education, and Welfare. To fulfill those contractual obligations, we have had, over the last few months, several telephone conversations and meetings with representatives from Abbott-Northwestern Hospital concerning the Minneapolis age and opportunity program.

In addition, we have also discussed the program with the Travelers Insurance Co., the part B Medicare carrier serving the Minneapolis area, and appropriate bureau of health insurance representatives. As an intermediary, our concerns centered around the issue as to whether certain services provided by the hospital's outpatient department were covered services under the Medicare program. The Medicare program is, as you know, an insurance program and similar to many private health insurance programs has certain deductible, coinsurance and exclusionary features. The program, for example, excludes routine physical exams and diagnostic screening tests associated with those examinations. To that point I would like to quote from section 3157 of the part A intermediary manual issued by the Department of Health, Education, and Welfare:

> The routine physical checkup exclusion applies to (a) examinations performed without relationship to treatment or diagnosis for a specific illness, symptom, complaint, or injury.

In adjudicating outpatient claims from Abbott-Northwestern Hospital, we became concerned when several claims were received with identical laboratory and radiological services and charges. It was obvious that these services might be part of a screening examination and, therefore, not covered under the program. Subsequent investigation confirmed the fact that initial visits involved diagnostic screening examinations and followup physicals. This is an integral part of the Minneapolis age and opportunity program and here I quote from a letter by Daphne Krause, executive director of the Minneapolis Age and Opportunity Center, to each new clinic member:

> In order to give you the quality health care and supportive services which we are committed to provide for you, we are setting up an appointment for you to receive a complete diagnostic screening. Following this, probably within a week, we will ask you to return for your physical with one of our doctors.

A copy of this letter is attached to my testimony.[1]

Blue Cross personnel met on March 4, 1974, with Abbott-Northwestern Hospital personnel to discuss reimbursement questions. At that time, we indicated it appeared the initial visit and laboratory services were for diagnostic screening purposes and, since Medicare excludes these services from coverage, we have to disallow them. A summary of that meeting will be supplied later.[2]

Another meeting was held on April 11, 1974, at which time we reiterated our concerns regarding the coverage issue. At that meeting, we again asked the hospital to screen those claims which involved

[1] See appendix, item 3, p. 1385.
[2] See appendix, item 3, p. 1386.

noncovered services as defined under the Medicare program. We would then be able to routinely reimburse the hospital for all other claims filed in connection with the Minneapolis age and opportunity program. This procedure is, incidentally, in effect at another Minneapolis hospital which has a similar but unrelated senior citizens' program. Therefore, to insure that we are meeting our contractual obligations of not paying for noncovered services, we have to screen the outpatient claims submitted by this provider.

It was also at the April 11, 1974, meeting the minutes reflected an attitude of discrimination against Abbott-Northwestern Hospital. Unfortunately, Mr. Chairman, Blue Cross and Blue Shield of Minnesota did not receive a copy of those minutes until your good office included them with your letter to appear at this hearing. Had we had a copy of the minutes, I'm confident our corrections, deletions, or additions agreed to bilaterally would have carried a different concept of the meeting proceedings as opposed to the unilateral minutes provided to your office.

A better word selection than "discrimination" should have been used by our employee to convey our course of action. The broad issue is to examine Blue Cross and Blue Shield's course of action in view of our testimony.

Intermediary's Obligations

In conclusion, I feel a few comments regarding our perception of an intermediary's obligations and responsibilities might be helpful to the subcommittee. Our responsibilities include acting in an agent role for both the Federal Government and the providers of services, but most importantly, we also represent the interests of the Medicare beneficiary. This is, as you are aware, a very difficult task in that each of these groups has certain vested interests which, at times, may be in conflict with each other. In Minnesota, we have, to the best of our ability, attempted to represent each of these groups in a fair and impartial manner consistent with our contractual obligations.

The Blue Cross and Blue Shield system as a whole has performed well in this role. We know of no comparable existing system which has the ability, experience, and expertise to adequately represent all these groups in this unique intermediary-type role.

Let me also state Blue Cross and Blue Shield of Minnesota's corporate policy with respect to our administering the Medicare program. It is our policy in adjudicating Medicare claims to rule in favor of the beneficiary if there is any reasonable doubt as to whether medical care is covered under the Medicare program. We feel that this was and is the intent of Congress. However, it is our judgment that the regulations are quite clear with respect to noncoverage of screening examinations. To fulfill our contractual obligations with the Department of Health, Education, and Welfare, we therefore have to deny the initial screening examination unless there are symptoms present which warrant the services rendered.

This will conclude my testimony. Once again, we thank the subcommittee for inviting us to appear.

Senator MUSKIE. Senator Hansen was unavoidably delayed, and I think at this point we ought to yield to him so he may make a statement.

STATEMENT BY SENATOR CLIFFORD P. HANSEN

Senator HANSEN. Mr. Chairman, thank you very much for your courtesy. I do regret another appointment I had was a little bit slow in being completed, and unfortunately delayed my getting over here.

Mr. Chairman, the testimony presented yesterday by the representatives of the Abbott-Northwestern Hospital offers all of us who are concerned with the situation of the aged person an opportunity once again to examine this issue with more clarity and perception.

Although in agreement that society should engage in efforts to help the aged procure essential medical care, I am somewhat disturbed at the recommendations to increase the scope of benefits of present Medicare law.

I see great difficulties that lie ahead if we increase the Federal role in providing medical care for our senior citizens beyond what it already is.

One of them is cost. In 1971, Medicare paid $7.5 billion in reimbursements. If this was actually only 40 percent of the medical costs of the elderly, then to have paid the full medical costs would have cost the Federal Government $18.75 billion. Such a figure staggers the imagination.

Taking into account inflation since 1971, the figure to provide needed medical care to our senior citizens at a Federal level now would be much higher. The fact is that the health needs of senior citizens are unlimited, and will never be able to be fully met by a Government handout program.

The task is one of herculean proportions, and may be beyond the capacity of our economy to sustain, without a renewed demonstration of personal and family commitment to help.

In a period when inflation is our Nation's No. 1 problem, and is

SHARP INCREASE IN DEMAND

principally caused and aggravated by spiraling Government expenditures, I find it highly irresponsible to propose increasing to unthinkable proportions the expenditures of the Federal budget for health, when these costs could and should be met at State, local, and individual levels.

Another serious problem that we should consider in removing the financial barriers is the sharp increase in demand that would be experienced within the health system if it were suddenly opened up to increased requests for health care services. If the experience at Abbott-Northwestern Hospital were duplicated all over the country when medical care was offered for free, can you imagine the turmoil and confusion that would result?

I suggest that all of our health care facilities would be inundated with demands for health care, legitimate and imagined, far beyond our capacity to provide it. Such a situation would have no other re-

sult than to repeat the experience of 1965 when medical prices sharply increased as the demand heavily exceeded the supply of medical facilities.

Many physicians noted that as the demands upon their time increased, as the patientload became greater, they were forced to spend less time with each patient. In order to assure that the patient had been diagnosed properly, the doctor often ordered varied laboratory and X-ray tests. These tests were not always necessary, but to "be safe," they were requested.

As the financial barriers are lowered, the doctor becomes further and further inundated with patients demanding care. Of course, he cannot continue to supply the same quality of care as before.

So you see, we have a very real practical problem with reducing financial barriers to medical care.

There is no doubt in my mind that, when medical services are offered at low cost or for free, most individuals—whether they are actually delaying going to the doctor because of limited resources, or whether they are just going some place where they will have to pay more—will opt for the cheaper of the two alternatives. I suspect that this is what happened in Minnesota.

Without demeaning or ignoring the crying need for providing medical care for our senior citizens, then, may I suggest that we turn from further Federal responsibility in this area and encourage private and local efforts?

Philanthropic Contributions

It is of great interest to me to know the extent of such efforts as represented by private philanthropic contributions to health care. During 1973, $3.98 billion was contributed by private philanthropy for health and hospitals—about 4 percent of total health spending, and about 19 percent of private, nonprofit construction costs.

A statistical report prepared for the American Association of Fundraising Counsel, presenting figures on 84 fundraising campaigns, shows contributions totaling $183,500,849. Goal attainments ranged from 210.8 percent of a $250,000 goal to 58 percent of a $1.5 million goal. Corporations accounted for 37.9 percent of the total raised; other individuals accounted for 16.3 percent, and foundations for 15.1 percent.

Of particular note is that of 244,680 gifts, 242,000 were gifts of $5,000 or less. In 32 instances, the largest gift was made by a corporation or financial institution; in 11 instances, by an individual or family; in 10 instances, by a foundation; and in 6 instances, by a hospital auxiliary organization.

Of supreme importance to me is that in these fundraising campaigns, 33,513 volunteer workers were involved—this is great.

The figures are significant, for it shows that the principle of private and local responsibility for philanthropic contributions is not lost. I assert that this is what we ought to encourage. Surely if such efforts were expanded, we could deal much more effectively with the problems of our senior citizens.

A proposal which shows real understanding of the basic issues is that made by William Buckley and printed in the Congressional Record several months ago. Mr. Buckley, the noted columnist, proposed that:

> The burden of the nonprofessional work done in behalf of the aged should be done by young men and women graduated from high school, during 1 year before matriculating at college. . . . The experience would remind young people at an impressionable age of the nature of genuine, humanitarian service, which is the disinterested personal act of kindness, administered by one individual directly to another individual. . . . The opportunity is great for initiative from the private sector.

Such a policy would return us to a realization of the responsibility of the individual and local association to provide help for the elderly. It would inculcate among our people a sincere interest of love, trust, and appreciation for the senior members of society. And that is the basis for sincere community efforts to help them procure needed medical care.

Mrs. Hunter Meets Challenge

I would like to refer to just one more example from my home State of Wyoming. This is the exciting story of Eileen Hunter of Jackson Hole, Wyo., who has played such an important role in the construction, operation, and expansion of the St. John's Hospital there. St. John's Hospital has just completed an expansion that adds six semiprivate rooms, a physical therapy department, and a nurses' station. The project was begun over a year ago and reflects the continuing commitment of Eileen Hunter and the public response her altruism stimulates.

Noting that the nursing home facility might be phased out due to a rapid increase of acute care patients during 1973, Mrs. Hunter raised the initial $50,000 of the total $150,000 for the expansion. She then spearheaded the drive to make up the full amount. When asked an approximate total of her hospital donations Eileen replies, with typical Eileen Hunter style, "if I can afford to give a lot and another can afford to give a dollar, then we're even."

While the contributions of Mrs. Hunter and John D. Rockefeller, Jr., were paradigms of philanthropy at its best, it must be noted that the working men and women of Jackson Hole, by pledging amounts of only a few dollars per month over a period of years persuaded the board of St. John's that it could build the new hospital facilities.

I submit that this is the type of thing we ought to consider. While the sustained dedication Mrs. Hunter exhibits is uncommon, I suspect that through some formal encouragement such efforts could become much more common and effective in carrying the burden of providing help to our senior citizens.

It is the principle of this issue that is most important—that individuals and private entities become active and involved in charitable support and contributions. It is far better for individuals to recognize their responsibility to help their neighbor than to shirk the responsi-

bility or abdicate it to the Government. Disinterested, third-party intermediary government roles will never match personal efforts based on sincere concern and motivated by love, trust, and respect.

I believe that demands for expansion of governmental programs of Medicare and Medicaid would be sharply reduced if private individuals, associations, and local governments, to the extent of their abilities, would take care of their families, kin, and the underprivileged.

I realize the political advantages to be gained by supporting far-reaching, comprehensive benefit programs for the aged. But in this instance, in all good faith and candor, I must defer the responsibility to your State and local governments, and private individuals and associations.

To do otherwise would be to hold out false promises that may never be met, and will surely result in further discontent and distrust of our public officials by all our people. Thank you very much.

Senator MUSKIE. I see Senator Domenici and Senator Brock are here. You have already heard Mr. Flavin's testimony, but if you have opening statements, I would be happy to yield for that purpose.

STATEMENT BY SENATOR PETE V. DOMENICI

Senator DOMENICI. Mr. Chairman, just a brief statement, I heard most of yesterday's testimony. Having actually conducted some hearings on barriers to health care, and having seen the diverse programs we have in existence, I was most struck yesterday by a summary that Dr. Farber made. After he went into some detail about his experience as a volunteer provider of medical services, working as part of a team of physicians that donated a substantial portion of their time to the effort that we heard yesterday, he went on to say that current funding of Medicare is grossly inadequate for patients dependent for their assistance on Social Security payments.

His conclusion, to me, was most emphatic and true, and if we could come to grips with it, I think we would be on the way to some success. He concluded, there is no doubt that early preventive medical care, with appropriate backup services, to this population of patients vastly reduces the overall cost to society of their medical care. I think this ties in with the national policy which seems to unnecessarily institutionalize our senior citizens.

This has been destroying other relationships which are good. I think if we could put the local package of costs together, we would find that a better preventive program and backup program for senior citizens over the long haul would be cheaper than what we are doing now, and certainly be the more honorable, more moral way to handle the problem.

It would increase relationships of parent to child, family relationships, and home care. I am extremely interested in this overall picture as we move in that direction.

I thank the chairman for permitting me to have a few comments today.

Senator MUSKIE. Thank you very much, Senator Domenici.

STATEMENT OF JAMES L. FLAVIN—Continued

Mr. Flavin, if I may get into your testimony of the issue that has been raised, first of all, with respect to the meeting of April 11, 1974, did your representatives keep minutes of that meeting?

Mr. FLAVIN. Not specifically minutes of the meeting, however, it is a common practice with our people, Senator, when they attend any kind of a meeting outside of our building, to write up a report for the file, it is a history of what went on, and we do have that particular document in our files.

Senator MUSKIE. What is that? Who prepared that document?

Mr. FLAVIN. May I see it?

Senator MUSKIE. Is this it?

Mr. FLAVIN. No, these minutes are the minutes I referred to in my testimony. Blue Cross had not seen them before you sent them to us.

Senator MUSKIE. Before I get into this, I want to know whether or not you kept minutes, and the report, have you made that report, would you make that report available to the committee?

Mr. FLAVIN. I have it with me.

Senator MUSKIE. I think it would be useful for the record to have it.

Mr. FLAVIN. We will provide it.[1]

Senator MUSKIE. Now, these minutes which Mrs. Krause provided to the committee were sworn on June 11 of this year by Richard Kramer, and there are several other certifications to the effect they do reflect the meeting, and I think those affidavits should also be a part of the record, and we will have your version also.

Mr. FLAVIN. Fine.

Senator MUSKIE. Now, who prepared that report?

Mr. FLAVIN. Our report, Senator, the one I am going to give you, was prepared by Sharon Blood, mentioned in the minutes.

Senator MUSKIE. She was present for all the meeting?

Mr. FLAVIN. Yes.

Senator MUSKIE. Does she challenge the statement attributed to her in the minutes which the committee has?

Mr. FLAVIN I do not think she has challenged them as such, however, she gives an explanation of some of her statements in her recollection of that particular meeting.

Senator MUSKIE. And those explanations are contained in the report which you are now filing?

Mr. FLAVIN. Yes.

Senator MUSKIE. I may have an opportunity a little later to look at her report, and I may have some questions about it.

Mr. FLAVIN. Fine.

Senator MUSKIE. First of all, let me ask you, what is your organization's attitude toward this program that we heard so much of yesterday, and which is now the subject of these hearings?

Do you think it is a good thing? Do you think it is a good way to deal with the problems of the aged? Do you support the central idea which is to provide medical care at no greater cost to the patient than the Medicare payment?

Do you think that is a sound concept, something that your organization would support?

Mr. FLAVIN. Senator, I would answer in this way. I think you asked what our attitude would be toward Government programs, specifically Medicare.

---

[1] See appendix, item 3, p. 1386.

Senator MUSKIE. I am talking about this particular program, the Abbott-Northwestern program, as developed and implemented in Minneapolis. What is your feeling about it? Do you support it; is it a good thing; is it performing a useful service?

Mr. FLAVIN. I think in our testimony we indicated we are supportive of this type of activity, not only for the senior citizens, but also for the rest of the population.

Senator MUSKIE. You say it in general terms. I want to concentrate specifically on this one. You say the intent of Blue Cross and Blue Shield's Minnesota corporate policy is to enthusiastically support programs which attempt to provide medical services to the population.

Does that statement of general enthusiasm apply specifically to this program?

Mr. FLAVIN. Yes, it was specifically written for that purpose.

Senator MUSKIE. So, if there is any way to make it work, you are interested in finding a way to make it work.

Mr. FLAVIN. That is right.

DIAGNOSTIC SCREENING TESTS EXCLUDED

Senator MUSKIE. And the issue which had been raised yesterday by those involved in that program, and described in your statement today, in this sentence, "The program, for example, excludes routine physical exams and diagnostic screening tests associated with those examinations."

Now, that is a major issue, is it not?

Mr. FLAVIN. It would seem to me, Senator, that is the issue.

Senator MUSKIE. Now, how would you define the diagnostic screening tests?

No, before I get to that, you have given in your statement the regulation from the manual that applies.

Mr. FLAVIN. Yes.

Senator MUSKIE. And if I may reread that, and get it in the context. "The routine physical checkup exclusion applies to (a) examinations performed without relation to treatment or diagnosis for a specific illness, symptom, complaint, or injury."

So what you are saying is that the tests for which the clinic seeks reimbursement, in your judgment, those tests are examinations performed without relationship to treatment or diagnosis for a specific illness?

Mr. FLAVIN. What we are saying, Senator, is there are certain charges to the program that have been made that are noncompensable, and there are some that are compensable.

It is not a general statement to say everyone that has this type of an examination in the outpatient department of this hospital has his claim denied.

There are many of the claims that are paid for examinations. I think the implication is, Senator, as far as our handling of the claims in the outpatient department of Abbott-Northwestern Hospital, that there is a 100-percent denial of these claims, and this is not true.

Senator MUSKIE. I am trying to get into the record your perspective with respect to these rejected claims and why it differs from that of

others who administer the program. I gather that this provision from the manual is the basis for your point of view.

Mr. FLAVIN. Yes.

Senator MUSKIE. And what that provision of the manual says is that payment is not permitted for examinations performed without relationship to treatment or diagnosis of a specific illness; that is what you said.

Mr. FLAVIN. Yes, coming out of the manual.

Senator MUSKIE. Now, the applicable provision of the law would appear to be this, and I ask you if you agree with me, section 1862(a), which reads:

> Notwithstanding any other provision of this title, no payment may be made on the part A or part B of Medicare for any expenses incurred for items or services (1) which are not reasonable and necessary for the diagnosis or treatment of illness or injury, or to improve the functioning of a malformed body member.

Are you familiar with that provision of the law?

Mr. FLAVIN. Vaguely, Senator.

Senator MUSKIE. You have not studied it with respect to the provision of the manual?

Mr. FLAVIN. Yes; we have. However, in reading the manual, I would like to take a look at the total section to refresh my memory.

Senator MUSKIE. I can show you the language so you will not be dependent on my oral recitation. I would like to ask you a question about it, and I would like you to have this in front of you.

Now I ask this question as a legislator concerned with the question of whether or not we need to change the law, or whether the intent of the law is being implemented. This question is not directed to your own conclusions about particular claims.

When that language says, "which are not reasonable and necessary for the diagnosis or treatment of illness or injury," it seems to me it is not as restrictive language as the language of the regulation. But that is a casual opinion, and I simply would ask you if you would focus on the difference in the language on those terms.

CLAIMS ADJUDICATED FROM MANUAL

Mr. FLAVIN. Senator, I do not have a comment on that interpretive issue.

From our point of view, we adjudicate our claims based on language from our manual.

Senator MUSKIE. The language from the manual?

Mr. FLAVIN. Yes.

Senator MUSKIE. If you have some subsequent thoughts about the language, we would like to have it.

Now, with respect to the procedures at Abbott-Northwestern, as described in the testimony yesterday—incidentally, were you present yesterday?

Mr. FLAVIN. Yes, Senator, I had the privilege of being there yesterday.

Senator MUSKIE. So you can correct my recollection of what we heard yesterday if you think my recollection is erroneous. As the procedures were described for us, it consisted of three phases, phase 1 was

the first appointment. The client sees the counselor, gives the social history, and sees the nurse to give medical history.

That was phase 1, and I think the testimony was no claims were submitted to Blue Cross for phase 1. That was the testimony.

Phase 2 was the second appointment, consisting of diagnostic tests.

Mr. FLAVIN. Yes.

Senator MUSKIE. Phase 3, third appointment, the client sees the physician; the physician reads the tests and gives the physical.

Now, as I understand it, at this period, from November 1 to February 3, claims were originally submitted to Blue Cross for phases 2 and 3.

Mr. FLAVIN. Yes.

Senator MUSKIE. These claims were rejected by Blue Cross. Abbott did not contest these rejections and did not appeal them. They absorbed the costs of both phase 2 and phase 3 in that period, amounting to $25,000.

That was the testimony yesterday.

Mr. FLAVIN. Yes.

Senator MUSKIE. Now, because of the enormous influx of patients of Abbott seeking help, the procedures after February 3, 1974, eliminated phase 2 and phase 3 entirely.

Only phase 1 is used, and only very sick clients were seen.

Phases 2 and 3 were eliminated. So many seriously sick persons were coming in that there were not enough doctors to treat them.

The clinic, in effect, was forced to choose between the sick and the very sick.

Now. that was the testimony as I understand it, yesterday.

Mr. FLAVIN. Yes.

Senator MUSKIE. So that the program from then on was designed to deal with the illnesses of people, all of whom were sick when they entered the hospital.

Now, that is my recollection in summary of the procedures and their evolution, as the program went along.

Mr. FLAVIN. Yes.

Senator MUSKIE. Now, it was in that context that this question of the rejected and disputed claims has come up.

Mr. FLAVIN. Yes.

Senator MUSKIE. The clinic arguing that every case was an illness, that every case involved a specific application to clear the obvious illnesses, and therefore eligible for reimbursement.

It was not a question of screening out the well or the phony from the sick. It was a question of dealing only with the sick.

That is, as I understand it, that is their argument. Now we have here a few of the files, and a few of the claims that were rejected.[1]

CLAIM REJECTIONS EXEMPLIFIED

Here is one of hypertension, abdominal discomfort, I am not sure I can decipher all of the abbreviations. Hypertension, of course, is a symptom that can give a warning sign leading to possible stroke.

We have here another one rejected, congestive heart failure, urinary infection.

[1] Retained in committee files.

Another one here, bright red blood in the stool. Another one here, atrial fibrillation.

Another one here, chronic obstructed pulmonary disease.

Another one, cardiovascular accident, that is, a stroke, as I understand it.

Another one, angina anemia.

Another one, hypertension, probably early congestive heart failure. Diabetes, hypertension, rheumatic heart disease.

Hypertension, cancer of the colon.

Hypertension, arteriosclerotic heart disease.

Hypertension.

First of all, with regard to these, I do not know whether you want to see the specific ones, but how do you respond to the argument that these claims are not related very specifically to illnesses?

The tests are made with full understanding that a sick patient must be dealt with. The purpose of the tests is to progress with treatment, not to decide whether or not treatment is necessary, and the illness is very specific.

How do you respond to that as being subject to the application of that provision of the manual upon which you rely?

Mr. FLAVIN. Senator, I think it would not be necessary for me to look at the claims, but there are many times when claims are submitted to our organization, or to any other carrier, or to any other intermediary, and if a claim is rejected, for example, it is returned to the provider, and the provider has the option of coming back to us, and indicating to us that they disagree with the decision made on that particular claim, because in our business, like in most businesses, we cannot be right 100 percent of the time, and the law provides for just that, so if you disagree with a decision, you have an appeals process you can go through. You also have a hearing process you can go through. However, I would suggest that claims like this, where there is a difference of opinion, be submitted to our claims department, and then we can talk to those people to see whether or not there is some additional documentation that has not been available to us previously.

Senator MUSKIE. Well, is it your view that when these obviously sick patients come in, that the tests ought not to be made at all?

SOME PROGRAMS NOT COVERED

Mr. FLAVIN. Senator, we are not saying that at all. All we are saying is if the M.A.O. program, as it was described by the group yesterday, and by their description of this particular program, it is part of their program to include, for example, a physical examination as part of their membership, or whatever other services they want to give to those people, it is perfectly all right and within their province, but they must realize that payment may not be allowable under Medicare regulations.

Senator MUSKIE. That was phase 1. Phase 1 has been dropped, as I understand it, and that is why I reviewed the procedure as I recall the testimony, and they are making no claims for this physical examination.

Mr. FLAVIN. Well, if this were to be a fact then they are taking care of fewer people now than they were in the last quarter of 1973, is this true?

Senator MUSKIE. I am not aware of that. I do not recall any testimony on the point. Could I ask Mrs. Krause.

Mrs. KRAUSE. Did he say we were taking care of fewer?

Senator MUSKIE. Fewer now than the last quarter of 1973.

Mrs. KRAUSE. Absolutely not. There are more people coming in. They are so sick that they keep coming in. I do not know what that has to do with it.

Mr. FLAVIN. The point I was making is that we have seen a tremendous influx in the number of outpatient claims in the last 6 months, and for the record, in December, we had from Abbott-Northwestern Hospital 299 claims that had been paid, and in January of 1974, it was 101; in February, it was 277; in March, it was 642; in April, it was 555; and in May, it was 557.

Senator MUSKIE. Are you rejecting these claims?

Mr. FLAVIN. These are paid claims that have come in and been paid by us during this period of time.

Senator MUSKIE. I understand that, but I am concerned about the ones that have not been paid. That is the issue that has been raised.

I did not raise it. The witnesses yesterday raised it, and I am trying to get to the heart of it to find out precisely why they were rejected, whether or not the rejection does interpret the law correctly and the regulations. If not, why not?

Senator BROCK. Will you yield for a question?

I am not sure I understand the case you have cited. Was the whole claim rejected, or was it only a specific portion?

Senator MUSKIE. The staff says the entire claim.

Senator BROCK. The entire claim. On what grounds?

Mr. HALAMANDARIS. That it was diagnostic screening, and therefore uncovered service. There is no other reason given.

Senator MUSKIE. That is why I raised it.

Mr. HALAMANDARIS. Today's testimony is the only explanation we've had.

Mr. FLAVIN. It is difficult for me to sit here and give you the reason on each specific claim.

If we had the opportunity to take these claims and research them, I am sure we could give you answers on them without any doubt.

Senator MUSKIE. What I am trying to get at here is important. We had 3 hours of testimony yesterday relating to this as an imaginative clinic. It may not be new, but I do not know of anything similar that has been developed elsewhere. It is an imaginative way to deal with the problems of senior citizens who simply cannot afford medical care, because they cannot afford the deductibles, coinsurance charges, the costs above Medicare reimbursable items, and so on.

They have postponed care and with this new program people who have stayed away come knocking by the hundreds.

POSTPONED CARE CREATES GREATER PROBLEMS

Because they have stayed away, they have accumulated a staggering array of illnesses and problems. It would be no surprise that the facility was flooded with people in physical distress. So you are not concerned with screening out a lot of people who do not need atten-

tion. You are talking about dealing with people who all need attention.

My question is, How do they make the entry into the system? By the outpatient clinic, by doctors, by nurses, or all of the other health professions. How do they make that entry?

What you say is that if they make that entry by way of a routine physical checkup, and unrelated to specific illness, that the claim is not reimbursable.

Now, you know, that could be described as nitpicking, unless there is a real reason, and I am trying to find out what the real reason is.

Are they being treated generously in the interpretation, or are they being held on some technical, legal point?

I am not looking at your motivations.

What we are getting at is a question that has been raised by interpretation of a law and a regulation under very unusual circumstances, and whether or not that interpretation makes human sense in the context of the problem and the reaction. That is what we are trying to get at.

Now, we have another file here of parallel cases. Cases that were approved before the expansion of this clinic, and comparable, if not identical cases, that were rejected since. There are several of them, and I will put them in the record without going through a recital.[1] They are attested to by yesterday's witnesses, that diagnoses approved for payment, prior to November 1, were rejected thereafter. How do you explain that?

Mr. FLAVIN. Senator, I heard the same testimony yesterday, and in this sort of an instance, the only thing I could do would be to take the cases that have been presented to you, as being paid prior to November 1, and take a look at the cases that have been denied after that period of time, and take a look at our records, to see if there is something in our records that would give us some kind of indication that there is a difference in the claim. You cannot tell by looking at the claim by itself.

Senator MUSKIE. I understand that, but I think it would be interesting to look at the claims. Systolic heart murmur, systolic hypertension, this is a paid one, before November 1. Here is one rejected, hypertension, hypertensive cardiovascular disease.

Now, they are the same kinds of cases, are they not?

RECORDS NEEDED FOR REVIEW

Mr. FLAVIN. Senator, on the surface, they are probably the same, but I would like to go into our records to see what we have to support our decision.

Senator MUSKIE. The staff says in each of these cases, the second one was a sicker patient than the first one, and the sicker patient was the one rejected.

I have no objection to you doing that, but we would welcome a response as to why.[2]

---

[1] Retained in committee files.
[2] See appendix, item 3, p. 1382.

Is it that this kind of occurrence reflects the change in attitude about these kinds of cases, geared to the fact that suddenly you are faced with an increase in load, and in claims that you find staggering?

Have you changed your policy suddenly, because instead of having a few cases, you are having 10 times the number of cases, so you have to find a way to cut down on your payments, and cut down on the claims you are going to reimburse?

You seem to be very impressed with the increase in the outpatient claims.

Mr. FLAVIN. It was a dramatic increase, yes. We are managing that load.

Senator MUSKIE. Is that the principal motivation?

Mr. FLAVIN. No, none whatsoever.

Senator MUSKIE. Well, I don't know. May I ask the staff, How many of these before-and-after situations do we have?

Mr. HALAMANDARIS. I think we have about 65.

Mrs. KRAUSE. There are many more. I just gave you some samples. It was not possible to bring you the thousands of records that we have, Senator.

Senator MUSKIE. Are they in your judgment a good sample?

Mrs. KRAUSE. Yes.

Senator MUSKIE. I think I would like, for the record, Mr. Flavin, if you would examine those, if you would find the reasons in the files and support the rejections, we would like to know what your reasons are.

Mrs. KRAUSE. Mr. Chairman, the point of the fact is that these cases were resubmitted to them.

Mr. Kramer is here from the hospital, and the very cases he said we should take back and they would go over them, that was done and they were rejected.

Senator MUSKIE. And re-rejected. There were 65 that you submitted to us?

Mrs. KRAUSE. Yes, as samples, Senator. There are 428.

Mr. ADAMOVICH. Of which a portion were the original screening.

Senator MUSKIE. All of those 428 were resubmitted and re-rejected?

Mr. ADAMOVICH. Excuse me 1 second. Approximately 250 of the 428 were with one submission in the early period, the balance of them were after February 3, and were also resubmitted and again rejected.

Senator MUSKIE. May I say to my colleagues, this is Mr. Adamovich. Mrs. Krause is sort of the guiding spirit.

Mr. FLAVIN. Senator, will your staff provide me with copies of these documents, so I may respond?

Senator MUSKIE. Yes, we sure will, and we would like to have an evaluation of each, and the reasons why. I particularly would like you to focus on the resubmittals and the re-rejections, and then to draw up for the committee general principles of rejection.[1]

What is the policy that resulted in this?

---

[1] See appendix, item 3, p. 1382.

It seems to me in all frankness, if you have a program of this kind designed to open up an avenue of relief to senior citizens in which they do finally see something to facilitate their care and which removes obstacles to their receiving such medical care, you have to look for ways to make this viable.

It seems to me that the challenge which you face is to demonstrate a policy of cooperation, to try to make it work, rather than raising technical points to undercut and threaten its existence. That is the challenge.

I raise that question, not prejudging the answer, but I think that is what you face.

I am going to shift to another subject, if my colleagues would like to ask followup questions on the one we have just been discussing, fine.

Senator Domenici?

Senator DOMENICI. Just a few comments, Mr. Chairman.

Let me ask Mr. Flavin, it seems to me the testimony we got yesterday would indicate that in this particular area of the United States, there is a huge buildup of illnesses, sicknesses, and diseases among the senior citizens that they are just willing to put up with, because, as we heard, various real or misconceived notions about Medicare, and what they are entitled to, and what they are not entitled to, or because of having to balance off the kind of money they have for food versus out-of-pocket dollars for medical care.

I believe that this particular clinic discovered, subject to whatever error you want to put in it, a huge number of valid claims by our senior citizens, that are out there floating around in that particular area in large numbers, in large percentages.

I think your 119 versus 462 claims, if followed through to what actual curative measures were taken, would indicate to me that that fact is true, rather than that something is wrong with the process that this clinic is using.

Now, assume that this is true, would there be any reason for you to doubt that such is probably the case in most American communities, where there are significant numbers of senior citizens? Is this a peculiar illness-laden senior citizen area, or might we conclude that a similar situation exists in my city, Albuquerque, N. Mex., or Senator Muskie's State, or a community in an urban area? Would you have an opinion?

Mr. FLAVIN. No, sir, I would not.

Senator DOMENICI. Is there any reason to suspect that this is a peculiar area for disease-laden senior citizens who, out of fear, or misconception, or perhaps a bad national law, do not want to present themselves for treatment? Is there any reason to suspect that this area is unique in that respect?

Mr. FLAVIN. I do not know whether we would be unique, or whether we would not be unique. I honestly cannot offer an informed opinion on it.

Senator MUSKIE. Well, does not Blue Cross handle claims all over the country under this kind of agency relationship with the Federal Government?

Mr. FLAVIN. Yes, Senator, we do.

Senator MUSKIE. Do you have any reason to believe that prior to this new influx of cases the statistics were significantly different than other American communities?

Mr. FLAVIN. I would have no comparative statistics on the subject that I could use to render an opinion.

Senator DOMENICI. You mean to tell me that you do not have an opinion whether or not the claims handled for senior citizens in your community, as apart from this clinic, have some similarity in terms of per capita claims in this Nation and in the average urban area?

Mr. FLAVIN. I would say there are statistics on the subject. There are volumes of statistics on this subject.

As far as making comparison between our area and some other area, your area, I have not done that.

Senator DOMENICI. Let me put it this way. I was certainly impressed with the competency of the medical people that made the diagnosis, the neurologists and others who testified yesterday, as pretty exemplary American medical people.

Let us assume further, in fact they made an adequate diagnosis, and found all of the various illnesses when these people finally presented themselves there.

Might I ask, do you have any reason to believe if a similar approach was carried out in another typical American city, we would not find comparable new influxes of senior citizens with this kind of dilemma—that they have been keeping to themselves, waiting until they are sick enough to be put in the hospital?

Mr. FLAVIN. I would have no opinion. I would not know how some other part of the United States would react to something like that.

Senator DOMENICI. Let me ask you, assume that the Congress of the United States found that indeed there is a high percentage of senior citizens that are keeping to themselves these very serious illnesses, and that they are just not going to be taken care of; assume we found that as a fact, would you agree that perhaps a good preventive approach to that would be to permit each of them to have an annual physical examination, without any question about paying for it, instead of awaiting development of the serious kind of institutional-type illnesses?

Mr. FLAVIN. I would say to that, Senator, if the decision of the Congress is to make changes in the Medicare law, and those changes were communicated to the carriers, and the intermediaries here in the United States, then we would fulfill our contractual obligation, and apply whatever the Congress wanted done with this particular program.

Senator DOMENICI. Would you not agree that if the statistics found here are somewhat valid in the Nation, and if our approach was to try to adopt the national policy of preventive medicine for our senior citizens, that getting them in, that getting them examined, would be a good approach to finding this kind of fact out, as they apparently have done?

Mr. FLAVIN. Well, if your investigations through the Congress and through your constituents that are talking to you about this particular subject, if you as a Senator feel that is good, I am sure your vote would be favorable on something like that; but if the constituents of other Senators, other Congressmen, might have some other concerns in this regard, they might not look at it in that particular fashion, so I guess it is entirely up to the Congress itself to decide what kind of benefits, or what kind of a benefit level, should be available for the citizens of the United States, and whatever decision is made by the Congress, then that decision comes back through your Federal administrative roles, either your carrier or your intermediaries.

Senator DOMENICI. I understand that, and I understand you get paid for your services, and whatever services are required, you are going to handle it. I'm not assuming you are prejudiced in the situation, but it does seem to me that we are not talking about a question of my preference over someone else's.

What I am getting at is, do you or do you not believe that large numbers of senior citizens in the United States are, based upon the existing Medicare laws, and the regulations as you and people like you have adopted and carried out, are inhibited in terms of getting the earliest kind of treatment and in terms of delivery of health care?

Mr. FLAVIN. I would have no opinion on that, Senator.

Senator DOMENICI. I have no further questions, Mr. Chairman.

Senator MUSKIE. Senator Brock?

Senator BROCK. I would like to go back to an implicit question on the part of the chairman earlier, and ask you, first, if you, at least as indicated by this particular situation, do not feel that maybe we have placed you in an untenable position with the law through what appears to me to be a three-way conflict.

You are an agent for the Government, you are an agent for the recipient, and you are a seller or provider of additional services. It seems to me that we have almost put you in a position where you are competing with yourself, and in that kind of setting, maybe there is, at least implicit in this, a motivation for the person or institution, as you are, who represents the Government to strictly interpret HEW regulations, because a liberal interpretation would be directly competitive with the services that you sell in the marketplace. Is that an unfair assumption?

Mr. FLAVIN. Well, actually, Senator, as far as complementary coverage, or supplemental coverage to Medicare, we have a certain market penetration in the State of Minnesota, as do many other health underwriters in this field.

We are not exclusive in this. There are many commercials that are writing this type of coverage, and as far as the conflict is concerned, I see no conflict, nor have we ever seen a conflict in this sort of arrangement that we have in providing complementary coverage to those that want it.

Senator BROCK. Have you had any study done on the number of people who might avail themselves of this new service under the plan, canceling their claim with you?

Mr. FLAVIN. That issue was brought up the first time yesterday. We had no opportunity to make any kind of study whatsoever in that regard.

Senator MUSKIE. If such an occasion were to arise, would you not feel that the potential for conflict was stronger than you might have indicated?

Mr. FLAVIN. I think, Senator and Mr. Chairman, if I may address myself to the problem raised yesterday with respect to the lowering of our complementary insurance rates——

Senator MUSKIE. I was going to get into that.

Mr. FLAVIN. It sort of ties in with the kind of interrogation that is going on at the present time.

BLUE CROSS-BLUE SHIELD MERGE

As far as complementary coverage within our specific organization, I would have to take you back about 4 years, at which time there was a separate corporation for Blue Cross and a separate corporation for Blue Shield, and it became evident to us that it would be in the best interests of both Blue Cross and Blue Shield at that point of time, to form one corporation, which was done; Blue Cross and Blue Shield merged in the State of Minnesota.

Now, at that point in time, we had several problems that were facing us, because of conflicting language in both Blue Cross contracts, and the conflict in language in the Blue Shield contracts, and sometimes were in conflict with one another, mainly because one organization was a separate entity for a while, and we were a separate entity. So when we merged the two corporations together, we noticed in going over our contracts, there were differences that made administration difficult. Over a period of time, we have been making changes in our contract language, in our group contract, in our individual contract, and also now in our complementary contract to Medicare, and that occurred back in November of last year. Combining the contracts, coupled with a good utilization picture, in other words, the utilization was such that a reduction could be made in the premium, and as the Senator commented, this is unheard of in the insurance field. Another contributing factor to that was the fact that there was generally in our business a shorter length of stay in hospitals across all lines of our business. Another factor was that the economic stabilization program in effect for the last couple of years acted as a constraint on the cost of medical care, and this also contributed to the money that we have as far as to be able to rerate our contracts and give subscribers a lower rate. That is what happened; and if it coincided with anything that occurred at Abbott-Northwestern, it was a coincidence, because you do not rate your contracts based on only what you anticipate, but also on utilization history.

You base your contract decisions on utilization history to see what you have in the way of funds available to expand either the benefits, for example, or lower the rate, and that is what happened with our complementary coverage contracts.

FURTHER RATE REDUCTIONS

To go further than that, we have made further rate reductions in our group contracts in the State of Minnesota, because of the favorable underwriting picture we have had, so this is also a part of our total business, and because it happened to happen as far as Medicare complementary is concerned, at that point of time, and that is all it was, was just a coincidence.

It had been a corporate policy that had been going on for a long period of time.

Senator BROCK. I understand how you establish your rates and I hope you understand the questions are not designed to be antagonistic. But if we do identify a conflict, if it is of our making, then it is our obligation to try to resolve it.

I do at least perceive the potential for some conflict. Whether it is existing or not in fact may remain to be determined, but I think the potential exists.

I see a three-way conflict with regard to existing law, the difference between the law and the regulations, and the interpretation of the regulation.

Now, if we write a law as we did, which says specifically that no payments shall be made for expenses for routine physical checkup, that does not then imply that any service that is acquired as a result of a routine physical checkup should be denied.

Mr. FLAVIN. That is true, Senator, and they are paid.

Senator BROCK. The question before us seems to be that the denial was based on the fact that there was a routine screening procedure, and not on what came from those tests. That certainly was not our intent.

Again, if we have placed you in a position where your own sales would be damaged, or the market would be damaged by a liberal interpretation of the regulation, it seems to me we have put you in a conflict-of-interest position, and we have jeopardized the availability of services which we intended to give to the aged people of this country.

That concern is what I am reaching for, and if it is a matter of fact that you do not know whether there have been cancellations as a result of the Abbott claim——

Mr. FLAVIN. I don't know, Senator. I've had no opportunity to examine it.

Senator BROCK. I would personally appreciate it if you could provide for the record some analysis of your history in the last 4 months.

Mr. FLAVIN. We would be happy to do that, Senator. We can make that study, and make it available.[1]

Senator BROCK. It would be very helpful. That is all, Mr. Chairman.

Senator MUSKIE. Senator Hansen?

Senator HANSEN. Thank you, Mr. Chairman. First let me say that I am sorry I was not able to stay through the full presentation yesterday.

I was very deeply impressed by what I heard here. The possible conflict that arises because of the responsibilities placed upon organiza-

[1] See appendix, item 3, p. 1382.

tions such as Blue Cross-Blue Shield by the Government, in that you are required to perform a triple role, has been addressed I think sufficiently so as to not require my repeating those points again.

I do sense though that there are some possible conflicts that could result in pulling and tugging as you try earnestly and sincerely and objectively to do what you think is best.

You are an intermediary for Medicare. You sell Medicare gap insurance, and you are also the agency that hears appeals against intermediary decisions on reimbursement. I can speculate that within this triple role, you could be pulling first one way and then the other, but I gather that part of the reasons back of this hearing being called—and I compliment you again, Mr. Chairman, for your perception—is to determine how well, or how nearly adequate Medicare—as it is presently constituted, meets the needs of people who are really ill, and basically the resolution of that question I think comes into focus from testimony such as we heard yesterday.

Can it be demonstrated that people who are ill have not been receiving the kind of attention that they deserve, and the kind the Congress intended they should have?

Estimated Annual Bill of $18.75 Billion

Now, I gathered that it was testified that it may be that despite the fact that Medicare paid about $7.5 billion in 1971 in bills, possibly not more than 40 percent of the legitimate needs of the people of this country were being met. If that is true, if my arithmetic is right, I assume we could contemplate a bill of $18.75 billion.

The question of deciding—trying to spell out in legislation guidelines that are practical and workable, that will guide doctors and intermediaries to know whom to treat, and whom not to treat—where to draw the line, as you testified here this morning, is exceedingly difficult.

I know when I was Governor of Wyoming, I was told by the head of our State welfare agency, he would like to take me for a ride one time.

This was back in the days when we still had a surplus commodity program, and in order to be eligible for welfare at that time, Federal law required that every welfare recipient take certain amounts of surplus food.

I took the ride with him one day, Mr. Chairman, and we drove out to Cheyenne, about 6 miles and back, and along either side of the road were cast out bundles of food.

I have forgotten all that was in them, rice and potatoes, one thing or another, but people were just throwing them away, they did not want them.

Having been raised rather frugally, it looked like it was all edible to me, I have eaten a lot of it as a kid. It may not be what I would like to eat, but I could not think that people in need, as these welfare recipients were presumed to be, would want to throw away that kind of product, but there it was. We went out there and made the trip the day after the surplus commodities had been distributed, so it is a tough thing sometimes to try to spell out in the law what you want

to accomplish, in a meaningful, understandable implementation. I can sympathize with doctors in trying to make that sort of determination, and I have great respect for your testimony.

I am sorry I did not get to hear you, Mr. Adamovich. I hear you did very well yesterday.

I would not ask you to quantify it in numbers, but what percentage, if any, would there be among these persons going to Abbott-Northwestern Hospital that came in because they had some cause to be concerned, first about their health and, second, that though they may not have felt that it was an acute illness, so long as there was no financial restraint imposed on them, what percentage if any do you think might have responded to that sort of motivation?

I am trying to find out if they were indeed ill. I would not argue at all with a single one of these cases, but whatever percent of them who came in you think might be so classified?

Mr. FLAVIN. Senator, I was made aware of a study that had been made by Travelers Insurance Co., and I would be glad to furnish it to the committee.

I have not seen the study and have no knowledge of how it came about, but it was on the subject that you are talking about and would be something we could provide for the record when it is made available to us.

Senator HANSEN. I should say, Mr. Chairman, if we could solicit a similar response to that sort of question, that sort of general question around the country, it might be helpful.

LABORATORY TESTS AND MALPRACTICE SUITS

There is one other thing that I am concerned about. I gather as the caseload increases on doctors, being aware as doctors are these days of the recourse a patient may have for a malpractice suit, it tends probably to present a situation that would be responded to by a doctor in this fashion: If he has to examine twice as many patients as otherwise normally would be the case, in order to be sure he is not sued, and is able to successfully defend a malpractice suit, he could recommend X-rays and series of laboratory tests in order to be backed up, and to make certain that he had not failed to discern something he should have picked up. Obviously if this is a typical reaction and whether it is or not I do not know, it would seem to me if I were a doctor, I would want to protect myself as best I could, and take all such steps which would not personally add to my burden. I would say get a lab test, and have X-rays made. I would do these other procedures that would give me the protection that would put me in good stead if I later got into court, and was told, "You did not pick up what was wrong with me."

If that should happen, then I should think that as we tend to bring more people in, how to keep those who are not critically ill, or not ill, from coming in, along with those who are ill, presents an extremely difficult job. I recognize that, but if we do not have some mechanism, whereby we can do that, it occurs to me that we could add greatly to the burdens of the ancillary services that are provided by a hospital,

in a number of instances for no good reason, excepting that the doctor does not want to be sued, and I can understand that.

Have you any suggestions as to how we might face and address this problem, if it is a problem? Maybe it is not.

Mr. FLAVIN. Senator, I am sure as you describe it so eloquently, it is a problem for physicians, and I think a part of our testimony indicated that. It is probably a very prudent practice for a physician to go ahead and do the thing he feels has to be done for his patient.

The problem you have with this practice is whether or not all of the services he performs for a patient are compensable under any kind of an insurance program.

I guess it is the same as automobile insurance, you would like to protect yourself right up to the very top limit, and it is a question then of whether or not you can afford to buy it, or whether they will sell it to you.

Senator HANSEN. I agree with you wholeheartedly, and I am sure the physicians feel that way about it, but the question is: Do you have the insurance coverage to pay for all of the services that the physician can provide?

I think there is another issue too, and that is, it is not just simply a case of saying that an appendectomy costs so much money, and if there are so many untreated cases, why you multiply that by the cost, and if we assume that we can put that much more money out of the Federal Treasury, everything comes out even. I think it would be wrong, because we come to the physical limitations of doctors too. Unless we can add to that professional skill, then I should think we could very well find out that simply appropriating more dollars will not be a complete answer.

I know the chairman is well aware of that fact, and has demonstrated on many occasions his concern for the medical training program, so as to make certain we have enough people to do the job.

RURAL DOCTORS DIFFICULT TO OBTAIN

Then there is another problem, Mr. Chairman, that arises in my State of Wyoming, because sometimes it is awfully tough to get doctors to go into rural areas. They kind of like the good life too, and I can understand that, and we have found that out the hard way.

Mr. FLAVIN. We have the same problem in Minnesota.

Senator BROCK. We all have that problem.

Senator MUSKIE. May I pursue this subject a bit more briefly. I am trying to understand the difference between a compensable and a noncompensable claim. Would this be an accurate way to put it?

It seems to me that it depends on what the patient tells the doctor. The patient says he has a specific pain here, the diagnostic service is related to a specific illness, and is paid.

If he says to the doctor something vague, like I don't feel well, and the test is then applied, and the specific illness then identified, then it is not paid. That may be oversimplistic, but is that a very descriptive picture of what is involved here?

Mr. FLAVIN. I think you are certainly on the right track using that example; however, I would say this; the complaint of an individual

has to be a genuine complaint. In other words, you might have a hypochondriac who would come in with some symptoms that he thinks he has.

I am talking about the legitimate complaint of a person coming in to see a physician. Then there is no question about payment.

Senator MUSKIE. Of course, the argument of the witnesses yesterday was that these are all genuine complaints, and they did not have the time really to adopt a procedure that would screen out nonsick people. That was the problem.

Getting to these minutes that you indicate you have some questions about, I would like to read part of it.

These are minutes that were kept by Richard Kramer and certified under oath by several who were present. Let me read these.

If you challenge any part of what I read, by all means say so. What I am trying to get at is the basic policy reflected by the incident, if the minutes are accurate.

Now, Sharon Blood was supervisor of the medical review team, was she not?

Mr. FLAVIN. Yes, sir.

CLAIMS PAYMENT DIFFICULT TO DETERMINE

Senator MUSKIE. The minutes say Mrs. Blood indicated that Blue Cross was stunned by the volume of the claims, and was finding it difficult to determine which claims should be paid.

She stated that it was almost a flip of the coin. Mrs. Blood indicated that Blue Cross was attempting to pick out acute problems and reimburse these claims. Blue Cross does not feel they can pay claims for diagnostic screening for chronic problems.

Mrs. Pearson, who is one of the nurses who testified yesterday, presented a case of a patient with congestive heart failure. She indicated this patient was acutely ill, yet Blue Cross rejected her total claim.

Mrs. Blood stated that Blue Cross cannot tell if the diagnosis was made by the doctor, prior to or after ordering the tests. Mrs. Blood indicated that they needed to know when the laboratory and X-ray tests were ordered.

If the diagnosis was made after the test results were reviewed, the claim would be rejected.

Mr. Kramer pointed out the recent Medicare claim form does not ask for this kind of information. He inquired if other hospitals were being asked to do this.

Mrs. Blood stated that this is not a standard procedure, but that Blue Cross was finding it difficult to cope with the volume of M.A.O. claims.

Now, this portion of the minutes suggests, it is suggested that you are inquiring into the minds of the attending physicians, and undertaking to determine from him whether or not his diagnosis was made before or after the tests, a requirement that you did not apply in other cases. It is not standard procedure. You are applying it only in this case because of the volume of claims.

Now, does Mrs. Blood challenge the accuracy of those paragraphs, to the best of your recollection?

Mr. FLAVIN. I think in the report, Senator, that she has written on this particular meeting, she does address herself to some of the issues you have just raised, and I will give you a copy of that so you may have an opportunity to read it.[1]

Senator MUSKIE. Would you state whether or not this requirement as described in these minutes was or was not standard procedure.

Mr. FLAVIN. As far as the outpatient clinics claims are concerned, I think maybe what we should do is to examine this issue just for a moment.

In my testimony, I think I indicated that it became obvious to us that there were a number of screening claims coming into us, because the hospital, as I recall, delivered to us, let us say, 100 claims. I am not sure if 100 is correct, but let us say 100 claims, and on every one of the outpatient claims they sent into us, the claims had approximately the same services, and the same charge, and my recollection of the charges would run somewhere between $90 and $110; these claims came in in a stack, and when you take a look at claims in that setting, you almost have to do something more than just take a look at the face of the claim to make some determination whether it is a payable claim or nonpayable claim.

CLAIMS EXAMINER NEEDS MEDICAL INFORMATION

In order for a claims examiner to function properly, as far as decisions are concerned in this particular area, they have got to have the same kind of medical information available to them as the hospital, or as the clinics would have, so they could make a determination.

The claims form itself is a very simple document. It is a billing instrument on the part of the provider telling how much they are charging for their hospital service.

It does not go much beyond that in the way of any information, and I think what she was saying in this particular instance, that when you have a stack of claims like that, just to take a look at that stack without any further information on it, it is most difficult to make a decision.

I would challenge anyone in the room to take a stack of claims with nothing more than the face information on them and try to make a decision, keeping in mind the regulations we have.

Senator MUSKIE. Did you meet the problem by imposing a requirement that was not standard procedure?

Mr. FLAVIN. What we asked on this, Senator, was of the hospital to take a look at these claims, because they have the medical information available to them, and to screen out those claims they knew would not be covered under the regulations, and send the rest of them to us for payment.

Senator MUSKIE. Well, they resubmitted them, as I understand, and you re-rejected them.

Mr. FLAVIN. Senator, that issue is something I want to review with our claims department and submit a report on each claim rejected.[2]

---

[1] See appendix, item 3, p. 1386.
[2] See appendix, item 3, p. 1382.

Senator MUSKIE. I understand, but these minutes suggest that you imposed a requirement for whatever reason upon this program that was not standard procedure.

Mrs. Blood is quoted as stating that this is not standard procedure, but that Blue Cross was finding it difficult to cope with the volume of M.A.O. claims.

It was pointed out that this created an expense for the business office of the medical records department. The implication is that this is a requirement you are imposing on these people that you are not imposing elsewhere.

Mr. FLAVIN. There are two hospitals that we have asked to do this particular screening for us. I mentioned one other in my testimony.

Senator MUSKIE. By screening, what do you mean, inquiring of the physician whether he ordered the tests before or after he made his diagnosis? What were you asking the hospital to do?

Mr. FLAVIN. That is part of it, yes. In other words, to take a look at the regulations, and we explained these regulations at several meetings with the hospitals, identifying the constraints we were under, and what we wanted to do was simply pay for as many cases as we could possibly pay for.

Senator MUSKIE. You have stated that, but what I am trying to ascertain specifically, is what specific requirement you were imposing. Were you requiring affidavits from the doctors?

Mr. FLAVIN. No.

Senator MUSKIE. What were you requiring?

Mr. FLAVIN. We were asking the hospital to submit those claims that they felt should be paid.

Senator MUSKIE. The testimony yesterday was they submitted them all as claims that should be paid.

Mr. FLAVIN. I realize that.

Senator MUSKIE. So what additional thing did you want? You are asking them to say, well, we were wrong in submitting these claims in the first place. Now, we think, in looking them over, that there are a lesser number of legitimate claims. Is that what you want?

Did you say what Mrs. Blood said, is alleged to have said, you required a statement of some kind from the doctor as to whether or not the diagnosis was made prior or after the tests?

Mr. FLAVIN. I am not sure that a specific question was asked.

Senator MUSKIE. Did you ask the hospital to provide answers to any kind of specific questions?

Mr. FLAVIN. We asked for medical documentation on the case.

Senator MUSKIE. This meeting of April 11, 1974, was called because of this very issue.

Mr. FLAVIN. Yes.

Senator MUSKIE. The purpose was to examine into the reasons for your rejection of the claims of this kind and to see what, if anything, could be done to solve that problem.

Mr. FLAVIN. Yes.

Senator MUSKIE. And as part of that, Mrs. Blood is quoted as having said, that this nonstandard procedure designed to get at the doc-

tor's judgment or decision as to when a test was to be ordered was imposed. Now, did that happen at that meeting?

Did she indeed say that was the critical question, as to when the doctor made the decision, and that you had to be satisfied on this point, before you would approve the claim. Is that the heart of the issue at that point?

Mr. FLAVIN. Let me take a look at something here for just a moment, Senator.

Senator, I am unable to answer your question from the documentation that I have.

Senator MUSKIE. Do you have a copy with you of that report prepared by Mrs. Blood? [1]

Mr. FLAVIN. Yes.

Senator MUSKIE. How long is it?

Mr. FLAVIN. It is about three or four pages long.

Senator MUSKIE. Could I have it to glance through?

Mr. FLAVIN. Yes.

Senator MUSKIE. It seems to me these doctors were saying yesterday that they had this flood of patients, obviously all sick, and they were not following any particular step-by-step procedure. They were trying to get at the patients' illness.

They were obviously ill. A high percentage of them were ill. It was sick versus sick, and it is in that context that I ask that question, and put that section of the minutes before you, and I would appreciate an answer.

Mr. FLAVIN. I appreciate that, Senator.

Senator MUSKIE. Now, I have before me the report. Do my colleagues have questions?

Senator BROCK. I would like to come back on one point I asked earlier of Mr. Flavin.

I had a question based upon law and regulation. Mr. Flavin, you are not allowed to pay costs of routine physical checkups, but you obviously are allowed and directed to pay for acute physical problems?

Mr. FLAVIN. Yes, sir.

Senator BROCK. Now, in rereading the minutes of this meeting, Mrs. Pearson presented a case of a patient who was uncompensated for congestive heart failure. She indicated this person was acutely ill, and yet the claim was rejected.

Mrs. Blood stated the Blue Cross could not tell if the diagnosis was made by the doctor prior to or after the tests.

Mrs. Blood indicated they needed to know when the patient saw the doctor, and what specific laboratory tests and X-rays were ordered. If the diagnosis was made after the test results were reviewed, the claim would be rejected.

Now, that says to me that you are rejecting what would under any normal circumstances be a legitimate claim based simply on the time of a screening test as opposed to a diagnosis of a particular illness. I thought I understood you to say, in answer to a question, that that was not the case. You were simply not allowed to pay for the routine

[1] See appendix, item 3, p. 1386.

screening, but if that screening which you did not compensate turned up on an acute illness, you could compensate for the illness.

Mr. FLAVIN. Senator, I think I interpreted your question to mean if based on the examination, the patient is subsequently taken into the emergency room for some sort of treatment that might be given in the emergency room, or they were subsequently hospitalized because of the examination given to them, the services are covered. There is not any question about them.

Senator BROCK. But this says they are not. Mrs. Blood indicated, and I am quoting exactly——

Mr. FLAVIN. Well, as I said, that is the way the cases are being adjudicated. If they are subsequently going into the emergency room for some treatment, or if they are being admitted to the hospital, then these cases are covered.

Senator BROCK. Well, I guess I am just not very smart, Mr. Flavin. I do not understand what the difference is if there is congestive heart failure, that obviously treatment was needed, so I would assume that they would then file a claim, and the claim was then rejected. It does not seem to jibe with what you are saying.

Mr. FLAVIN. This is a difficult area that we are in, Senator, and I think when you take a look at the claim forms that come in, you would probably identify some chronic conditions that might be listed on that particular claim form.

ACTUAL SICK ARE COVERED CASES

I think what we are trying to say here, it is difficult to say, if the condition is an acute condition, then this is something that can be paid for, but what is happening, in the screening techniques on this sort of a claim, is that—I think you brought this out earlier—is that it is a question as to—and Senator Muskie also brought this out—it is a question as to the patient, as he comes into the doctor's office, if he has a specific complaint, he is not feeling well, he has an ache here or something else, and the doctor is trying to diagnose that particular condition, this is a covered case, as opposed, Senator, to someone that is walking through the door for the first time because he is a member of the organization, and has available to him a physical examination, and he walks through the door to get his physical examination.

Senator BROCK. Thank the Lord, I have never had congestive heart failure, as far as I know, but I would not think I would feel real well. It seems to me, I would come in and say, Doc, I feel awful.

Now, is that the difference; if I come in and do not say anything, I am not recompensed; but if I say, Doc, I feel lousy, I am? Is that the kind of situation we have put you in?

Mr. FLAVIN. I would not say that is the kind of position you put us in, but it is bringing it down to some very simple terms, and the question that you always have is as to how the patient entered the doctor's office. Did he enter without any symptoms or complaint, or did he have a complaint?

Now, in the case that you are citing here, if the fellow did have congestive heart failure or condition, he might, you know, be that sick

that he needed care right away. I cannot tell you. I honestly don't know.

Senator BROCK. I think the thing that troubles me is the statement that you made which says if the diagnosis was made after the test results were reviewed the claim would be rejected, and that is the whole claim, and I do not think there is anything in the law that requires that. That is what I cannot seem to get a handle on.

Mr. FLAVIN. I do not know what tack I can make on this particular issue. It is a difficult issue. I can appreciate your concern.

On the statement that Mrs. Blood made here, she might have had a specific case in mind. I don't know. I honestly don't know what she had in mind when she made the statement.

Senator BROCK. It was a specific case.

Mr. FLAVIN. And when you talk about a specific case, it is most difficult unless you take a look at the record.

Senator BROCK. I don't care about the case. That is not the point. The point is the premise upon which you make the claim or make the payment. The premise, as I read Mrs. Blood's statement, Mrs. Blood indicated that when the diagnosis was made, after the tests, the claim would be rejected. I do not see what that has to do with it.

Senator MUSKIE. Would the Senator permit me to state something?

Mrs. Blood said, "I then suggested they supply us with some documentation to facilitate our reviews, and possibly prevent the rejection of claims that did meet program payment requirements."

Now, that is not in conflict with that version of what took place. That is more specific in suggesting the documentation ought to take some form of some statement from the doctor.

This version of what took place does not specify that form of documentation, but clearly what was being discussed is some evidence, presumably from the doctors, since we have nothing else on the point.

LAW EXCLUDES PHYSICAL CHECKUPS

Senator BROCK. I agree with that, but I think, Senator, the point you make is abundantly clear. The law was written to cover a payment of acute treatment, a treatment of an acute illness.

It was explicitly written to exclude routine physical checkups, but the two are not connected with each other. I gather from the testimony here, and from Mrs. Blood's statement, that it is being connected, that if a patient is picked up in a routine screening, that whatever disease is detected, cannot then be compensated.

Senator MUSKIE. No, I do not think that is the thrust of his testimony.

Senator BROCK. That is what this statement here says. The diagnosis was made after the results were reviewed, the claim would be rejected, and to me it says the claim is paid on the basis of when and where the test was made, and not the condition of the patient.

Mr. FLAVIN. I think the subsequent care of that patient is taken care of.

Senator BROCK. That is not my understanding.

Mr. FLAVIN. That is the case. I stated that earlier.

Senator Brock. That is what you said, but here, it seems to me, we have contradictory information.

Mr. Flavin. Again, let me point out something, we did not see these minutes until Senator Muskie sent them to us, so we had no idea of what had been going on.

Senator Brock. I am not trying to put you in a difficult position, but I do hope in having seen this, and having some time after this meeting to review the cases, that you can answer the question for me: Does the fact that a patient went through a routine screening then preclude their application for reimbursement for specific treatment and for specific illness? If it does, there is something wrong.

Mr. Flavin. In our statement to the committee, among other things, we can make a point of that.[1]

Senator Brock. Thank you.

Senator Muskie. May I at this point clarify something the Senator said. The claim that was rejected included the claim for hospital services, not the doctors.

Senator Brock. That is correct.

Senator Muskie. I just wanted to make this clear.

Senator Brock. This is what I understand it as being.

Senator Muskie. Now, may I add here, Senator Mondale has torn himself away from another hearing, since this is taking place in his State.

Senator Mondale. This issue is very close to the State of Minnesota. Are you Mr. Flavin?

Mr. Flavin. Yes.

Senator Mondale. And you are Mr. Johnson?

Mr. Johnson. Yes.

Senator Mondale. What is your position?

Mr. Flavin. I am director of Government programs.

Senator Mondale. How long have you been in that position?

Mr. Flavin. I have been director of Government programs for 8 years and employed by Blue Cross a total of 18 years.

Senator Mondale. And you, Mr. Johnson?

Mr. Johnson. I am vice president of finance. I have been with Blue Cross for 23 years.

Senator Mondale. And you have been involved on the business side, on the money side all this time?

Mr. Johnson. Yes.

Senator Mondale. Mr. Flavin, I also apologize that if I go over old ground, because I did come in late.

As I understand the law draws a distinction between routine screening and medical care. Screening is a routine checkup of people who may be perfectly healthy, and the other kind of medical care is maybe tests that doctors order in order to care for people whose symptoms suggest illness. Is that a fair distinction?

Mr. Flavin. Yes.

Senator Mondale. Now, as I understand it, the rub with Abbott-Northwestern is that you have 465 cases in which the hospital claims

[1] See appendix, item 3, p. 1382.

they provided medical services, but Blue Cross refuses to make that payment on the ground it was just routine screening. Is that correct?

Mr. FLAVIN. I do not know the number of cases.

Senator MONDALE. Is that approximately correct?

Mr. FLAVIN. Yes.

Senator MONDALE. That would be roughly correct, without pinning you down?

Mr. FLAVIN. Yes.

Senator MONDALE. And over what period of time have these 465 cases that you refused payment on accumulated?

Mr. FLAVIN. I have no idea how long it was, Senator.

Senator MONDALE. When did you first start having problems with Abbott-Northwestern on this issue?

Mr. FLAVIN. I am not sure of the exact date that we had a large number of claims presented to us.

Senator MONDALE. Well, approximately.

Mr. FLAVIN. I would say probably around the first of the year, shortly thereafter.

Senator MONDALE. Mr. Johnson, can you help him?

Mr. JOHNSON. I have no knowledge on this.

Senator MONDALE. Around February 3, says Abbott. Would that be correct?

Mr. FLAVIN. I would say after the first of the year, sometime.

Senator MONDALE. What do you do, you have approximately 460, give or take a few, refusals with Abbott-Northwestern. Is this unusual, do you have that number with other hospitals?

Mr. FLAVIN. I would say no, Senator, we do not.

Senator MONDALE. Well, what usually happens, say with the other major hospitals, do you have any refusals based upon screening versus medical?

Mr. FLAVIN. Yes, we do.

Senator MONDALE. How many?

Mr. FLAVIN. I could not give you an exact number. I have no knowledge.

Senator MONDALE. 400 for each hospital, would you say?

Mr. FLAVIN. Senator, I cannot give you an answer.

Senator MONDALE. Mr. Johnson, can you give us an answer?

Mr. JOHNSON. No.

ABBOTT-NORTHWESTERN REFUSAL RATE HIGH

Senator MONDALE. Do you think the Abbott-Northwestern refusal rate is higher than other hospitals?

Mr. FLAVIN. I would have to say, due to the volume they have, that this is a true statement.

Senator MONDALE. Substantially higher?

Mr. FLAVIN. I would say that it is higher.

Senator MONDALE. How much higher?

Mr. FLAVIN. Well, I could not give you a percentage on that either. If you have 400-some claims out of probably 2,500 that have been submitted, or something like that, it is a 15-percent ratio. I do not know whether 15 percent is high or low, as far as the other hospitals are concerned.

Senator MONDALE. You are testifying that some of the other hospitals might have just as many refusals based on this issue as Abbott-Northwestern?

Mr. FLAVIN. I would say that we would have some that were.

Senator MONDALE. As many? What I am getting at, is it not the case that this is sort of a celebrated case with Blue Cross? This is a major issue with Blue Cross-Blue Shield, Abbott-Northwestern, and health care of Minnesota, and that is what I am trying to get at, and this is probably a very high number of refusals, it is a major dispute. I am just trying to get it straight.

Now, what do you do when an application for payment comes in to you, signed by a doctor, for medical care, in which the doctor cites symptoms of one kind or another, and has ordered tests. How do you decide whether to believe the doctor or not?

Mr. FLAVIN. Senator, the claims that are coming into us are being submitted by Abbott-Northwestern Hospital, and the claims they send in to us are a reflection of the medical records that are accumulated.

Senator MONDALE. Right, but it usually includes statements by a doctor of the symptoms he observes.

Mr. FLAVIN. It would be a transcription of his record.

Senator MONDALE. Now, I have seen some of them, and they often recite hypertension, or blood in the stool, or other kinds of things. How do you decide whether to believe, or not, the doctor?

Mr. FLAVIN. I think that a little earlier here we indicated we would like to take a look at these cases, on a case-by-case basis, for the examples you have given to us, to see what, whether or not there has been some medical evidence or documentation to help us make a decision.

Senator MONDALE. To go back to my question; you get a doctor's report, that says he or she identified the symptoms that indicated illness. You decided to turn it down. On what basis would you decide to disagree with the hospital or the doctor?

Mr. FLAVIN. It would depend on the nature of the test. If it were a routine examination, we would look for the usual test given in conjunction with a routine examination.

Senator MONDALE. Give us an example of a test that is always routine.

Mr. FLAVIN. Well, it would be, generally speaking, the diagnostic studies that are being done as far as laboratory tests, X-rays, and EKG's might also be a routine test.

Senator MONDALE. If it is an EKG, is that always a screening test?

DIAGNOSTIC TESTS ON ALL CLAIMS

Mr. FLAVIN. I guess what I would have to base my statement on is the fact that the claims submitted to us, Senator, had the same battery of diagnostic tests on all of them. In other words, it was not selective. When a patient came in he had to have a specific complaint, and as far as the claim forms were concerned, they were just coming in in a general way, so that we would see three different items, X-ray, lab, for example, and then maybe one other test.

Senator MONDALE. So, what you did, you saw a pattern you perceived as routine tests, in your opinion raised suspicion that it was a screening

process rather than treatment, and that was probably the basis on which that decision was made.

Mr. FLAVIN. Yes.

Senator MONDALE. Now, Abbott-Northwestern comes in and says, we disagree with you; they file a claim for review. What do you do then when you get a claim for review?

Mr. FLAVIN. Well, generally speaking, if we do not have medical information from the hospital, or from the provider, we will ask for more information.

Senator MONDALE. Now, how many of the petitions for review from your first denial were granted?

Mr. FLAVIN. I don't know that.

Senator MONDALE. Do you know, Mr. Johnson?

Mr. JOHNSON. No.

Senator MONDALE. Were any of them granted?

Mr, FLAVIN. Were any of the re-reviews granted? I have no knowledge of that aspect of it. We can make some inquiry, and we can give you some statistics on that.

Senator MONDALE. Mr. Adamovich, do you know?

Mr. ADAMOVICH. I do not know offhand.

Mr. KRAMER. I do not know. It was very few of those.

Senator MONDALE. Now, how do you make this second review? Do you do it based on paper?

Mr. FLAVIN. Sometimes it is on the basis of paper. Other times, it would be a consultation, a telephone consultation with someone who would be knowledgeable of the case for the record.

Senator MONDALE. Who would you call?

Mr. FLAVIN. Well, I cannot give you the name. We would have communication channels, generally speaking, established between the medical review team and then some persons that would be designated from the hospital.

Senator MONDALE. In case you have a national experiment of significance to the health industry, you have hospitals that agree to provide service without deductible, without coinsurance, and have fees paid for within Medicare fee schedules, which I think is probably the only hospital in the country doing that, and as a result, you turn down a large number of applications on the ground that it was screening, and not care.

Did you do anything special with these applications to look behind them, to make certain that you were making the correct judgment, recognizing the seriousness of this effort?

Mr. FLAVIN. We held meetings with the providers to establish communication channels with them, to reassure ourselves that the claim is a good claim.

Senator MONDALE. Did you look at the individual applications, or did you just hold a meeting with the provider, by that you mean the hospital?

Mr. FLAVIN. Yes.

Senator MONDALE. You had a meeting with the hospital?
Mr. FLAVIN. Yes.
Senator MONDALE. Were you there?
Mr. FLAVIN. No.
Senator MONDALE. What took place there?
Mr. FLAVIN. We have as part of my testimony, a meeting that was held on March 4, I believe. Yes; that was held with Mrs. Blood and other medical records people.[1]

"DRAMATIC CHANGE OF POLICY"

Senator MONDALE. You are aware of the fact that the hospital testified that there had been a dramatic change of policy by Blue Cross, the checkups that were covered are no longer covered, you are aware of that?
Mr. FLAVIN. Yes, we are going to address the committee on that.
Senator MONDALE. You do not believe that is correct?
Mr. FLAVIN. All I can say is that we will give you the best of our thinking on that issue when we reply to the committee.[2]
Senator MONDALE. Now, I guess we do not have the name, but this is a form of a particular application for insurance, and the doctor, Dr. Fisher, says among other things, that the patient had blood in his stool, says that in effect there was fear of cancer, and he ordered the tests. Now, you do not believe Dr. Fisher?
Mr. FLAVIN. Senator, to that point, sir, we are not questioning Dr. Fisher.
Senator MONDALE. But you did not pay the money.
Mr. FLAVIN. But we will have to take a look at all of these claims.
Senator MONDALE. Have you not looked at them?
Mr. FLAVIN. What I am saying, I personally have not looked at them, and what we are going to do is take the claims that have been presented to the Senator, and give you the rationale as to why these claims were either paid or denied, and make that a part of the record.[2]
There is no way that I can address myself to that particular subject, unless I have the files before me.
Senator MONDALE. You did not look at the files before you came down?
Mr. FLAVIN. There was no way I could look at the files in these specific cases.
Senator MONDALE. Why?
Mr. FLAVIN. Mainly because I would not know what would be presented.
Senator MONDALE. Don't you have people in your organization to look and evaluate a file?
Mr. FLAVIN. Yes; we have that.
Senator MONDALE. Was that done prior to your coming down here?

[1] See appendix, item 3, p. 1386.
[2] See appendix, item 3, p. 1382.

Mr. FLAVIN. You mean on a specific case-by-case basis?

Senator MONDALE. Yes.

Mr. FLAVIN. No; because we did not know what kind of testimony would be presented.

Senator MONDALE. You did not know which cases had been rejected?

Mr. FLAVIN. We knew what cases had been rejected, but we did not know of the cases that had been rejected which would be a part of the hearing.

Senator MONDALE. Now, we are at the second stage. They have applied for insurance and been turned down, they come back, and you turn them down again. When they applied the first time for insurance, to whom did they apply, to whom does the patient apply?

Mr. FLAVIN. I guess maybe I am missing your question.

Senator MONDALE. Let me put it this way. They apply to you, do they not?

Mr. FLAVIN. No.

Senator MONDALE. They fill out the Medicare form and ask for coverage, right?

Mr. FLAVIN. No; that particular form goes to the part B carrier. If a claim is being submitted on the part of a beneficiary, the claims we are paying in this instance would flow through the hospital.

Senator MONDALE. So the hospital applies?

Mr. FLAVIN. Yes; and the patient signs a claim.

Senator MONDALE. So then you turn that down, and then the hospital appealing your judgment, appeals to whom?

Mr. FLAVIN. To us again. In other words, that is the normal sequence of events, and they would appeal their case, and I would say because of this decision, they submit additional evidence so we rereview the claim for payment, and at that point of time, another decision is made.

NO APPEAL FROM DECISION

Senator MONDALE. I understand from counsel, if the claim is less than $1,000, they are not permitted to go into court.

As I understand it, part A, the hospital side, you make a Medicare claim. If it is refused, you resubmit it, and there is a hearing before the same body, but there is no appeal.

On the part B, which is professional care, you make the claim to Blue Cross. If it is denied, you resubmit it to Blue Cross, and there is a hearing—but that is the end of it if it is less than $1,000. Is that correct?

Mr. FLAVIN. The $1,000 that we are talking about is part B benefits, and is actually what we are talking about here too, according to the 1972 amendments. I think that is what counsel is giving information on.

Senator MONDALE. Have hearings been requested? All right. They have gone through the first step.

What bothers me—you may recall, I worked very hard to get Blue Cross as the intermediary in Minnesota. When the intermediaries were announced, Blue Cross was out.

Mr. FLAVIN. Blue Shield.

Senator MONDALE. They came to me and asked if I would intervene, and I got the entire congressional delegation and we went down and knocked on HEW's door and insisted that they be made the intermediary of Minnesota, and I must confess at the time, I did not realize the possible conflict of interest that is involved. It did not occur to me that you also would be placed in a position where you were both the insurer and could benefit by denials in your capacity as intermediary. Don't you think that is a potential conflict of interest?

Mr. FLAVIN. Not in the least, Senator.

Senator MONDALE. Tell me why not in the least.

Mr. FLAVIN. Well, as far as Minnesota is concerned, I think at the point of time you were so graciously helpful, that was a separate corporation.

Senator MONDALE. But the Blue Shield now is part of your company.

Mr. FLAVIN. Yes; as I indicated to the committee earlier.

Senator MONDALE. But at this point, Blue Shield covers professional care which is doctors, and they would be the intermediary for doctor's fees?

Mr. FLAVIN. Yes.

Senator MONDALE. So there is that same issue.

Mr. FLAVIN. Yes.

Senator MONDALE. So would it not be possible—let us take another State where the insurer and the intermediary are the same—would it not be possible for that insurance company, in its role as intermediary, to deny claims which are valid, and thereby improve its financial position, and blame the program for failing to compensate it—is it not possible?

Mr. FLAVIN. I see no relationship to it whatsoever.

Senator MONDALE. Why?

NO CONFLICT OF INTEREST

Mr. FLAVIN. In the first place, when you are talking about singling out Blue Cross and Blue Shield as having a potential conflict of interest, I think this has to be generalized in saying if it bears a conflict of interest, a conflict of interest would apply as far as all of your carriers and intermediaries are concerned.

Senator MONDALE. Yes, I do not mean to say——

Mr. FLAVIN. What I am saying, I have failed to see where there would be a conflict of interest, because Medicare claims are handled in an entirely separate and different fashion from complementary coverage claims.

Senator MONDALE. Do you think a pitcher should be able to call strikes and balls?

Mr. FLAVIN. Let me go on further here. As far as the volume of the business that is being done in the complementary area to Medicare, it is extremely insignificant as a part of the total volume that is done, for example, by the health underwriters of the United States.

Your premiums—for example, if you want to take a look at it from that aspect, generally speaking—your premiums for supplemental coverage is probably, from $3.50 a month to probably $10 a month,

depending on the supplementation, and this is really not an impact on your total business.

I think in our State, we have maybe 50,000 supplemental contracts, between group and nongroup people, which is not a great number for us. It is a very small percentage.

Maybe some of the other underwriters have a greater percentage than that, but the point I want to make is there is no significant number whatsoever in that kind of business.

Senator MONDALE. I am not trying to browbeat you. Yesterday, Mr. Adamovich said he considers Blue Cross-Blue Shield one of the best in the country, but I do believe that there is an essential conflict of interest between this carrier being both the insurance company and the intermediary—because being very conservative on approving payments in your role as intermediary, you improve the financial posture of the corporation you also represent.

I'm not saying you did that, but human nature being what it is, is it not possible that from time to time these people might get their two roles confused to their own benefit?

Mr. FLAVIN. No.

Senator MONDALE. It is not possible?

Mr. FLAVIN. I am saying the possibility obviously exists, but whether it would happen in that particular case, is extremely remote.

Senator MONDALE. You reduced premiums and expanded coverage at one point. You announced you were reducing premiums, and you were opening up enrollment without a prior physical examination of those eligible for Medicare, so that a person with a history of ill health could still join at a reduced premium.

Mr. FLAVIN. Senator, I would not say it is a reduced premium, but it would be a premium level we had been selling coverage.

Senator MONDALE. And you had announced a reduction in those premiums?

Mr. FLAVIN. Yes.

Senator MONDALE. Could that have had anything to do with the efforts at Northwestern, or is it totally unrelated?

Mr. FLAVIN. Totally unrelated.

Senator MONDALE. Tell me why that was done.

Mr. FLAVIN. I went through it with the committee a little bit earlier, and I will not make the same lengthy statement, other than to say that due to the experience that we had with this category of business, a favorable experience, we were able to cover this particular contract at a lower rate, for example, than we did in years previous.

The reason for that being that we had lower utilization, and also phases 1, 2, 3, and 4 had an effect on costs, so that we did have an advantage in that regard; so that is the reason for it.

Senator MUSKIE. Could the Senator yield at that point? I have listened to this explanation, and I think it ought to be followed by addressing some other points.

I understand what you said and the rationale, you tend to point in the direction of reduced rates, but here are some other offsetting factors, it seems to me, and I would like you to take them into account in your response.

It is my impression that health costs are climbing twice as fast as the cost of living. It is clear that Medicare coinsurance and deductible increased last year, the latter going from $72 to $84.

I think it is true that this is the fourth straight year that Medicare has paid less of the average senior total health expenses, dropping from about 42 percent to only 40 percent at the end of last year.

ELDERLY PAYING MORE

In short, the seniors are paying more out of pocket. It costs them more and more to participate in Medicare, and they are getting less and less in return. It is true, it seems to me, because of these factors, the so-called medi-gap policies sold by private insurance must absorb the load of decreased Medicare coverage. If you sell a senior coverage that Medicare will not cover, it seems to reason this policy must cover more today than a year ago, because Medicare is covering less. All of this being true, and I think it is, then how do you offset all of those upward pressures with the explanation that you have given? That is the first part of my question.

The second part of my question is, in what other States has Blue Cross reduced rates in light of these facts?

Mr. FLAVIN. Senator, to your first point, I certainly agree with you, the statistics that you have recited here are well known statistics; however, there is one thing I think we have to take into consideration, it is this: when you take a category of business, such as our complementary coverage to Medicare, this part of our business, or this segment of our business, has to be rated strictly on the utilization of that particular part of our business, or that chunk of our business, so if we had a favorable period, and, notwithstanding all the other considerations, and we have a favorable experience on this contract, it is then within the province of the corporation to reduce rates or increase benefits.

We had a couple of options, and in our case, the decision was made to reduce the rates. You are looking at a very small part of the health care dollar, or health care picture. You are only looking at just those people, and their experience, and their experience was good, so, therefore, they received a rate reduction.

Senator MUSKIE. Could you provide the statistics for Minnesota between 1972 and 1973, and give us a comparison between those statistics and statistics from other States and the country as a whole? Then I would like you to answer the second part of my question. Is there any other State in which Blue Cross reduced rates for the same reason?

Mr. FLAVIN. Senator, I would have to yield to our national organization for that type of inquiry. I would not have that information sitting over in Minnesota, but I am sure that that information is available.

Senator MUSKIE. I always knew that you Minnesotans were a healthy breed. How about the open season business?

Mr. FLAVIN. That is a common thing to do with a contract offering. I think there is a certain period of time when Federal employees can change their coverage around, and it is also done on Medicare.

Senator MONDALE. I am excited by the fact that it was in Minnesota where a highly skilled and respected hospital and team of physicians, commenced a program which permitted all of our elderly citizens to come in with no costs to them, except the part B premium, and their coverage under Medicare, and this is a thrilling concept, and according to their testimony, although they did not get rich, they could see where they were going to make it go.

In other words, we were seeing the beginning of what could be part of the answer in America to this heartbreaking health need of senior citizens, and they were letting everyone come in with no additional costs, and they were able to make it go.

NATIONAL IMPLICATIONS SEEN

The thing that jeopardizes that whole effort now is that they are getting a lot of turndown on their insurance coverage on the grounds that it is screening, and not actual professional care, thus it seems to me that this issue takes on national implications, and I would hope in Minnesota we could solve this and be the leader in the country, and I would hope that the Blue Cross-Blue Shield could go back now, and work with the hospital and the professionals there, see if they could iron this out, and we could show how it could be done, and all over the country, private insurers, working with hospitals, could say to our senior citizens, "Come on in, you are covered by Medicare, we will take care of your problems," because this would be a thrilling achievement. Do you not agree?

Mr. FLAVIN. I think that would be a thrilling achievement. I particularly like the statement that you made, to get the two constituents together, which would be Blue Cross and the hospital in this particular issue.

Whether or not some of the things you envision being accomplished at this meeting, will depend on regulations or a new view toward regulations in concert with the Bureau of Health Insurance. We will certainly take a new look at the problem.

Senator MONDALE. As I understand, the manager of the hospital, he said they were making a go with it, but they have to get coverage for the services they were providing, and of course, it seems to me we have a particularly difficult problem here.

It is not a senior citizen fighting for himself or herself, or for $300, as they claim.

First of all, you cannot go to court. Second, if you did, knowing my profession, it would cost more than you would get.

Pardon me, Mr. Chairman.

Senator MUSKIE. You said it was your profession.

Senator MONDALE. Yes; so that there you sit, so there they sit, some of them die, some of them very ill, and with pennies.

I think this shows here when they open this up so that it is just a few dollars saved monthly in premiums, they swamp the hospital.

This is not $300 or $400. This is a difference of a few dollars a month. Just that made the difference which brought a gusher of senior citizens coming in, and according to the testimony of these professionals, some of them were close to death, many of them were very sick, desperately

needing care—so we are talking about something here that is very fundamental, and I am sure you realize that, and I am hopeful that we can solve this.

That is why what you are going to submit to us is very important. What you might be able to work out with that hospital could have national implications.

Senator MUSKIE. Thank you, Senator Mondale. I would like to echo Senator Mondale's expression of hope, and I think probably every member of the committee would.

It seems to me there is some evidence of failure of communication. I think there is some evidence of failure to fully take into account the special circumstances of this program.

BASIS FOR NATIONAL POLICY

I would like to see this program work. I think you have got something here that could well form the basis for national policies, and if there are problems in this particular demonstration, we ought to know what they are and try to work them out.

I think all of us come to this hearing with a positive point of view. I think you do, Mr. Flavin, but I think we do not always, even with a positive attitude, take fully into account the thing that we are trying to do.

We have another witness. The cloture vote on the floor is about 1 p.m., so I would like to give our witness an opportunity to perhaps present and complete his testimony before that vote.

We would appreciate the submission [1] that you have agreed to give us, in the reasonable near future, and I express my appreciation to both of you.

Mr. FLAVIN. Thank you for inviting me, Senator.

Senator DOMENICI. Mr. Chairman, I must leave, and I think my colleague, Senator Hansen, has to leave. We both have to go to another meeting. Will the chairman permit me to just supplement Senator Mondale's remarks just before I leave?

Senator MUSKIE. Of course.

Senator DOMENICI. Senator Mondale, I compliment you on your observation of what this might do. From my standpoint, I think I am prepared to say that not only do I hope that they work out the present dilemma to the maximum extent possible under the laws, but if the problem is the fault of the law, I think that we have an excellent opportunity to address ourselves to a very specific legislative solution to many of our problems.

I would tell the distinguished Senator from Minnesota that the nurse yesterday who summarized what she saw, impressed me most. What she was saying was don't consider this to be a clinic and a care center for senior citizens, but rather consider that we have put together an agency for senior citizens and have built into it a responsive ingredient of health care. To the extent they built into this senior citizen center total comprehensive availability of care, to the extent they built in a reputable hospital, the medical society, volunteers from the

[1] See appendix, item 3, p. 1382.

medical profession, supplemented by their clinic, to the extent that we can show that this will work, and to the extent that we are willing to make modifications to see that it does, then we offer hope for a senior citizen agency in all parts of the United States, one which can try to put together the health ingredient that this total agency developed.

Program Destruction A Step Backward

If we destroy that ingredient, by making this unworkable, I submit we are taking a step backward to the piecemeal solution to senior citizen problems, and we are throwing out the health care element. We are saying do it out there on its own, under traditional approaches to Medicare and volunteerism and cooperativeness between hospitals and doctors, whereas here we have an opportunity to pull it into a comprehensive program. As one doctor said, the volunteerism aspect would solve the problem, if there were not such restricted Medicare payments to supplement their volunteerism.

The neurologist said that very succinctly, that those who were contributing to this program are going to fail, and this as an example will fail, if in fact they do not see their way clear to even breaking even on the things that they otherwise would get paid for out in the community.

That is all they are asking of the program, and this is our dilemma, because they are using the hospital for that kind of service, and the hospital is being denied the claims that they think they need to compensate and supplement their volunteer effort. Not only do I think this could be a model, and they should try to make it work, but I think we should try to find out to what extent we can change things to make sure it does become a model available in other parts of the country.

Senator Mondale. I think that is a very valid statement. I also think that we have got to focus on the phenomena of the situation in which the insurance carrier and the judge are the same.

This is not to in any way integrate their attempt, but it is conceivable that the one passed on by the intermediary could be used by the other, and I think appearances are important, and I could understand why there would be suspicions.

Senator Domenici. I just wanted to add one more thought, and then I will turn it back to the chairman.

Basically, it seems to me, Mr. Chairman, that in most of these programs, the old adage of being penny wise and pound foolish applies.

I would leave for the record an example. Within the last 5 days in my own home State, we had two senior citizens who were probably sick enough to be hospitalized, but they had a homemaker service available to them, where someone came around and helped them, so they were more than pleased to stay at home, even though they were ill.

Their Social Security payments went up. They were then asked for a statement on the amount of money they were making. They moved into another income bracket, and because of another set of rules, the home helper was denied to them.

Now, what we did in that instance was call a doctor. He went over and looked at them. He said if there is nothing else available, they are both admittable to a hospital, and we will put them in a hospital. There goes the institutional approach.

Institutionalization More Costly

They will be in there, and we will pay far more money from the tax coffers of this country, we will deny a far better environment. That is inherent in this whole discussion, because the preventive aspects of this are enormous. Wherein we have taken those out of the health care approach, we have really moved toward a system which says: "Wait until you are so sick that we can institutionalize you." Then all of the things we have spoken of today go down with it, and I would not be surprised from the money standpoint, if we end up using more money for that national policy than we would another approach, a portion of which is here.

Senator Muskie. Thank you, Senator Domenici. I might recommend to your attention my bill, S. 2690, pending before the Senate to include homemaker services under the Medicare program.

Senator Domenici. I am cosponsor of that, Mr. Chairman.

Senator Hansen. I would like to just add one small comment.

Mr. Chairman, let me say this, I think we have to keep in mind what we have as Americans is only a reflection of the total output of this country in goods and services. It is not simply a case of doing what we would like to do.

We would all like to do more and more. I am one who feels that way. I would hope not less keenly than anybody else, but I recall what Senator Hughes said, a man not without compassion, some time ago, when we were talking about what could be done with nursing homes in this country.

The hearings followed some tragic fires in which a number of people were burned to death. One idea that was presented was to have one-story buildings with two doors, one to a central hallway, and the other out into a backyard, so in case of a fire, people could get away. This, and what was proposed to be done about upgrading the food services, and the nurse availability generally on a 24-hour basis, prompted Senator Hughes to say: "You know, if you do all of the things you are talking about, we cannot afford it."

Thank you, Mr. Chairman.

Senator Muskie. Well, I think one of the real points in this Minnesota experience is not simply better care, but it is people that are not receiving it, and to structure a program that would provide proper care to patients is the issue.

We thank you very much, Mr. Flavin and Mr. Johnson.

Mr. Flavin. Thank you, Mr. Chairman.

Senator Muskie. We will now hear from Mr. Thomas M. Tierney, Director of the Bureau of Health Insurance, Social Security Administration.

Mr. Tierney. Thank you, Mr. Chairman.

Senator Muskie. Mr. Tierney, we have kept you waiting long enough. It is certainly a pleasure to welcome you back.

Mr. Tierney is appearing in response to a letter which I addressed to him on June 13, 1974, bringing to his attention the minutes of the meeting which took place on April 11, and he was good enough to appear today to respond.

STATEMENT OF THOMAS M. TIERNEY, DIRECTOR, BUREAU OF HEALTH INSURANCE, SOCIAL SECURITY ADMINISTRATION

Mr. TIERNEY. Thank you. I will not go over all of the details, which I know you all know so well now.

Let me say, if I may, Mr. Chairman, a couple of things about the Medicare coverage to get them in total perspective, and then speak directly to your question.

We do cover in the Medicare program outpatient services, both in the outpatient department of hospitals, in the clinics, and in the doctor's office, and the basic coverage is defined as those services which are comprehensively furnished.

Now, on the negative side, and I guess that is what we are all talking about and expressing concern about here today, is the provision that you referred to, Mr. Chairman. In section 1862(a) of the law, it is provided that notwithstanding any other provisions of title XVIII, the program will not cover expenses incurred for services which are not reasonable and are not necessary for the diagnosis and treatment of illness or injury, or improving the function of a malformed body member.

The applicability of that provision to this situation is debatable, I am sure, from a philosophical point of view, Mr. Chairman. However, there is another part of that section which I think is perhaps more directly involved here, and that is subsection 7, which excludes from Medicare coverage expenses for routine physical checkups.

Now, as I sat and listened this morning, it seemed to me all of the conversation was really revolving about whether these were routine physical checkups or were there symptoms for which a doctor was seeking further documentation of a diagnosis.

Let me say further, if I may, Mr. Chairman, that we think that the services that the hospitals are rendering, and that the Minneapolis Age and Opportunity Center is rendering, are excellent. Obviously, they are doing that. But if you look through the record, you find that there was a letter,[1] a very honest, straightforward, good letter to potential clinic members, in which it says:

> We are setting up an appointment for you to receive a complete diagnostic screening. We will ask you to return for your physical, and someone will be there to direct you.

Nothing wrong with that. It is excellent, but I think I would have to say that it raises a question as to whether or not this is within the exclusion that is so mandatory in the law.

Let me say further, Mr. Chairman, I am sure you know that the congressional decisions setting up the Medicare program and amending it every 2 years since its inception, has been appropriately based on establishment of priorities, and selection of priorities, with limited funds.

[1] See appendix, item 3, p. 1385.

There is not and has never been any purpose in the Medicare program merely to deny claims. Within the limits of the law, it is established to pay claims. That is the philosophy of the Congress, and that Mr. Chairman, has, on occasion, been forcibly brought back to our attention by the Congress. It is our intention to try to do that not only within the word, but also within the spirit of the law. We are obliged, therefore, to identify situations where there is a routine physical checkup, and direct that it not be compensated.

That is a very tough problem. What is a routine physical checkup, as opposed to a diagnostic workup? I do not know how to answer that problem. We have thought of it in these terms.

If you are feeling fine and robust, and nevertheless go to your doctor and get your annual physical checkup, because that is a good thing to do, then that is what it is.

If you have got a stomach ache or something else wrong with you, that you are concerned about, and you go in to ask the doctor about it, and he does a diagnostic workup, then that is something different.

Before you tell me I am fooling with words, I know I am fooling with words, but there is a distinction.

Senator MUSKIE. Could I put a specific question to you?

What you have here is something that is not either of those. As I understand the testimony, what we have here is a backlog of people who have been accumulating symptoms, pains, illnesses, and refusing to do anything about it because they cannot afford the doctor's fee. Suddenly they are given an open door, and they go in and get some treatment, some health care, and so almost by definition, they are people who are coming in with specific symptoms.

Now, are you saying that they must specifically identify their illness before the doctor opens his mouth. Before any contact is established, they must identify a specific symptom which is later related to a specific illness?

It seems to me we have got a different kind of case. I may be wrong, but what I discussed up to this point is clearly black and white.

I have no problem with that, but here you have a flood of patients who have been held back of a wall, back of a dam, because they cannot afford to come in.

Senator MONDALE. Were you here yesterday?

Mr. TIERNEY. No.

Senator MONDALE. Did you have anybody from your office?

Mr. TIERNEY. Yes, I think I did.

Senator MONDALE. I am wondering whether they heard those doctors. These are very able doctors, and some are on the University of Minnesota hospital staff, and they have been testifying of direct symptoms that could lead to death.

Mr. TIERNEY. Then if they go in because of that situation, and the doctors have to perform services to diagnose and treat, they should be paid for that.

Senator MUSKIE. Is it fair to make an assumption of the class of people when they come in? Do you have to meticulously lay out a step-by-step procedure which avoids the risk that you pay a claim that is

really a routine physical examination when what you have got is a class of patients all of whom are in trouble healthwise? Do you have to go through the meticulous programing of procedures?

Senator MONDALE. It sounds like the common law of remedies of 1200, where if you said the wrong thing, you are out of court.

Mr. TIERNEY. I think it is a difficult but valid distinction.

If, for example, you said, one of the things we should provide is an annual physical examination. You could send all 23 million people in for those. That would be a wonderful thing especially since aged people often have something wrong with them, but it costs a lot of money. So when you start out to take care of people's health, it is a question of whether that is one of the benefits that we should try to cover.

I am not here to argue with the Senator that it is not. I am arguing that it is not in the present law.

PHYSICAL EXAMINATION FOR ALL EXPENSIVE

Senator MUSKIE. Then you see no difference here between the initiation of this program, in Minneapolis, which had the specific appeal to a specific group of old people, and the enactment of the Medicare program? That is the comparison you are making. We did not include it in the Medicare program in the first instance, because we cannot afford to provide an annual physical examination for all.

That is one case, but you see no difference between that and the circumstances of this group of patients? That is what I am asking.

Mr. TIERNEY. I think I do see a difference, Senator, in this respect, and I am not saying this because these people are here or there is anything wrong with the rest of the health system of the Nation.

These people were refreshingly open and honest. They said that there is a need in Minneapolis to detect and define the health problems of the aged people, so please come in and have your physical checkup, and that was wonderful.

Of course, other hospitals have checkups going on, and doctors are doing routine diagnostic workups in their offices, and often there is no way to detect that. Please understand that although routine physicals are prohibited from coverage under the law, detecting them can be very difficult.

Senator MONDALE. Will you yield there?

As I understand it, for a few weeks they were sending out that letter, but in any event, under that program, the hospital itself, they never submitted a claim to Blue Cross and Blue Shield for the original visit by the senior citizen.

Not only that but the hospital picked up the cost of diagnostic tests; it was only when a client saw a physician which was the third step, and the physician thought there was a need for tests, and required a physical.

It was only then that they submitted the cost of what was then the third appointment.

Mr. TIERNEY. If that be true, Senator——

Senator MONDALE. Is it true?

Mr. TIERNEY. I don't know.

Senator MONDALE. Why are you saying what you are saying, if you do not know?

Mr. TIERNEY. I am saying that is what appears in the letter. Is what you say——

Senator MONDALE. You have made a charge based on a letter, and you apparently have not checked into this. Are you aware of this issue?

Mr. TIERNEY. Yes, sir.

Senator MONDALE. Do you consider it a serious one?

Mr. TIERNEY. Yes, sir.

Senator MONDALE. Have you looked into it yourself?

Mr. TIERNEY. Yes, in the time that has been available to us.

Senator MONDALE. How much time have you had?

Mr. TIERNEY. Since June 20.

Senator MONDALE. Have you sent anybody out there to look into it?

Mr. TIERNEY. We have had our regional office make a report on it.

Senator MONDALE. What did they tell you?

Mr. TIERNEY. They report very much what has apparently been reported to you for the last few days.

Frankly, I did not get out of the last witness' testimony that there was no charge for the services. I thought he testified he was swamped with bills for these services.

Senator MONDALE. Am I correct in my statement of the facts?

Mr. ADAMOVICH. What happened on the first group, Senator, was that all of the Medicare forms were sent in, and the first batch sent back. The batch was never contested by us, and then beyond that, I think it was the February 3 date, from that time on, there was no point for us to contemplate anything like the screening, because of the volume, and load of very sick patients coming through the door.

Senator MONDALE. So it was only from then on out that the clients or the physician, and the physician ordered tests, that the bills were submitted?

COSTS ABSORBED BY ABBOTT

Mrs. KRAUSE. Senator, phase 1 was never submitted. The nursing costs were absorbed by Abbott—they were never submitted. The reason the letter was sent out was because the seniors were never told, they were never told that there was going to be a diagnostic and a physical, and senior citizens get embarrassed about underwear and that kind of thing, so I sent a letter out saying you are going to have a physical.

That is the charge that Mr. Adamovich is referring to. That finished that entire thing by the end of January, because we did not have enough doctors to do it and take care of those sick people, and yet those people were still rejected.

Mr. TIERNEY. Then I would suggest to you, Senator, there is a failure of communication. If the facts are that these people are getting an examination by a doctor, and a determination of a therapeutic need, and it is after further tests are made, and not at the time of the screening exam, then I do not think the two parties have been conferring very well, Mr. Chairman, because as you read it in the law, diagnostic services which are reasonable and necessary for the treatment and health care of the people are covered, physical examinations are not.

Senator MONDALE. Will you have somebody check into that?

Mr. TIERNEY. Yes, sir, of course I will.

Senator MONDALE. What about this discussion of the situation in which the insurer and the intermediary are the same? Does that raise problems with you about a possible conflict of interest?

Mr. TIERNEY. Senator, I think when you say the possible conflict of interest, you have to say yes, it raises a question.

I thought there was one point that maybe was not made with you, and that is that the intermediary and carrier have no financial gain or loss in paying or denying Medicare bills. It is all Federal money. They do not underwrite benefits. They draw on the Federal Treasury every week, and the more they pay, the more they are reimbursed. There is no profit in their paying less.

Senator MONDALE. What about part B?

Mr. TIERNEY. That is true with part B.

Senator MONDALE. There is no incentive then to be conservative in the determination?

MEDI-GAP INSURANCE

Mr. TIERNEY. Yes, in one area, Senator. There is a potential, and that is that some companies have put out complementary insurance in which they say that they will pay, for example, the amount that Medicare does not pay of the Medicare reasonable charge in part B.

To the extent they make a determination that this is not a Medicare eligible payment, then their money is not involved either. That is a potential conflict.

Senator MONDALE. You are talking about medi-gap insurance, and here you have a situation where the medi-gap insurer and the intermediary are the same person.

Now, since they are underwriting what Medicare does not cover, the more Medicare does not pay, the more they have got to insure; is that not correct?

Mr. TIERNEY. Not really, except that if you turn down the thing as a whole, if you find, for example, this is a noncovered service, then we are off the hook, they are off the hook.

Senator MONDALE. In other words, they are off the hook, and they are going to save money.

Mr. TIERNEY. If they make a decision this is a noncovered service; yes, sir.

Senator MONDALE. Do you think it is possible that there may be one person in America who might get into that conflict where he will be enriched by denying the people coverage which they deserve?

Mr. TIERNEY. One person out of 220 million; yes, sir, certainly.

Senator MONDALE. Does this conflict bother you?

Mr. TIERNEY. Yes, sir, it bothers us, but we think that the mechanisms are there to assure its nonoccurrence: The surveillance, and continuing watch to see that is not done, and some reliance on State insurance commissions, and a tremendous reliance on the people.

When this sort of thing happens, we now have 1,100 district offices, and we do hear a lot of complaints, but we do not see a pattern of this. It is a possibility.

Senator MONDALE. Would you support legislation to bring us out of this conflict of interest, so that the intermediary would not have an incentive to deny claims in order to enrich themselves in their other role of insurers?

Mr. TIERNEY. In fairness to the whole industry, Senator, I would think there ought to be some evidence that that is happening, in even a remote case, rather than just the assumption.

Senator MONDALE. You have never seen any examples of this; is that right?

Mr. TIERNEY. No.

CONFLICT OF INTEREST POSSIBLE

Senator MONDALE. I do not believe you. Maybe you think you are telling the truth, but I think the conflict is so obvious, it is almost inevitable; and when we realize these poor people do not have any money, they do not have lawyers, they are not going into court, and what is more, under the law, their only appeal is the people who will be enriched by turning it down; and you sit there and say there is not any problem. I think it is ridiculous.

Mr. TIERNEY. Senator, let me say this to you. There is a basic common procedure when a patient goes into a Medicare facility, or to a Medicare doctor, or gets any Medicare services, the intermediaries and carriers draw on the Federal Treasury to pay the bill, and that is the end of it.

On the part A or hospital side, for example, what the complementary insurer is then called upon to pay is the original $84. If you are saying that there could be a pattern of turndown in order to avoid paying that $84, I would have to say that I would have to see more evidence of such a practice.

Senator MONDALE. You do not think an insurance company would rule against the claim of benefit itself?

Mr. TIERNEY. I think in the business, this has always been said, Senator, that when you do rule against a claim, you avoid a loss, but I think it is minimized where it is not their money.

Senator MONDALE. But where it is their money, then you say there is a conflict that might exist?

Mr. TIERNEY. Yes.

Senator MONDALE. I had a mother that went to a hospital with cancer, and they canceled her insurance; so I am not convinced that private insurance companies are the same as the United Fund, and I think, we ought to try to separate these conflicts of interest where we can.

Senator MUSKIE. Just one final question, Mr. Tierney.

To the extent that the minutes indicate the lack of real effort to determine individual patient situations, they are not in keeping with the Bureau's ongoing efforts to a clearer understanding between providers and fiscal contractors. We intend to address that problem.

My question is how?

Mr. TIERNEY. In this particular situation, Senator, the obvious way to do it is to sit down with the parties and find out what is behind

all of these minutes, and when did they start submitting claims which were not for routine physical examination, and try to iron it out. I have every intention of doing that.

Beyond that, we have to just constantly try to communicate what is and what is not covered. Even in this hearing this morning, I think there was confusion, that if there is a health condition detected by a routine physical examination, then the beneficiary is out of luck with regard to subsequent therapy.

That is not so. We still might not pay for the routine physical, if that is what it was, but if an illness is detected through such an examination, then Medicare would certainly pay for all of the services involved.

Senator MUSKIE. I think it would be very helpful to the committee if you would thoroughly inquire into this particular situation with a view toward identifying their hangups, resolving them if possible, and make this program work, and then submitting a report to us.[1]

You have been here all day. You have listened to the testimony. There is no point in my belaboring the questions that have been raised.

I think you fully understand that what we want is not a confrontation. What we want is a workable program, and we think this is sufficiently exciting to look at with a positive perspective.

I would think that Blue Cross-Blue Shield people would do the same, from everything I have learned, they have an excellent reputation in Minnesota. So I would like to see them address it with the same spirit and then report back to us. Then we can get a job done and stay off the television, although, I think, their presence helps us to tell a story.

Mr. TIERNEY. I know of your constant interest in the health of the aged people of this country, and I can only tell you the administration has an equal interest, and will be glad to work with you and report to you on this.

Senator MUSKIE. I am sure of that. Thank you.

The hearing will be recessed.

[Whereupon, the hearing was adjourned at 1 p.m.]

---

[1] See appendix, item 2, p. 1378.

APPENDIX

LETTERS AND STATEMENTS FROM INDIVIDUALS AND ORGANIZATIONS

ITEM 1. POLICY STATEMENT REGARDING COVERAGE OF OUTPATIENT SERVICES, MINNEAPOLIS AGE AND OPPORTUNITY CENTER, INC.; SUBMITTED BY THOMAS M. TIERNEY, DIRECTOR, BUREAU OF HEALTH INSURANCE, SOCIAL SECURITY ADMINISTRATION

As we understand the situation which has evolved in Minnesota, the Minneapolis Age and Opportunity Center developed a plan with Abbott-Northwestern Hospital to provide health services for aged people who were members of the Center. A clinic known as Community Medical Associates PA was set up to provide physicians' services and to bill for all services provided. This clinic is a separate organizational entity operating as a physician-directed clinic independent from the hospital. The hospital performs all of the laboratory and X-ray tests for the members of the Center, and the clinic furnishes only the physicians' services, working with the results of the laboratory tests.

The Minneapolis Age and Opportunity Center sends out letters to all its members (aged persons with limited incomes) inviting them to visit the Abbott-Northwestern Hospital for complete diagnostic screening tests at designated times. Subsequently they are asked to report for a physical examination by a physician at the Community Medical Associates Clinic. The results of the hospital tests are used by the clinic physician in conjunction with the physical examination to determine the state of the individual's health and to provide any needed drug prescriptions.

Part B of the Medicare program covers outpatient services, both in the outpatient hospital setting as well as in a nonhospital setting such as a doctor's office or a clinic. The basic coverage is defined in section 1861(s)(2)(A) and (B) of the law in terms of:

> "Hospital services . . . incident to physicians' services rendered to outpatients", and
>
> "Services and supplies furnished as an incident to a physicians' professional services of kinds which are commonly furnished in physicians' offices and are commonly either rendered without charge or included in the physicians' bills."

On the negative side, however, section 1862(a)(7) of the law provides that:

> "(a) Notwithstanding any other provisions of this title, no payment may be made under part A or part B for any expenses incurred for items or services—
>
> "(7) where such expenses are for routine physical checkups . . ."

The denial of the claims filed for diagnostic services provided to members of Minneapolis Age and Opportunity Center was based on this statutory exclusion.

Intermediaries and carriers who assist the Secretary of Health, Education, and Welfare in the administration of the program have the responsibility of reviewing all bills to determine whether the requirements of the law are met. The basic guideline which has been followed in determining whether a diagnostic test is part of a routine screening procedure is whether the particular service was prompted by a specific illness, symptom, complaint, or injury. Such determinations are not simply lay judgments. Carriers and intermediaries are expected to be assisted by their medical staffs in making these determinations and, if necessary, are expected to consult with outside professional bodies in difficult or unusual cases.

I would like to emphasize that the statutory exclusion of these services was not intended to reflect on their value or on the importance of preventive medicine generally. It is simply a matter of the way the priorities were assessed in the initial enactment of the Medicare law. The decision then was to primarily cover hospital costs and related care and physicians' services for persons who are ill since these are the health care costs which a majority of older people find difficult to finance. As you know, the Department has proposed to cover as part of its comprehensive health insurance proposal those preventive services that have been demonstrated to be both medically desirable and economically cost effective. With regard to routine physicals, these criteria are only met for children.

A review of the minutes of the meeting between the representative of Abbott-Northwestern Hospital and a representative of Minnesota Blue Cross indicates to me that there has been a lack of communication and a mutual lack of understanding. In response to the Chairman's specific question as to whether or not the minutes reflect official BHI policy, I would say that perhaps the description of legislative limitation on the basic Medicare benefit is exact but failure to delve into the specific facts of various specific situations is unfortunate and reflects the necessity of a much clearer understanding between the clinic and the intermediary as to the appropriate definition of services. If a large number of the rejections were based on the fact that the claims really did result from an invitation to come in for a physical examination, that would be in keeping with the law and regulations. To the extent that the minutes indicate the lack of any real effort to determine individual patient situations, they are not in keeping with the Bureau's ongoing efforts toward a clearer understanding between providers and fiscal contractors. We intend to address that problem.

ITEM 2. LETTER AND ENCLOSURES FROM THOMAS M. TIERNEY, DIRECTOR, BUREAU OF HEALTH INSURANCE, SOCIAL SECURITY ADMINISTRATION; TO SENATOR EDMUND S. MUSKIE, DATED SEPTEMBER 16, 1974

DEAR SENATOR MUSKIE: This is a followup to my previous report of July 31, 1974, with regard to Medicare payments to the Abbott-Northwestern Hospital and the Minneapolis Age and Opportunity Clinic. You will recall, of course, that complaints from these two organizations were, in part, the subject of your subcommittee hearings on June 26.

This final report from our regional office is very lengthy but perhaps the statements made by our Regional Representative in his memorandum to me of August 30 are of particular significance. They indicate that both Mr. Daum and the director of the clinic appear to be satisfied with the results obtained.

If there are further developments, I will let you know, and if there are any other questions from you or members of your subcommittee, I will be glad to answer them.

Sincerely yours,

THOMAS M. TIERNEY,
Director, Bureau of Health Insurance.

[Enclosures]

MEMORANDUM

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE, REGION V—CHICAGO.

HI–22–a.
July 29, 1974.
Refer to: IHI:95:C22.
To: Director, Bureau of Health Insurance
From: Regional Representative, HI.
Subject: (1) July 23, 1974 meeting between Travelers Insurance Company—Minnesota, Abbott-Northwestern Hospital (ANH), the Minneapolis Age and Opportunity Clinic (MAO) and Community Medical Associates (CMA); (2) July 24, 1974 meeting between B/C of Minnesota, ANH, MAO Clinic, CMA, and Minneapolis Age and Opportunity Center.

As I stated in my July 24 telephone conversation with you, the two meetings produced what I believe will continue to be a cooperative working relationship between the participants which will allow the prompt and proper processing of claims. Both meetings produced a common understanding of the issues involved in the problem, the coverage policy which needs to be applied, and a working agreement to move forward and to process both accumulated and future claims. In addition, the channels of communication were solidified so that any further question can be resolved.

I am providing a rather lengthy report on each of the meetings since I think it explains the basis for concluding that this problem is resolved.

I. THE JULY 23, 1974 MEETING—A LIST OF PARTICIPANTS IS INCLUDED AT THE END

The Travelers Insurance Company opened the meeting by identifying the objectives. These were:

(1) To clarify the routine physical examination exclusion,

(2) To apply this clarification to the claims the carrier is holding,

(3) To reach agreement upon the information needed to process future claims, and

(4) To address the other issues of reasonable charge and patient obligation to pay for the services.

The representatives of the Hospital, MAO, and CMA agreed that these were the objectives.

The carrier went on to state that where a beneficiary comes in as a result of a call-in letter and the beneficiary has a complaint which requires a followup, it would consider that the patient came in to see the physician for the complaint and that the exam would be covered, unless the complaint was so slight that it would be unreasonable to expect the individual to seek medical care.

The carrier's investigation of a sample of the 400 claims which it is currently holding resulted in the conclusion that the great majority of beneficiaries visited the Minneapolis Age and Opportunity Clinic because of symptoms or complaints that required treatment. Both the hospital and CMA representatives substantiated this conclusion from their description of how the MAO program operates. Dr. Werges, CMA, stated that the vast majority of individuals who visit the CMA doctor came because of a medical problem which they wanted to have treated. He estimated that about 10 percent of the patients were complaint-free and he would be the first to conclude that the service provided was a routine physical exam. Furthermore, it was agreed that in the event that the routine physical resulted in the need for further treatment or diagnosis, those subsequent services are covered under the law subject to medical necessity.

Based upon the above, the carrier stated the general conclusions it had reached regarding the claims it is holding. The carrier's review of the claims shows that 50–70 percent of those claims show medical conditions which substantiate the coverage of the physician visit. Another 20–40 percent may require additional information which is within the clinic's medical records. The carrier and the clinic agreed to work together this week to identify any needed information. The clinic asked what would serve the carrier's future needs best. The carrier said it would like to see both complaints and diagnosis on the claims form. Dr. Werges stated that this is exactly what he has been trying to do and would expect to see this procedure followed by the other clinic physicians. Essentially all parties agree that this would be a sound and unencumbering procedure to follow for future claims. In addition, Dr. Werges stated that the physician would be in the best position to identify those situations where the beneficiary came in for the purpose of a routine check-up and that these claims would not be submitted.

The discussion concerning the reasonable charge involved two issues. First, it is clear that CMA is charging 4 different rates for an office exam ranging from $10 to $50 depending on the nature of the exam.

The other issue concerned the level of reimbursement. The carrier explained a problem of different allowances for the same service which is not corrected and provided CMA with the prevailing charge levels it had requested.

The carrier asked CMA whether it was billing other third parties. CMA is to the extent that there is other third party coverage. Claims are being submitted to Title XIX and reimbursement is being received. Thus the no legal obligation to pay exclusion does not apply as this is all we require of other similar clinics.

In conclusion, the carrier indicated that they would confirm, in writing, that

the "call-in" letter would not be the sole basis for denying a claim as a routine physical exam. As you know, Travelers had earlier written to the clinic advising them that claims *would* be denied on the basis of the "call-in" letter. The carrier is meeting with CMA personnel this week to resolve the problem claims and to help CMA set up a mechanism to provide the information the carrier needs to process claims on an ongoing basis. The carrier will also audit a sample of claims frequently at first in order to make sure that the process is working smoothly. CMA supported this idea wholeheartedly.

My own conclusions are:

(1) Understanding of what is and what is not a covered service exists.

(2) The current backlog of claims can, in most cases, be processed without the need to contact the beneficiary.

(3) The clinic physicians are providing different levels of services according to the medical needs of the patient, and are charging accordingly.

(4) The no legal obligation to pay exclusion is not at issue.

The carrier expects to process the vast majority of the 400 accumulated claims within two weeks. I will supply you with processing information until the job is completed.

II. The July 24, 1974 Meeting—See the Listing of Participants at the End

Because the difficulties in this situation seemed more severe, the meeting objectives appeared to be more broad. Mr. Kramer, assistant administrator of Abbott, stated that he hoped to:

(1) Describe how CMA and the Hospital related and operated.

(2) Reach agreement concerning the routine physical exam exclusion.

(3) Resolve claims processing problems, thereby ensuring the processing of claims Blue Cross has pending and reaching an understanding for future claims processing.

The clinic has a three year history but services were provided primarily on an outpatient and emergency room basis until November 1973 when services were expanded to the Minneapolis Age and Opportunity Center membership. As of November, the patient load increased dramatically. Essentially, the patient would first see a health counselor who would determine general financial status and who would explain the program. Secondly, the individual would be interviewed by a nurse to screen out those needing immediate medical attention. Approximately 10 percent of the patients were determined to need this attention and were referred to the emergency room for services. Thirdly, the remaining patients were scheduled to see a physician and also scheduled for a battery of tests generally prior to the physician visit. This set-up continued until February 3, 1974. After February 3, the patients were scheduled first for the physician visit and diagnostic testing occurred subsequently, if necessary.

The period after February 3 did not present difficulty in reaching agreement upon the definition of a covered service. Dr. Werges understood the requirement that diagnostic tests be related to the medical necessity of the patient's condition. He explained the medical decisions he has made in evaluating clinic patients. Dr. Woodley, Medical Director of Blue Cross of Minnesota, agreed that the medical procedure which CMA followed was consistent with the nature of the beneficiaries' complaints, symptoms, and history. Screening tests such as pap smear were understood to be excluded under Section 1862(a)(7) by all parties in the absence of symptoms, complaints, or medical history relating to the test. Dr. Woodley and other B/C personnel stated that based upon the review of the claims submitted after February 3, the majority of the tests were medically indicated, were not routine screening tests and would, therefore, be covered. The conclusion of the intermediary and Dr. Werges was essentially identical in that there would be a small percentage of services which were routine and also a large percentage of pap smears which were given for routine screening.

Pre-February 3, 1974 claims were more difficult to adjudicate because of the fact that many patients were given an identical battery of tests for screening purposes. Therefore, the parties agreed that claims involving the pre-February 3 services would be reviewed against the medical records of the Clinic.

A sample review occurred immediately after the meeting. This review showed that a number of diagnostic tests were performed as a result of a CMA physician or emergency room physician order upon examination of the patients. In other words, the sample indicated that a sizable number of claims for this period would be covered and payable; other claims showed services which were a battery of screening tests and would not appear to be covered. Mrs. Lavetta Pearson,

Director of the Clinic, participated in this review and reached the same conclusion. This concluded the meeting.

In my opinion, the meeting produced the following conclusions:

(1) All parties reached a general understanding of covered versus noncovered tests.

(2) B/C would begin processing of the 1,300 claims inhouse. Those involving services after February 3 can be processed mostly from the information already indicated on the claim. For those prior to February 3, the intermediary will send two of its personnel to the clinic. They and clinic personnel will use the clinic's medical records to determine coverage. This will be scheduled promptly at the convenience of the clinic.

(3) Mr. Daum, the hospital's director of finance, had to leave the meeting a little early, I spoke to him before he left and he felt very satisfied. B/C Management are going to meet with him promptly to discuss audit related questions and to assure that there is a common understanding of claims processing decisions.

(4) CMA physicians and the hospital will establish procedures in the next few weeks to eliminate submission of claims for routine services.

I will provide ongoing processing information to you.

I think it is necessary to add that this July 24 meeting also involved the events which occurred between the parties within the last few months.

Robert Miller, president of Abbott-Northwestern, stated strongly that past events were unfortunate. He concluded by stating that the meeting today was indicative that future communication would be no problem.

Daphne Krause, executive director, MAO, stated that she would write to the Senate subcommittee stating that a good meeting took place. The Senate has also asked the hospital to document on an ongoing basis those services which are not paid and to identify their cost.

I think we can reasonably conclude that the meetings produced results satisfactory to all parties.

PARTICIPANTS OF JULY 23, 1974 MEETING

H. Hansen, assistant director of finance, Abbott-Northwestern Hospital.
Richard Kramer, assistant administrator, Abbott-Northwestern Hospital.
Ray Daum, director of finance, Abbott-Northwestern Hospital.
Lavetta Pearson, director, Community Medical Services.
Thomas Werges, M.D., Community Medical Services.
William Lanzo, administrator, The Travelers Insurance Company.
Richard Vargason, The Travelers Insurance Company.
Vern Olsen, The Travelers Insurance Company.
Kate Oleen, The Travelers Insurance Company.
Pat Donohue, The Travelers Insurance Company.
Robert Green, SSA.
Judy Stec, SSA.
Terry Cullen, SSA.

PARTICIPANTS OF JULY 24, 1974 MEETING

Robert Miller, president, Abbott-Northwestern Hospital.
Donald Woodley, medical director, B/C of Minnesota.
James Flavin, Medicare coordinator, B/C of Minnesota.
Gerald B. Long, claims manager, B/C of Minnesota.
Betty Eddy, claims supervisor, B/C of Minnesota.
Richard Kramer, assistant administrator, Abbott-Northwestern Hospital.
Ray Daum, director of finance, Abbott-Northwestern Hospital.
Lavetta Pearson, director, Community Medical Services.
Thomas Werges, M. D., Community Medical Services.
Daphne Krause, executive director, Minesota Age and Opportunity Center.
Chuck Wieson, Minneapolis Age and Opportunity Center.
Jim Vargness, Minneapolis Age and Opportunity Center.
Joseph Walhowicz, attorney, Minneapolis Age and Opportunity Center.
Homer Kinney, attorney, Minneapolis Age and Opportunity Center.
Robert Green, SSA.
Judy Stec, SSA.
Terry Cullen, SSA.

ROBERT C. GREEN.

MEMORANDUM

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE, REGION V—CHICAGO.

HI-22-a
Date: August 30, 1974
Refer to: IHI:R5:C22
To: Director, Bureau of Health Insurance
From: Regional Representative, HI
Subject: Abbott-Northwestern Hospital and the Minneapolis Age and Opportunity Clinic—Current Status

Since my July 29 report to you on this situation, both the intermediary and the carrier have completed the processing of backlogged Abbott-Northwestern and Minneapolis Age and Opportunity Clinic claims. The subsequent claim flow and adjudication is proceeding smoothly. Ongoing communication between the parties has been established and is cooperative. A more specific summary of the situation with each contractor follows:

MINNESOTA BLUE CROSS

The intermediary completed processing of the bulk of backlogged outpatient claims (about 1,300) early this month. About 500 claims required added development and were adjudicated onsite. Of these, 76 claims represented noncovered services at charges of about $90 per claim and are being fully denied. The intermediary is in the process of taking this action and has reviewed these decisions with clinic personnel. The clinic director has indicated agreement with prior miscellaneous denials by her signature on each claim and will do the same with this larger volume.

Blue Cross cannot give payment and denial dollar amounts for these claims without considerable manual effort since subsequent claims were processed simultaneously. Our resident representative contacted Ray Daum, financial director of Abbott-Northwestern, early in the month and was advised that payment for most of the backlogged claims was received. Mr. Daum was satisfied with the results.

THE TRAVELERS

The carrier completed processing of the 400+ backlogged claims early this month. Although the carrier cannot supply exact dollar figures for the claims, the following estimates give a summary of the adjudication.

Submitted charges totalled about $20,000–$25,000. About 90 percent of the claims represented covered services and were accordingly paid. The total amount paid cannot be estimated precisely but MAO is satisfied despite the fact that most visits were reduced for reasonable charge. It was not necessary to contact beneficiaries for information nor has this become necessary in the ongoing process.

Currently, the carrier is receiving nearly 1,000 claims per month resulting in payment of about $25,000. Denials range from 5–10 percent. The bulk of ongoing claims represent followup office visits and in-hospital physicians' services. The claim involving the initial comprehensive office exam is now rare since the clinic is unable to accept many new patients given their staffing.

Any added information is developed onsite although about 90 percent of the claims can be processed without added development.

In summary, the reports from both contractors are favorable and in addition, our resident representative spoke with George Adamovich, Administrator of Abbott-Northwestern, early this week who advised that the Hospital is satisfied and will probably prepare a letter to you indicating their satisfaction with the resolution of the problem.

ROBERT C. GREEN.

ITEM 3. LETTER AND ENCLOSURES FROM JAMES L. FLAVIN, DIRECTOR OF GOVERNMENT PROGRAMS, BLUE CROSS-BLUE SHIELD OF MINNESOTA; TO SENATOR EDMUND S. MUSKIE, DATED AUGUST 15, 1974

DEAR SENATOR MUSKIE: Consistent with my statements made during your committee hearing on June 26, 1974, relative to a review of Abbott Hospital outpatient claims for members of the Minneapolis Age and Opportunity Clinic, I am

herewith submitting for the record our findings and the subsequent decisions made based on those findings. In addition to the claims issue, other issues raised at the hearing will also be responded to for the record.

CLAIMS ISSUE

It is our understanding that at the hearing the claims discussed below were used as examples of inconsistency between the way outpatient claims were adjudicated in 1970 as opposed to claims adjudicated after November 1, 1973, with similar diagnosis.

Minneapolis Age and Opportunity cases 603, 605, 607, 610, 612, and 614 were all outpatient claims for services incurred in 1970. These claims were subject to the normal screening procedures employed at that time. The services involved were determined to be covered under the Medicare program and reimbursement was made.

In December, 1973, we became aware that the Minneapolis Age and Opportunity Clinic had greatly expanded their program. Initially, they submitted a substantial volume of claims for services that appeared to be part of "routine screening" examinations. Because the hospital was unable to screen the claims, a procedure was set up whereby we, in our capacity as intermediary, would return any questionable claim to the hospital. If the hospital felt that the claims contained covered services, they were to submit additional medical information for our review. Claims 602, 604, 606, 608, 609, 611, 613, and 615 were adjudicated under this procedure.

Subsequent to your hearing, we received from Abbott Hospital the necessary medical information for review of these claims and have made the following determinations in consultation with our medical director.

Case No. 602—Claim will be paid with the exception of the Pap smear which was performed without relationship to the diagnosis.

Case No. 604—Claim will be paid.

Case No. 606—Claim will be paid.

Case No. 608—Claim will be paid with the exception of the Pap smear which was performed without relationship to the diagnosis.

Case No. 609—Claim is not payable since the services were performed to meet the requirements of a routine physical examination to complete the necessary papers for admission to a nursing home.

Case No. 611—Claim will be paid.

Case No. 613—Claim will be paid with the exception of the Pap smear which was performed without relationship to the diagnosis.

Case No. 615—Claim will be paid with the exception of the Pap smear which was performed without relationship to the diagnosis.

In considering alleged inconsistencies in claims processing, it is not relevant to compare the claims processing techniques of four years ago with current methods because none of the patient treatment phases defined by Minneapolis Age and Opportunity were in effect prior to November 1, 1973.

Four sources of information are used to complete item 13 on the outpatient claim form, "nature of illness or injury." They are (1) present symptoms, (2) past history and physical, (3) laboratory and X-ray test results, and (4) final diagnosis. It would be highly unlikely that, in any two cases, the data from these four sources could be similar enough to make a meaningful comparison of individual claims possible. Phase one, again as defined by the Minneapolis Age and Opportunity Clinic, began on November 1, 1973, and the outpatient claims submitted subsequent to that date confirmed a different method of entry into their health care delivery system than was in effect from the inception of their program to November 1, 1973. In our view, prior to November 1, 1973, a conventional entry into their system was used whereby a physician was seen prior to any diagnostic tests being ordered. Phase one changed that concept and standing orders were used to perform certain diagnostic and screening tests on all patients before they saw a physician.

With regard to other outpatient claims submitted by Abbott Hospital for Minneapolis Age and Opportunity members, 3,167 claims were received between July 1, 1974, and August 7, 1974, of which 3,091 were processed and seventy-six (76) are pending. Of the total 3,167 claims, 504 claims in contention were reviewed on August 6, 1974, at the Minneapolis Age and Opportunity Clinic site by Betty Eddy, manager of part "A" claims, Kathy Walstad, provider relations

representative, Beth O'Leary and Donita Dahm, both registered nurses from our medical review department.

The on-site visit was made to expedite claims adjudication by reviewing medical records in the Clinic rather than reproducing medical records and sending them to the intermediary. Ms. Pearson, manager of the Minneapolis Age and Opportunity Clinic, was with the Blue Cross representatives a majority of the time and was very cooperative. The results of the on-site review are shown below:

STATUS OF CLAIMS

	Services prior to Feb. 3, 1974	Services after Feb. 3, 1974	Total
Paid in full	17	47	64
Total rejects	180	10	190
Partial payment (Pap smear deleted)	2	172	174
Pending additional information	62	14	76
Total			504

The 76 pending claims will be adjudicated in the same routine as the 428 already processed. Ms. Pearson will be a part of the review team and cosign any claims that are determined noncovered.

Medicare Complementary Coverage Issue

In compliance with the committee's request to study and report on cancellations of Blue Cross Medicare Complementary Contracts after November 1, 1973, impliedly due to the Minneapolis Age and Opportunity mode of operation, we have the following comments and observations.

We contacted the Minneapolis Age and Opportunity office to secure a roster of their membership to compare to our membership roles and further check Blue Cross and Blue Shield of Minnesota cancellations from Minneapolis Age and Opportunity members. Our requests was refused on the ground that supplying the information would violate confidentiality.[1]

In a further attempt to satisfy the committee's request, a review was made of all the outpatient claims submitted by Abbott Hospital from the Minneapolis Age and Opportunity Clinic members, from November 1, 1973, to July 1, 1974. The review is significant as lines 10 (10) and eleven (11) on the SSA outpatient claim form No. 1483C ask the beneficiary to list his insuring organization and his policy number. *Not one claim form listed Blue Cross and Blue Shield of Minnesota as an insuring agent.*

Blue Cross and Blue Shield Medicare Complementary Rate Reduction

Blue Cross and Blue Shield of Minnesota offer a selection of six different complementary-to-Medicare contracts to our senior citizens. These contracts offer different benefit levels with commensurate rates. Our two most popular contracts, representing 92 percent of our complementary subscribers, had a combined loss ratio and administrative expenses of 75 percent in calendar year 1972 and a comparable 82 percent ratio for the first six months of 1973. Since we are not in business to make a profit, we felt, based on this favorable economic experience, that we owed it to our senior subscribers to reduce the rates on the various Medicare complementary contracts by fifty cents to one dollar and fifty cents a month. In addition to the rate reduction, we have also absorbed the latest increases in Medicare deductibles and coinsurance.

Although we appear to be the only Blue Cross plan which has reduced its Medicare complementary contract subscription rates during the past year, at least 25 other plans have found it possible to increase their benefits and/or absorb the higher deductibles and coinsurance imposed by Medicare without increasing their rates.

[1] See p. 1385.

I hope that this information concerning the alleged cancellation of complementary coverage by Minneapolis Age and Opportunity Clinic patients and the reasons for our reduction in subscription rates will dispel any misconceptions that may have arisen at the hearing.

For the record, we are submitting a copy of Miss Sharon Blood's memorandum [1] relative to the April 11, 1974, meeting with Abbott and the Minneapolis Age and Opportunity staff people.

Thank you for permitting me to respond to those issues raised during our testimony; if you have any further questions regarding information for the record, please contact me.

Sincerely yours,

JAMES L. FLAVIN,
Director, Government Programs Division.

[Enclosures]

AUGUST 1, 1974.

Mr. GERALD R. LONG,
Manager, Government Programs, Medicare,
Blue Cross of Minnesota, St. Paul, Minn.

DEAR MR. LONG: Thank you for your letter requesting the names of our clinic patients so that you could check for how many of them have dropped their supplementary insurance. Unfortunately, I do not see my way clear to provide you with this list without breaking client confidentiality.

The only way I could legally do this is to obtain a written consent from each of our clients, giving us permission to supply you with their names and addresses.

As this would mean writing to some 8,000 clients, you can see how this would overburden our agency to the point that we would have to stop serving many of our clients in order to do so.

Therefore, I am sorry that I must refuse your request for the above reason.

Sincerely,

DAPHNE H. KRAUSE,
Executive Director, M.A.O., Inc.

MINNEAPOLIS AGE AND OPPORTUNITY CENTER, INC. (M.A.O.),
Minneapolis, Minn.

DEAR CLINIC MEMBER: In order to give you the quality health care and supportive services which we are committed to provide for you, we are setting up an appointment for you to receive a complete diagnostic screening. Following this, probably within a week, we will ask you to return for your physical with one of our doctors, at which time you will also receive the reports on the diagnostic screening and any prescription you need. This will enable you to take advantage of the discount prices for prescription drugs at either Abbott or Northwestern pharmacies if you wish to do so.

Because of the many new people coming into the clinic, we do urge your patience and cooperation, so please try to keep the appointment we have assigned to you which is Wednesday, December 19th at 10:00 a.m. The appointment will be at Abbott Hospital, 110 East 18th Street. Someone will be there to direct you to the place for your tests.

If you are unable to come at the appointed time, please call the Minneapolis Age and Opportunity Center at 332–6311 immediately, at which time a new appointment will be made for you. This will allow us the opportunity to schedule someone else in your place.

If you are unable to provide your own means of transportation, we will provide you with a ride to and from the clinic. Call M.A.O., 332–6311 if you need transportation. We ask that you request transportation only if no other means are available. Our services are limited, but we will help anyone who has the need.

Sincerely,

DAPHNE H. KRAUSE,
Executive Director, M.A.O., Inc.

---

[1] See p. 1386.

BLUE CROSS AND BLUE SHIELD OF MINNESOTA

INTEROFFICE MEMORANDUM

To: J. Flavin
From: B. Eddy
Date: March 5, 1974
Subject: Meeting on MAO program—Abbott Hospital—Held March 4, 1974
Provider representatives: Mr. Wayne Abell, Marian Kuehn, Medical Records
Intermediary personnel: Betty Eddy and Sharon Blood

This meeting was held at the request of Mr. Abell to discuss the disallowed outpatient claims for services rendered to enrollees of the MAO program.

Before we discussed the claims in question, I asked Mr. Abell to give us some background on the MAO program and explain to us what the procedures were for providing these services.

He indicated that several thousand applications had been mailed out to senior citizens, 65 or over and that most of these had been returned.

These were then screened to insure the financial status of the applicant met the requirements. At this time over 500 applicants qualified for enrollment and had already been given a physical examination.

He said that they had been screened by an R.N. in the MAO clinic and then sent to the outpatient department at Abbott Hospital for lab, chest x-rays and EKG tests.

On a return appointment the history and physical examination was then completed by a physician.

This confirmed what Scott Froelich had told me earlier.

At this point I explained the fact that outpatient services must be incident to physician's services to be covered under the Medicare program.

He said that some patients had been referred to a physician prior to the diagnostic tests because they had an immediate need.

It was explained to him that in most of these cases payment could be made only for services relating to the complaint or symptom.

After a general discussion of what constitutes covered services, I then asked if they (the hospital) would assume the responsibility for screening these claims and submit to us only those that were not routine physical examinations.

Mr. Abell indicated that "administration" would not allow them to do this.

Consequently, we set up a procedure whereby our claims department would carefully review these claims.

After learning of the requirements for coverage Mr. Abell stated that he was going to verify the financial status of each of the MAO enrollees. This had not been done initially. He indicated that some of these people might be disqualified and this would lessen their liability.

BLUE CROSS AND BLUE SHIELD OF MINNESOTA

INTEROFFICE MEMORANDUM

Copy to: Betty Eddy, Dick Lindquist
To: Provider File
From: Sharon Blood
Date: April 22, 1974
Subject: Abbott Hospital—MAO Clinic

On April 11, 1974, I met with the hospital-clinic staff to discuss the MAO program in terms of Medicare requirements for reimbursement of the cost of the services rendered to the MAO clinic patients.

Provider representatives included Mr. Abell, Doctor Bonewell, Mr. Daum, Mr. Kramer, the R.N. clinic coordinator—Mrs. Pearson, and medical records and business office personnel.

The discussion was opened by myself at which time I stated Medicare's position regarding reimbursement. I cited the definition of a routine physical examination and how it applied to the initial health assessment examination that was given to every MAO clinic patient as he enrolled in their program. Doctor Bonewell was adamant in disagreement with our concept since he, as a physician, had to provide a complete checkup for every patient to identify their medical prob-

lems because he could be charged with malpractice if he missed something. He also stated that almost every patient had a complaint or symptom of some disease or condition that required diagnostic or therapeutic consideration. I explained that simply due to the type of people that were solicited for enrollment, it would be a rare and unusual case to identify a completely healthy individual among the group. I also stated we appreciate the fact that persons who are financially indigent can now receive proper medical care is of undisputable value in terms of health care. However, the fact that the enrollment in the program includes a health assessment physical examination does not negate the routine aspect of that service.

I stressed the fact that it is only the initial examination that is not payable under the Medicare program. Once health problems have been identified and the patient requires treatment, the services provided as a followup are not considered to be routine in nature and are therefore reimbursable services.

The question was then raised as to who would be making the determination of whether or not the services were routine. I indicated that we felt it was up to them to screen the claims and not submit those that were for the routine screening physical examination. It was pointed out to me that administration would not or could not allow them to do this and therefore, they would continue to submit all claims for all services to our office and that we would have to make the determination. I then suggested that they supply us with some documentation to facilitate our reviews and possibly prevent the rejection of claims that *did* meet program payment requirements.

When asked if we require other hospitals to submit records with their outpatient claims, I stated that we do not routinely require such information and that it was not a requirement of them—only a suggestion to facilitate our reviews. When asked if we are reviewing all outpatient claims this closely, I stated no—it is only because of the nature of the MAO clinic and our determination that Abbott is routinely submitting claims for services that are not covered under the program. The statement was then made that we are discriminating against their hospital. I replied that Mt. Sinai Hospital, who has a similar program, has also been asked to comply with our request to either not bill for the services or submit records with the bill for review. Again, we were accused of discrimination against them and I replied that it was a matter of interpretation of the word "discrimination." That is to say, if only two hospitals have a program of this nature and because of that program we require special documentation and do more intensive reviews of the outpatient services provided by those hospitals, then we are discriminating against them. However, if and when any other hospital sets up such a program, then they too would fall in that category of review. I then concluded that *only if* every hospital in the state had such a program could there no longer be "discrimination" since the same requirement would then apply to all of them.

The entire group was generally dissatisfied with the disallowance of the services and not at all receptive or understanding of our position as an intermediary. Their defense of the need for reimbursement of the services was based entirely on the grounds that "these persons need medical care and they cannot obtain it any other way." I explained that Medicare is a Federal Hospital *Insurance* Program and was not set up to be an HMO or welfare program. To date, Medicare does not make provisions for health promotion and maintenance and preventative medicine, or take into consideration such factors as social, environmental or economic problems.

The exception to the group was Mr. Abell. He is quite knowledgeable of the Medicare program requirements and had given them all photos of the manual where routine physical examinations are defined in an attempt to clarify our position and supported me throughout the discussion. While he feels that this type of program is definitely needed and worthwhile, he does appreciate our position and has been most cooperative in all areas of concern.

The meeting started at 8:30 a.m. and ended at 11 a.m. I was then taken on a tour of the MAO clinic by Mr. Abell and Mrs. Pearson.

○